DECEMBER 2020

NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

As the COVID-19 crisis evolves, we're continuing to make updates on our COVID-19 Preparedness and our COVID-19 Related News pages. Be sure to check these pages frequently for updates including COVID-19: Texas Provider FAQ and COVID-19: FAQs for Medicare Providers.

Updates on our Prior Authorization Expansion to AIM®

What's Changing?

In October, we notified you the utilization management vendor that manages certain outpatient prior authorizations for some members will be AIM Specialty Health® (AIM) effective Jan. 1, 2021. Be sure to review that notice for the impacted plans and services.

Consider these Key Dates for the Transition of Care between eviCore and AIM

- AIM's ProviderPortal℠ will be open for you to begin submitting prior authorization requests on Dec. 21, 2020, for dates of service on or after Jan. 1, 2021. You can submit requests via the AIM ProviderPortal 24/7 or by calling **1-800-859-5299** Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a.m. to noon, CT on weekends and holidays.
- Do not submit prior authorization requests to eviCore for dates of service that start on or after Jan. 1, 2021.
- Continue to submit prior authorization requests to eviCore through Dec. 31, 2020, for dates of service before or on Dec. 31, 2020.

Join Us for A Webinar to Learn More

It's important to attend online training sessions to learn how to use the AIM ProviderPortal. Visit the AIM training page to view and register for webinars coming in December and January.

Also, you can find **code lists** for the services that require prior authorization on our provider website. Remember code lists are periodically updated.

Check which services need prior authorization for your patient by using Availity® or your preferred vendor or call the number on the back of the ID.

How can you prepare?

- Attend a training session listed above.
- Make sure you have an **account** with **AIM** by accessing the AIM ProviderPortal or call the **AIM Contact Center** at **1-800-859-5299.** If you are already registered with AIM, you do not need to register again.

Reminders

If benefit prior authorization is required, services performed without benefit prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Look for future news and updates on upcoming training and FAQs that will provide important information you need regarding AIM. If you have any questions, you may contact your Network Management Representative.

Requests for Medical Records

Medical record documentation may be requested by BCBSTX to determine the medical necessity for services in conjunction with BCBSTX policies. Additionally, medical records may be requested to meet quality standards in applicable health care regulations.

BCBSTX participating providers are required by their agreements to establish and maintain an accurate medical record for members. At a minimum, the medical record should:

- Include information about the member and a description of all services rendered as dictated by generally accepted practices and standards,
- Be maintained for the period of time required by applicable law
- Be established and maintained in all instances as required by the BCBSTX Policies and Procedures, as defined in your participation agreement.
- Be legible, complete, dated, timed, and authenticated.

As set forth in your participation agreement with BCBSTX, Providers are required to respond to requests for medical records from BCBSTX timely and **at no cost**. This requirement extends to records requested by not only BCBSTX but also its designees/third party vendors. All records must be submitted to BCBSTX within the requested timeframe **at no cost**. If you receive a request for medical records, we encourage you to reply within 3 to 5 business days to ensure there are no delays in claims processing.

BCBSTX values its relationship with all participating providers and appreciates their prompt response to all requests for medical records. If you have any questions, please contact you Network Management Representative.

BEHAVIORAL HEALTH

Billing for Psychological and Neuropsychological Testing

Proper coding of specific services provided for psychological and neuropsychological testing can help expedite claim processing and support accurate claim payment. Review common Current Procedural Terminology codes for billing these testing services. Read More

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Screening and Treatment of Depression

Screening and Treatment

The Anxiety and Depression Association of America (ADAA) states that major depressive disorder affects 16.1 million American adults, 6.7% of the adult population (ADAA, 2020). Depression may adversely affect treatment, barriers, and management of other chronic medical conditions. Patient outcomes improve when the patient is screened for depression, assessed for symptoms and provided treatment. Screening should be implemented with adequate evidence-based screening tools to ensure accurate diagnosis, efficient treatment and appropriate follow-up.

Treating Depression

A positive depression screening should consist of advising on screening results, providing an individualized, evidence-based treatment that includes a follow-up assessment and support for medication adherence and referral to behavioral health when needed.

Depression is remarkably responsive to antidepressant therapy, but only if the patient receives appropriate treatment in a timely manner. Proper treatment of depression has been proven to effectively reduce depressive symptoms, decrease the risk of relapse and recurrence, and decrease emergency department visits and hospitalization rates (Simon, M.D., 2019).

Screening for Depression in Adults: Recommendation Statement. (2016, August 15). Retrieved September 29, 2020

Depression and Diabetes

Members living with diabetes are at risk of developing several psychological conditions. Approximately 40% of people living with diabetes struggle with their mental wellbeing[1]. The demands of diabetes often lead to depression and studies show there is a bidirectional relationship between diabetes and depression.

Depressive disorders occur two to three times higher in people with diabetes mellitus[2]. Disability occurs up to two to three times higher in people with diabetes and depression[3]. There are numerous considerations for people living with diabetes, such as medication management, managing multiple comorbidities and monitoring their blood glucose. This balancing act and continually changing environment can negatively affect their emotional wellbeing. As diabetes self-management can be complicated, a multifaceted approach must optimize treatment and offset the adverse risks. The timely diagnosis and treatment of depression may improve members' quality of life and increase their social participation.

Mental Health Considerations

Help empower your patients to manage their own care. Patients with diabetes may feel more comfortable discussing depression and other psychological pressures with a primary care provider instead of a mental health specialist. Medication reviews and counseling on medication changes should be a part of every encounter. Identify patients with psychological and emotional needs, ask them about their emotional wellbeing and use a validated screening tool. Make a plan together for treatment options and the next steps. Consider referring to mental health provider and even consider providing the member with structured education. If you are referring to a mental health provider, coordinate care together and let the patient know you will remain active in their care.

[1]Kalra, S., Jena, B., & Yeravdekar, R. (2018). Emotional and Psychological Needs of People with Diabetes . Retrieved September 29, 2020

[2]Diabetes and Mental Health. (2018, August 06). Retrieved September 29, 2020.

[3]Riddle, M., M.D. (2019, January). Diabetes Care. Retrieved September 29, 2020

Magellan Connection: Partnering with PCPs for Behavioral Healthcare

Magellan Healthcare® is contracted to perform **behavioral health** managed care functions for some Blue Cross and Blue Shield of Texas plan members. Magellan offers access to a variety of resources and services that can assist you in enhancing medical and behavioral outcomes for your patients.

Website resources

The *Magellan PCP Toolkit* is designed to give medical practitioners the information and screening tools needed to assist in making behavioral health referrals. The *Toolkit* offers numerous platforms and tools for standardizing and streamlining effective collaborative relationship such as:

- Clinical Practice Guidelines
- HEDIS Quality Measure Information Specific to Behavioral Health
- Diagnostic Screening Tools
- Community Resources

Collaboration of the PCP and the behavioral health professional

- can improve the safety and efficacy of services to support better
- outcomes for members.

The Magellan Health member website offers useful behavioral health self-management and educational tools. The member website also provides access to the Magellan *Provider Search* (provider directory).

Magellan's Customer Care Contact Numbers:

For Blue Advantage HMO℠ members call **1-800-729-2422 or call the number on the back of the member's ID card to arrange a referral to a behavioral health provider, request a consultation with a Magellan medical director or speak with a care manager.**

- Contact Magellan Healthcare for **assistance with screening your patients for co-occurring depression and substance abuse.**
- Magellan also offers case management support for members with complex behavioral health needs to assess, plan, implement, coordinate and evaluate options and services to meet a member's clinical and medical needs. Activities vary based on the specifics of the member's needs.
- Case managers help create a personalized plan of care for every member.

We strongly recommend referral to Magellan's case management program for patients whom you suspect may be suffering from severe and persistent mental illness.

Magellan's Webinar Series: Improve patient outcomes

Care coordination is an integral component of the relationship between behavioral health providers and a primary care provider. It is especially important for members with chronic conditions who are receiving care from various settings. When behavioral health care is coordinated and integrated, our Blue Cross and Blue Shield of Texas members will benefit.

Magellan Healthcare® has a series of webinars to assist primary care providers, using National Committee for Quality Assurance (NCQA) preferred practices and performance measures for coordination across all settings of care. These webinars provide recommendations and guidance on crucial Healthcare Effectiveness Data and Information Set (HEDIS) Measures such as:

- Strategies for care transition
- Improvements and recommendations specific to mental health populations, and those with mental illness who could subsequently develop an acute medical disease such as diabetes.

The Magellan Healthcare HEDIS Webinar series include:

- Follow-Up After Hospitalization for Mental Illness (FUH)
- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Initiation and engagement of Alcohol & Other Drug Dependence Treatment (IET)

For more information, access Magellan resources and/or contact Magellan's Provider Services directly at **1-800-788-4005**. Please direct our Members to Magellan's Customer Care Line at **1-800-729-2422**.

CLAIMS & ELIGIBILITY

New Electronic Duplicate Claim Rejections for Commercial Claims

In the March 2020 News and Updates, we announced that, as of April 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) would start implementing new electronic claim submission validation edits for commercial Professional and Institutional claims (837P and 837I transactions).*

Starting in December 2020, duplicate claim validation edits will be implemented for commercial 837P and 837I transactions when submitted to BCBSTX. Upon implementation, you may see new duplicate claim rejection messages on the response files from your practice management/hospital information system or clearinghouse vendor(s).

If you receive a duplicate claim rejection, the affected claim will not be found in our system, as BCBSTX does not create claim numbers (document control numbers) for rejected claims. To verify real-time status of the **original** claim number, use the **Search by Member** option in the Availity® Claim Status tool. For navigational help, see the Availity Claim Status user guide on our Provider website.

If you have questions regarding an electronic claim rejection message, contact your practice management/hospital information system software vendor, billing service or clearinghouse for assistance.

This new duplicate rejection edit does not apply to Medicare Advantage or Texas Medicaid electronic claim submissions.

Submit Electronic Claims via Availity® at No Cost!

The Availity Provider Portal offers providers a **no cost** solution to submit electronic Professional and Institutional claims (ANSI 837P and 837I transactions) to us. Electronic claim submission can accelerate the claim and reimbursement process.

You must be registered with Availity to use the **Claim Submission tool** for electronic professional and facility claims. You can sign up at Availity, at **no charge**. For registration assistance, call Availity Client Services at **1-**

800-282-4548. This Availity portal option doesn't require the use of a separate clearinghouse or practice management system.

How to Access and Use Availity's Claim Submission tool

- Log in to Availity
- Select **Claims & Payments** from the navigation menu
- Select **Facility Claim** or **Professional Claim**
- Within the tool, select your **Organization, Transaction Type and Payer**
- Complete the required fields

Online claim submission via Availity allows you to submit a single claim or add to batch and send multiple claims to BCBSTX at the same time. Once submitted, you can confirm BCBSTX's receipt of the claim(s) and check claim status in real time, all within the Availity portal.

For More Information

Watch for the new **Electronic Professional Claim Submission User Guide** and **Electronic Facility Claim Submission User Guide** coming soon to the Provider Tools section of our website.

Learn more about the electronic claim submission process by referring to Claims Filing Tips - Claims Submissions on our provider website.

If you need further assistance or customized training, contact our Provider Education Consultants.

Availity Provider Portal Offerings

Review the advantages of using Availity and learn why they should be your preferred vendor for checking claims and eligibility. Read More

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Check Multiple Patient's Eligibility and Benefits via Availity®

Providers are encouraged to use the Availity Provider Portal or their preferred vendor to check eligibility and benefits before every scheduled appointment. The Availity Eligibility and Benefits Inquiry offers an **Add Multiple Patients** feature for providers to check real-time eligibility and coverage details for 2 to 50 patients in the same request. In the Availity Eligibility and Benefits response, a Patient Card will appear in the left-side Patient History list for each patient requested. Patient Cards will be available for interpretation for 24 hours at which time will auto-delete from the Patient History list.

Tips for Using the Add Multiple Patients Option:

- Enter each patient's information on a separate line.
- Press Enter on your keyboard to start a new line.

- Separate each piece of information on each line with a comma.
- Make sure to enter the information that matches the search option you selected in the Patient Search Option field.

This feature is available for Blue Cross and Blue Shield of Texas (BCBSTX) commercial, Federal Employee Program® (FEP®) and marketplace health plan members. Start saving time and streamlining your eligibility and benefits inquiries by utilizing the Add Multiple Patients option. Refer to the Availity Eligibility and Benefits User Guide for step-by-step instructions.

Please note, the Add Multiple Patients is currently unavailable for Medicare Advantage and Texas Medicaid members.

View BCBSTX Member ID Cards via Availity®

We are excited to offer providers the ability to view, download and print the member's medical ID card online via the Availity Eligibility and Benefit Inquiry results (271 transaction). This new and more convenient option will be available for medical ID cards issued to Blue Cross and Blue Shield of Texas (BCBSTX) members in Dec. 2020, making it easier to obtain the member's ID card for your records.

How to view the member ID card via Availity

1. Log into Availity
2. Select **Patient Registration** from the navigation menu
3. Select **Eligibility and Benefit Inquiry**, then complete and submit request
4. Select the **View Member ID Card** from the top of the results screen, if available·
5. View, download and print the BCBSTX ID card

·The online ID card is a courtesy feature offered to assist you. There may be instances when the BCBSTX member ID card is not readily available online. The eligibility and benefits response provides sufficient details to determine patient coverage and benefits in absence of an ID card.

Please note that Federal Employee Program® (FEP®) member ID cards are not currently available in the Availity eligibility and benefits results.

Providers not yet registered with Availity can sign up today at Availity, at no charge. For registration assistance call Availity Client Services at **1-800-282-4548**.

For More Information

Refer to the Availity Eligibility & Benefits User Guide for navigational online assistance. If you need further assistance or customized training, contact our Provider Education Consultants.

Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding policies on our website describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is a resource for our payment policies; it is not intended to address all reimbursement-related issues. We regularly add and modify clinical payment and coding policy positions as part of our ongoing policy review process. The following have been recently added or updated:

- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Effective 03/01/2021
- Outpatient Facility and Hospital Claims: Revenue Codes Requiring CPT or HCPCS Codes – Effective 02/10/2021
- Telemedicine and Telehealth Services – Effective 02/12/2021

CLINICAL RESOURCES

Hospital Discharge Summaries Both Empowers and Informs

It is important for primary care providers (PCPs) to know details about the care their patients receive during inpatient hospital stays. The hospital discharge summary is the key source for this information and used to improve coordination and quality of care ultimately reducing the number of preventable readmissions.

We want to remind you about some important information when discharging Federal Employee Program® (FEP) members after inpatient hospital stays. Use of Electronic Health Records (EHRs) when available ensures smooth flow of information from hospital to the member's extended healthcare network. Provide culturally appropriate member instructions, medication reconciliation and educate caregivers to support the member's transition.

Studies have shown that providing timely, structured discharge summaries to PCPs helps reduce readmission rates, improves patient satisfaction and supports continuity of care. One study found that, at discharge, approximately 40 percent of patients typically have test results pending and 10 percent of those results require action. PCPs and patients may be unaware of these results.[1,3]

A prospective study found that one in five patients discharged from the hospital to their homes experienced an adverse event (defined as an injury resulting from medical management rather than from the underlying disease) within three weeks of discharge. This study found 66 percent of these were drug-related adverse events.[2,3]

Providers should include the following in every discharge summary:

- Course of treatment
- Diagnostic test results
- Follow-up plans
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes/medication reconciliation

Communication helps ensure a smooth transition of the patient to the next level of care. FEP Case Management staff are available to work with members, collaborate with medical team while inpatient and post discharge to facilitate discharge planning instruction. BCBSTX and FEP applaud PCPs who have adopted utilizing discharge summaries along with medication reconciliation from their patients' inpatient admission.

[1]Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143(2):121–8.

[2]Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161–7.

[3]Snow, V., MD. (2009). Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. Journal of Hospital Medicine, 4(6), 364-370. doi:10.1002

Encourage Regular Pre- and Post-Natal Care

The following information is important to help provide pre- and post-natal care and services to Federal Employee Program® (FEP) members. A practice advisory from the American College of Obstetricians and Gynecologists (ACOG) reported that pregnant women with COVID-19 may be at increased risk for more severe illness compared with nonpregnant peers although still substantially lower than that of pandemic H1N1 influenza infection during pregnancy. Though there are community efforts to mitigate the spread of COVID-19, these efforts should not inhibit the medically necessary prenatal care, referrals and consultations that are necessary for members.[1]

Communication between health care professionals during a patient's pre-pregnancy, pregnancy and postpartum medical journey is important. It is important to document the following in the patient's chart to help ensure coordination and continuity of care:

- Prenatal Visit in First Trimester
    - Prenatal risk assessment, including the diagnosis of pregnancy, complete medical and obstetrical history and physical exam as referenced in the ACOG Form
    - Prenatal lab reports (e.g., obstetric panel (OB)/toxoplasmosis, rubella, cytomegalovirus, herpes simplex and HIV antibody (TORCH) panel/Rubella antibody test/ABO (O, A, B or AB blood group testing)/Rh factor testing)
    - Ultrasound, estimated due date (EDD)
    - Patient education/counseling
- Post Postpartum
    - Documentation of a postpartum visit on or between 7 to 84 days after delivery including an evaluation of weight, blood pressure, breast exam, abdominal exam and pelvic exam.

- **Best practice supports calling member within one week after delivery to schedule postpartum follow-up visit.**

Thank you for your help supporting positive outcomes for our FEP and all other members.

MEDICARE ADVANTAGE PLANS

New Prior Authorization Lists for Blue Cross Medicare Advantage℠ January 1, 2021

There are important updates to the Prior Authorization Lists for patients enrolled in Medicare Advantage plans offered by Blue Cross and Blue Shield of Texas (BCBSTX) effective ***January 1, 2021***. These updates are the result of new, replaced or removed codes implemented by the American Medical Association (AMA).

Use Availity® or your preferred vendor to check eligibility and benefits, to determine if you are in–network for your patient and to determine whether any prior authorization or prenotification is required. Availity allows you to determine if prior authorization is required based on the procedure code. Refer to Eligibility and Benefits under the Claims and Eligibility tab on the BCBSTX provider website for more information on Availity.

The updated Blue Cross Medicare Advantage Prior Authorization Lists are posted on the BCBSTX provider website on the Clinical Resources page under Prior Authorizations and Predeterminations. Payment may be denied if you perform procedures without obtaining prior authorization when prior authorization is required. If this happens, you may not bill your patients.

If you need assistance or do not have internet access, please contact your BCBSTX Network Management Representative.

NETWORK PARTICIPATION

Blue High Performance Network℠ (Blue HPN)℠ to launch in January 2021

Beginning Jan. 1, 2021, Blue Cross and Blue Shield of Texas (BCBSTX) is launching **Blue HPN,** a new national high-performance network for large Administrative Services Only (ASO) employer groups. Blue HPN will provide additional access to quality and affordable health care nationwide in 55 major markets. **For Blue HPN service areas within Texas**, **see the table below of counties in and near Austin, Dallas-Fort Worth, Houston and San Antonio*.**

Blue HPN value
Provider participation in Blue HPN is based on a range of factors, including:

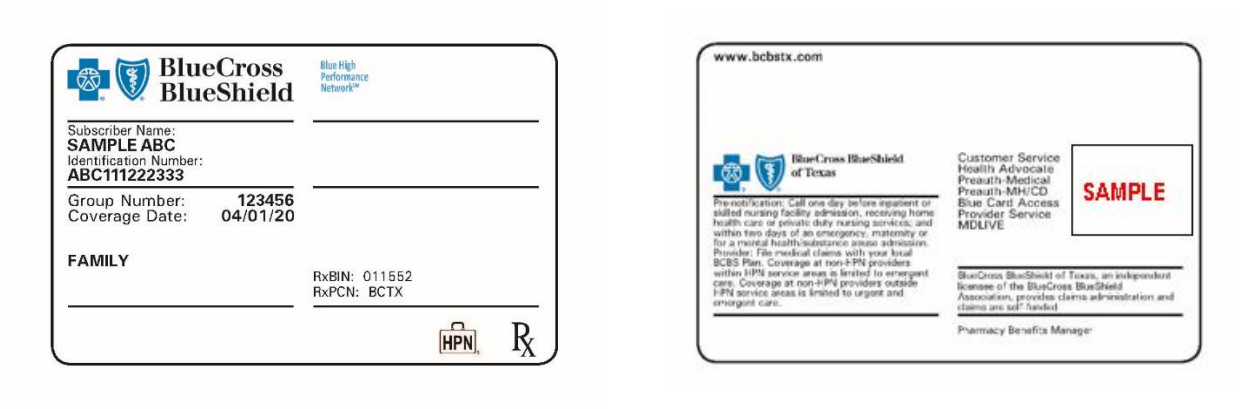
- Performance on national quality indicators, such as measures to close clinical care gaps and impact patients' quality of life
- Performance on local quality indicators, including measures to address local health care challenges and align with community health disparities
- Partnership with BCBSTX to improve affordability, efficiency and health outcomes

Treating Blue HPN patients

- Blue HPN follows the current processes and requirements of our Blue Choice® PPO network*
- There are no Primary Care Provider (PCP) or referral requirements for in-network specialists
- In Blue HPN service areas, patients have access to **emergent care** with non-Blue HPN providers
- In non-Blue HPN service areas, patients have access to **urgent and emergent** care

Recognizing Blue HPN members

You can identify Blue HPN members by their BCBSTX ID card. Look for the Blue High Performance Network name and the "HPN in the suitcase" logo on the front. This logo indicates that Blue HPN rates apply. To receive additional information on rates, please contact your local Network Management office.



Checking eligibility and benefits

Patient eligibility and benefits should be checked using Availity® Provider Portal or your preferred vendor before every scheduled appointment. Eligibility and benefit quotes include patients' coverage status and other important information, such as applicable copays, coinsurance and deductibles. It's strongly recommended that providers **ask to see patients' ID** card and **photo ID** to guard against medical identity theft. If services may not be covered, patients should be notified that they may be billed directly.

Prior Authorization

- You can check the Prior Authorization and Predeterminations page for the list of ASO services and procedure codes that require prior authorization for Blue HPN. Refer to **How to Submit a Prior Authorization or Prenotification** to learn about submission processes.
- For out-of-area members, see our BlueCard® information and the BlueCard authorization process and requirements.

Reminders

Submit claims to BCBSTX as you typically would for Blue Choice PPO. Refer to Claims and Eligibility for more details. Watch News and Updates and our Blue Review newsletter for more details on Blue HPN.

If you have additional questions, need **Blue HPN** rates, would like to apply to join the network or do not have Internet access, please contact your local BCBSTX Network Management Office:

*Network Management Office (city with designated Blue HPN county service areas)	Telephone Number	Fax Number
Austin (Hayes, Travis and Williamson)	800-336-5696 / 512-349-4847	512-349-4853
Dallas, Fort Worth (Collin, Dallas, Denton, Ellis, Johnson, Rockwall, Tarrant)	972-766-8900 / 800-749-0966	972-766-2231
Houston, Beaumont (Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery)	713-663-1149 / 800-637-0171 press 3	713-663-1227
San Antonio, Laredo	361-878-1623	361-852-0624

(Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall)		
Ancillary–Visit BCBSTX Contact Us for ***phone and fax by specialty***		

As a reminder, it is important to check eligibility and benefits before rendering services. This step will help you determine if benefit prior authorization is required for a member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

PRIOR AUTHORIZATION INFORMATION

Prior Authorization Expansion to AIM®

What's Changing?
The utilization management vendor that manages certain outpatient prior authorizations for some members in the plans listed below will be AIM Specialty Health® (AIM) effective Jan. 1, 2021:

- Blue Choice PPO℠
- Blue Essentials℠ and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- Blue Advantage HMO℠
- MyBlue Health℠
- Blue High Performance Network℠ (New plan effective Jan. 1, 2021)

(Note: There are no changes to the vendors for BCBSTX Government Programs (Medicare Advantage and Medicaid plans).

What's Not Changing?
The **care categories and procedure codes** that currently require prior authorization will stay the same* as the previous vendor:

- Advanced imaging**
- Cardiology
- Sleep medicine
- Pain management
- Joint and spine surgery
- Radiation therapy
- Genetic testing

***** *Exception are updates for new, replaced or removed procedure codes that may occur to comply with American Medical Association or Centers for Medicare & Medicaid Services or other industry-standard entities.*
***The AIM Radiology Quality Initiative program (RQI) for Blue Choice PPO members will continue for members that do not require an advanced imaging prior authorization.*

You can find **code lists** for the services that require prior authorization **on our provider website**.

Check which members and services need prior authorization
Use Availity® or your preferred vendor or call the number on the back of the ID card to:

- Check eligibility and benefits
- Determine if you're in-network for your patient
- Find out if the patient and services require prior authorization or a RQI prenotification
- Learn whether prior authorization is required for a procedure code and who to contact

How can you prepare?
Make sure you have an **account** with **AIM**. To **create** an account:

- Access the AIM ProviderPortal, or
- **By Phone** – Call the **AIM Contact Center at 800-859-5299** Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a,m. to noon, CT on weekends and holidays.

If you are already registered with AIM, you do not need to register again.

Submit prior authorization requests to AIM. when applicable, for Jan. 1, 2021, in one of the following ways:

- **Online** – Submit requests via the **AIM ProviderPortal** 24/7.
- **By Phone** – Call the **AIM Contact Center** at **1-800-859-5299** Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a,m. to noon, CT on weekends and holidays.

If benefit prior authorization is required, services performed without benefit prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Look for future news and updates on upcoming training and FAQs that will provide all of the important information you need regarding AIM.

If you have any questions, you may contact your Network Management Representative.

Update to Prior Authorizations – Jan.1, 2021

What's New: On Jan. 1, 2021, Blue Cross and Blue Shield of Texas (BCBSTX) will update its list of Current Procedural Terminology (CPT®) codes requiring prior authorization to comply with changes as a result of new, replaced or removed codes implemented by the American Medical Association (AMA) and BCBSTX Utilization Management updates.

More Information: For a revised list of codes effective Jan. 1, 2021, go to our provider website in the prior authorization section. Check the AMA website for more information on CPT code updates.

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.
