FEBRUARY 2021

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 FAQs and COVID-19: FAQs for Medicare Providers.

COVID-19 Vaccines and Coverage

In the face of the COVID-19 pandemic, pharmaceutical companies have moved to produce vaccines. The Food and Drug Administration (FDA) awarded an Emergency Use Authorization (EUA) to two companies for their vaccines: Pfizer on Dec. 11, 2020, and Moderna on Dec. 18, 2020.

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

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

Phase	Access	Projected Start Date
1a	Health care workers	December 2020
1b	Long-term care facility residents via federal partnership with Walgreens and CVS	December 2020
2	Vaccinate broader population with the help of retail pharmacies	January 2021

3	Integrate vaccination into routine vaccine programs like influenza vaccine	Fall 2021

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

Fully insured:

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

Self-funded employer groups:

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

Medicare Advantage and Medicare Supplement

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

Medicaid

- Most Medicaid members will have no cost-sharing on vaccines from in- and out-of-network providers. See the CMS Medicaid toolkit for more details.

Reimbursement:

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

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

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

Code	Use	Description
91300	Vaccine	Pfizer-Biontech Covid-19 Vaccine SARSCOV2 VAC 30MCG/0.3ML IM
0001A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 30MCG/0.3ML 1ST
0002A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 30MCG/0.3ML 2ND
91301	Vaccine	Moderna Covid-19 Vaccine SARSCOV2 VAC 100MCG/0.5ML IM
0011A	Admin	Moderna Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 100MCG/0.5ML1ST
0012A	Admin	Moderna Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 100MCG/0.5ML2ND

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

More information:

- CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations
- Provider Relief Fund – for reimbursement for administering the COVID-19 vaccine to the uninsured
- CMS Medicaid Toolkit - Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program
- CMS guidance on Medicare billing for the COVid-19 vaccine administration

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

Telehealth 2021

We updated this notice to include information on Intensive Outpatient Program (IOP) telehealth coverage.

In response to the COVID-19 pandemic, Blue Cross and Blue Shield of Texas (BCBSTX) expanded access to telehealth services to give our members greater access to care. The experience confirmed the importance of telehealth in health care delivery. Members can access their medically necessary, covered benefits through providers who deliver services through telehealth. Many of our members also have access to various telehealth vendors, such as MDLIVE.

What's covered?

Coverage is **based on the terms of the member's benefit plan** and applicable law. As of Jan. 1, 2021, for our state regulated **fully insured HMO** and **PPO** members and our **self-funded employer group members**, we cover telehealth codes consistent with the **permanent** code lists from:

- The Centers for Medicare and Medicaid Services (CMS), and
- The American Medical Association (AMA)

By, permanent, we mean those codes that are not temporarily available for the duration of the public health emergency (PHE) or the year of the PHE.

CMS and AMA periodically update their lists. **We will follow their updates**.

Intensive Outpatient Program (IOP) - IOP services are not included on the CMS telemedicine code list because they are not a covered benefit for Medicare recipients. However, IOP services can be appropriately delivered by telemedicine. Therefore, we **will cover IOP services** delivered by telemedicine.

We will **not cover** the following codes:

- Codes that are not on the telemedicine code list provided by CMS **or** the AMA **except** for IOP services and those required by state statute
- CMS codes that are temporary for the PHE
- CMS Codes that are active for the year of the PHE only
- AMA codes listed as Private Payer

Our self-funded employer group customers make decisions for their employee benefit plans. **Check eligibility and benefits** for any variations in member benefit plans.

We **recommend** the following:

- Consider telehealth a mode of care delivery to be used when it can reasonably provide **equivalent outcomes** as face-to-face visits.
- Choose telehealth when it **enhances the continuity of care** and care integration if you have an established patient-provider relationship with members.
- **Integrate telehealth records into electronic medical record systems** to enhance continuity of care, maintain robust clinical documentation and improve patient outcomes.

Eligible members

Providers can use telehealth for members with the following types of benefit plans. Care must be consistent with the terms of the member's benefit plan.

- State-regulated fully insured HMO and PPO plans
- Blue Cross Medicare Advantage (excluding Part D) and Medicare Supplement (see Medicare info below)
- Self-funded employer group plans

We will continue to follow applicable state and federal requirements.

Submitting claims

The provider submitting the claim is responsible for accurately coding the service performed. Submit claims for medically necessary services delivered via telehealth with the appropriate **modifiers (95, GT, GQ, G0) and Place of Service (POS) 02**. If a claim is submitted using a telehealth code, no modifiers are necessary. Only codes that are not traditional telehealth codes require a modifier.

Acceptable modifiers:

- 95 – synchronous telemedicine (two-way live audio visual)
- GT – interactive audio and video telecommunications
- GQ – asynchronous telecommunications system
- G0 – telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke; G0 must be billed with one of the approved telemedicine modifier (GT, GQ or 95)

Member cost share

As of Jan. 1, 2021, **copays, deductibles and coinsurance apply** to telehealth visits for most members. The cost share varies according to the member's benefit plans. **Check eligibility and benefits** for each member for details. Our self-funded employer group customers make decisions for their employee benefit plans and may choose to waive telemedicine cost share. **Check eligibility and benefits** for any variations in member benefit plans.

What's covered for Medicare Advantage and Medicare Supplement members

CMS identifies covered services for Medicare members. This means we will cover all the CMS telemedicine codes, including those available only during the PHE for Medicare Advantage and Medicare Supplement members.

For the duration of the PHE, we are waiving cost share for our Medicare Advantage members. This means these members will **not** owe any **copays, deductibles or coinsurance** for telehealth visits. The cost share waiver does not apply to Medicare Supplement members.

Medicaid

We will follow the applicable guidelines of the Texas Department of State and Health Services for Medicaid STAR, CHIP and STAR Kids members.

Referrals and prior authorizations

Some telehealth care will require **referrals** and **prior authorizations** in accordance with the member's benefit plan. **Check eligibility and benefits** for each member for details.

Delivery methods

Available telehealth visits with BCBSTX providers include:

- 2-way, live interactive telephone communication (audio only) and digital video consultations
- Asynchronous telecommunication via image and video not provided in real-time (a service is recorded as video or captured as an image; the provider evaluates it later)
- Other methods allowed by state and federal laws, which can allow members to connect with physicians while reducing the risk of exposure to contagious viruses or further illness

Delivery methods for Medicare members

- Providers should use an interactive audio and video telecommunications system that permits real-time interactive communication to conduct telehealth services. CMS permits audio only in limited circumstances. See the CMS website for designated audio-only codes.

Providers can find the latest guidance on acceptable Health Insurance Portability and Accountability Act (HIPAA) compliant remote technologies issued by the U.S. Department of Health and Human Services' Office for Civil Rights in Action.

Telehealth Vendors

For state-regulated fully insured members, providers are not required to use a vendor for telehealth services. For self-funded members, providers may be required to use specific vendors as outlined in the member's benefit plan.

Reimbursement

Currently, covered telehealth claims for eligible members for in-network medically necessary health care services will be reimbursed at the same rate as in-person office visits for the same service. We will continue to evaluate reimbursement. Submit claims with appropriate codes and modifiers. For claims using a specific telehealth code, the applicable telehealth reimbursement will apply.

Member benefit and eligibility assistance

Check eligibility and benefits for each member at every visit prior to rendering services. Providers may:

- Check general coverage by submitting an electronic 270 transaction through Availity® or your preferred vendor.
- Connect with a Customer Advocate to check eligibility and telehealth benefits by calling our Provider Customer Service Center at 1-800-451-0287.
- For Medicare Advantage members, call Blue Cross Medicare Advantage Network Management at 1-972-766-7100.

COVID-19 Fee Schedule/Reimbursement Update

Effective April 1, 2021, unless otherwise specified in the provider's agreement, Blue Cross and Blue Shield of Texas (BCBSTX) will align the codes below with the Centers for Medicare and Medicaid Services (CMS) and local Medicare Intermediary reimbursement levels for the Blue Choice PPO℠ (including Blue HPN℠), Blue Essentials℠ (including HealthSelect℠ of Texas Network), MyBlue Health℠ Blue Premier℠, Blue Advantage HMO℠ and PAR Plan networks.

Code	Description
87426	IAAD IA SEVERE AQTRESPIRSYND CORONAVIRUS
0224U	ANTB SEV AQT RESPIR SYND CORONAVIRUS 2 TITER(S)
0226U	SUROGAT VIR NEUTRLZJ TST SARSCOV2 ELISA PLSM SRM

General Reimbursement and Fee Schedule Information

The updated fee schedules will be posted on the General Reimbursement Information page under "**Reimbursement Schedules and Related Information (Secure Content)". To access this area, please obtain the password from your Network Management Office. Then refer to "Hospital/Ambul. Surg Ctr./Endoscopy Ctr. "** section and select **"Hospital Schedules**".

Have Questions?

If you have any questions, please contact your Network Management Office.

BEHAVIORAL HEALTH

Tiered Payment Rate Modifiers for ABA Effective April 1, 2021

Applied Behavior Analysis (ABA) Therapy is a treatment that is often rendered at a high intensity to individuals from vulnerable populations. The bulk of the therapy hours a member receives is rendered by an unlicensed technician under the supervision of a Qualified Healthcare Professional. To improve the quality of care for our members and be responsive to the needs of our provider network, we will be making some changes to reimbursement rates by allowing the use of modifier codes.

What's changing?

As part of our initiative to improve health care delivery as well as find solutions to aid in reducing unnecessary health care costs for everyone, we will be implementing a tiered payment rate based on modifiers for CPT® 97153

– ABA Adaptive Behavior Treatment by Protocol. We want our commercial members to receive the best health outcomes for the dollars spent on their care.

Reimbursement Details

Many providers have requested higher reimbursement rates when Licensed Behavior Analysts render this service. Additionally, many providers have inquired if rates were available that reflect their commitment to best practices by ensuring all their Registered Behavior Technician (RBT) staff obtain and maintain certification. Based on similar changes across the industry and feedback from our provider network, the reimbursement rate should reflect the education, training and credentials of the clinicians providing care to our commercial members.

Based on the clinician rendering the services, the following modifiers should be used **effective April 1, 2021:**

- **HN:** RBT, Board Certified Assistant Behavior Analyst (BCaBA) or clinician with a bachelor's degree; rate will remain equivalent to the existing rate.
- **HM:** Clinician with less than a bachelor's degree and no RBT certification; rate will be reduced by 20%.
- **HO:** Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst – Doctoral (BCBA-D) or clinician with a master's level or higher education; rate will increase by 20%.

If providers do not include a modifier with code 97153, the reimbursement will default to HM.

Using provider type modifiers to compensate providers of direct services will help to ensure ABA remains a high quality and accessible service for our members.

CLAIMS & ELIGIBILITY

Atrial Fibrillation and Diabetes Mellitus - Documentation & Coding Guidance

High quality documentation and complete, accurate coding can help capture our members' health status and promote continuity of care. In order to assist providers, Blue Cross and Blue Shield of Texas (BCBSTX) has developed tips for documenting and coding **Atrial Fibrillation** and **Diabetes Mellitus**. This guidance is from the ICD-10-CM Official Guidelines for Coding and Reporting and industry-approved sources.

Please review the following documentation & coding guidance located under Claims Filing Tips/Billing and Coding on the provider website:

- Atrial Fibrillation
- Diabetes Mellitus

Watch for additional topics announced in news and updates in the future. If you have any questions, please contact your Network Representative.

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:

- Preventive Services – Effective Jan. 15, 2021
- Telemedicine and Telehealth Services – Effective Feb. 12, 2021
- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Effective April 1, 2021
- Neonatal Intensive Care Unit (NICU) Level of Care Authorization and Reimbursement Policy – Effective May 5, 2021

CLINICAL RESOURCES

Updates to Clinical Practice Guidelines

Blue Cross and Blue Shield of Texas (BCBSTX) updated the following Clinical Practice Guidelines:

- Asthma – Management and Prevention
- Cardiovascular Disease Guideline
- Chronic Obstructive Pulmonary Disease (COPD) – Diagnosis, Management and Prevention
- Metabolic Syndrome Guideline
- Tobacco Cessation Guideline
- HIV (Human Immunodeficiency Virus) – Recommendations on First and Second Line Antiretroviral Regimens

Why it matters:

Clinical Practice Guidelines (CPGs) are adopted by BCBSTX and are the foundation for Condition Management Programs. These guidelines are:

- Based on established evidence-based standards of care, publicized by specialty societies and national clinical organizations
- Updated at least every two years and when new significant findings or major advancements in evidence-based practices and standards of care are established
- Current, reviewed and approved by the BCBSTX Clinical Quality Improvement Committee

For help:

- Questions about the guidelines or to provide feedback, contact the Quality Improvement Department at **1-800-863-9798** or by email at ClinicalPracticeGuidelines@bcbstx.com
- CPGs are meant to serve as general guidelines and are not intended to substitute for clinical judgment in individual cases
- Refer to Clinical Practice Guidelines under Clinical Resources on the provider website for the Clinical Practice Guidelines and Preventive Care Guidelines that are available

- For questions or if you need additional information, please contact your BCBSTX Network Management Representative

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BCBSTX Federal Employee Program Annual Medical Record Data Collection for Quality Reporting

Why it matters:

Blue Cross and Blue Shield Federal Employee Program (FEP) collects performance data according to National Committee for Quality Assurance (NCQA) specifications for Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is the most widely used and nationally accepted effectiveness of care measurement available and used for Federal Employees Health Benefits Program (FEHBP).

How you can help:

BCBS FEP will be collecting medical records using internal resources and an independently contracted third party vendor, Change Healthcare.

The goal:

Change Healthcare will reach out to schedule the medical record retrieval. They will provide a medical record request list with members' names and identify the measures to be reviewed.

Submit medical records within 5 business days using one of these methods:

- via secure email
- fax
- mail
- remote electronic record (EMR) download
- onsite scanning by a Change Healthcare medical record technician

Medical records not received timely will trigger outreach in February or March 2021 by BCBS FEP or the vendor referenced above.

Next steps:

- Identify a key contact person and to ascertain which data collection method your office or facility prefers (fax, secure email, SFTP (Secure File Transfer Protocol) or onsite) for scheduled appointments.
- Watch for letter outlining the information that is being requested, and the medical record request list with members' names and the identified measures for review.

Related:

Patient authorization for release of medical record data is not required. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) of 1996 and its

implementing regulations (45 C.F.R. Parts 160 and164), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as incorporated in the American Recovery and Reinvestment Act (ARRA) of 2009, and its implementing regulations, each as issued and amended.

We appreciate your time and continued collaboration. For questions about medical record requests, contact the BCBS FEP Quality Initiative (HEDIS) Department at 1-888-907-7918.

2020-21 Preventive Care Guidelines Are Available

We have added the updated 2020-21 Preventive Care and Wellness Guidelines on the Blue Cross and Blue Shield of Texas (BCBSTX) provider website related to preventive care, health screenings and immunizations. Each year, recommendations from the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force, American Academy of Pediatrics, American College of Obstetricians and Gynecologists and other professional organizations are reviewed by our medical staff and these Guidelines are updated as needed.

The Preventive Care Guidelines offer specific recommendations for:

1. Children from birth to 18 years
2. Adults 19 years and older
3. Adults 65 years and older
4. Women needing perinatal care

The guidelines indicate that recommendations may vary, especially if there are risks involved. In addition, recommendations are not intended as medical advice, nor meant to be a substitute for your individual medical judgement or that of other health care professionals. Members are directed to their physician for individualized advice on the recommendations provided.

If you have questions or comments about the guidelines, please contact the Quality Improvement Programs department at **1-800-863-9798.**

MEDICARE ADVANTAGE PLANS

Medicare adds benefit for members with inherited ovarian or breast cancer

The Centers for Medicare & Medicaid Services (CMS) added a benefit in 2020 for Medicare members with germline or inherited ovarian or breast cancer. The benefit covers a laboratory diagnostic test using **Next Generation Sequencing (NGS).** These tests provide genetic analysis of a patient's cancer.

What we cover:

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

- Performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory
- Ordered by a treating physician
- And the patient has all the following:
  - Ovarian or breast cancer
  - A clinical indication for germline testing for hereditary breast or ovarian cancer
  - A risk factor for germline breast or ovarian cancer
  - Has not been previously tested with the same germline test using NGS for the same germline genetic content

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

Check eligibility and benefits

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

NEW: Obtain BCBSTX Patient ID Numbers for Government Program Members via Availity®

In September, we introduced a new online tool via Availity called Patient ID Finder. This tool allows you to quickly obtain a Blue Cross and Blue Shield of Texas (BCBSTX) patient's insurance ID and group numbers after entering patient-specific data elements

What's New?

We are excited to announce that you can now use the Patient ID Finder to obtain the insurance ID and group numbers for Blue Cross Medicare Advantage℠ and Texas Medicaid members.

How do you use the Patient ID Finder via Availity?

Searching online for BCBSTX patient ID number is easy and consists of only four steps:

- Log into Availity
- Select Payer Spaces from the navigation menu and choose BCBSTX
- Select Patient ID Finder from the Applications tab, then complete and submit the request
- Patient ID and group numbers are returned

Eligibility and Benefits

This tool does not reflect the patient's eligibility or benefits. Refer to the Eligibility and Benefits User Guide for assistance with obtaining real-time eligibility and benefits information via Availity.

Sign Up for Availity

If you are 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 Patient ID Finder User Guide in the Provider Tools section of our website.
- Visit the Training page on our website to register for an upcoming Availity 101 session hosted weekly to learn more about online offerings, including the Patient ID Finder.
- If you need further assistance or customized training, contact our Provider Education Consultants.

NETWORK PARTICIPATION

Contracting and Credentialing Midlevel Providers

Blue Cross and Blue Shield of Texas (BCBSTX) directly contracts and credentials with Midlevel providers. With the upcoming 2021 implementation of the ClaimsXten edit of the SA modifier for non-payable services which will result in the SA modifier being non-reimbursable, we would like to encourage all board certified Midlevels not currently contracted with BCBSTX to consider doing so to ensure their claims are not impacted.

This direct contracting effort includes the following BCBSTX networks: Blue Choice PPO℠, Blue Advantage HMO℠, Blue Essentials℠, Blue Premier℠, HealthSelect℠, Blue High Performance℠ (Blue HPN)℠, Texas Medicaid, Blue Cross Medicare Advantage HMO℠, Blue Cross Medicare Advantage PPO℠ and MyBlue Health℠.

What Midlevel Specialties?

Physician Assistants must be board certified by the National Commission on Certification of Physician Assistants (NCCPA) and maintain certification for continued participation.

Nurse Practitioners must be certified by one of the following national certification boards and maintain certification for continued participation.

- ANCC: American Nurses' Credentialing Center subsidiary of the ANA (American Nurses' Association). Certification through the American Nurses' Association (ANA) must be achieved through the ANCC.
- AANPCP: American Academy of Nurse Practitioners Certification Program
- AACN: American Association of Critical Care Nurses
- PNCB: Pediatric Nursing Certification Board
- NCC: National Certification Corporation for Women's Health (OB/GYN) Nurse Practitioners (WHNP)
- NNP: Neonatal Nurse Practitioner (NNP) or
- Texas Grandfather Clause: Advanced Practice Nursing educational program that was completed prior to January 1, 1996, provided the program was accredited by a National Nursing Education Accrediting Body that is recognized by the Texas Board of Nursing, may be granted an exemption to the national certification requirement. Per Title 22, Par 11, Chapter 221, Rule 221.7.

What should you do?

Midlevels can begin the process of directly contracting with BCBSTX by checking the How to Join Network Instructions.

- Get a BCBSTX Provider Record ID and get credentialed
- Utilize the check credentialing status option
- Remember to Get Connected to use all available BCBSTX electronic options

We appreciate your consideration to become a directly contracted provider. Please contact your Network Management Consultant if you have further questions.

PRIOR AUTHORIZATION

Infusion Site of Care Drugs Prior Authorization Update

To help ensure reviews for medical necessity and site of administration are being conducted according to member benefit plan details, 14 new procedure codes have been added for Infusion Site of Care to the Prior Authorization Services Lists for ASO and Fully Insured groups, **effective Jan. 1, 2021**. These lists are located on the provider website under the **Utilization Management** page then Prior Authorization Lists. It includes specialty drugs (infusion site-of-care or provider administered drug therapies) that may require prior authorization through Blue Cross and Blue Shield of Texas (BCBSTX) before administration for some members.

Codes being added effective Jan. 1, 2021, include: **J0222, J0223, J0584, J0638, J0791, J1303, J1558, J1746, J3032, J3060, J3241, J3245, J3397 and Q5121.** BCBSTX's Specialty Medication Administration Site of Care Medical Policy (RX501.096) is available in the Medical Policy section of our website to help clarify when and how prior authorization requirements may apply.

Remember: Member benefit plans and requirements vary, so it's critical to **check eligibility and benefits first** through the Availity Provider Portal® or your preferred web vendor, prior to rendering care and services, to confirm coverage and other important details.

UTILIZATION MANAGEMENT

Update to Prior Authorization Codes for Commercial Members

What's New: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its lists of Current Procedural Terminology (CPT®) codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA).

More Information: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website, The new lists can be found on the **Prior Authorization Lists for Fully Insured and Administrative Services Only (ASO) Plans** link and will have an effective date of:

- **Jan. 1, 2021** - Updated to include additional codes added by the AMA
- **April 1, 2021** – New lists to include Utilization Management 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.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without 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.

Use AIM *Provider*Portal℠ for Pre & Post-Service Reviews

Providers need to use the AIM Specialty Health® (AIM) *Provider*Portal to request prior authorization and respond to post-service review requests required by AIM. **Do not submit medical records to Blue Cross and Blue Shield of Texas for prior authorization or post-service reviews for the care categories managed by AIM. If medical records are needed for pre or post-service reviews using the AIM portal, you will receive notification to submit them.**

Providers can submit prior authorization requests between 12/21/20 and 12/30/20 via the AIM portal **only for services that have a start date on or after 1/1/21.**

Benefits of the AIM *Provider*Portal for Pre & Post-Service Reviews:

- **Medical records for pre or post-service reviews are not necessary unless specifically requested by AIM.**
- Offers self-service, smart clinical algorithms and in many instances real-time determinations
- Check prior authorization status
- Increases payment certainty
- Provides faster pre-service decision turnaround times than post service reviews

Check Eligibility and Benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® or your preferred vendor.

Contact Us
View our quick directory of contacts for BCBSTX.

Update Your Information
Do you need to update your location, phone number or other important details on file with BCBSTX? Do we have the most current email address for you and your staff? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local BCBSTX Network Management Representative to have up to 10 of your office email addresses added.

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com.

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

Checking eligibility, benefit information and/or if a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

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Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits.

Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

bcbstx.com/provider