MARCH 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.

System Issue Sending Incorrect Provider Term Notice to Members

Blue Cross and Blue Shield of Texas (BCBSTX) has identified a system error which caused certain members to receive letters notifying them their providers will no longer be in-network. Our technical team is implementing a system fix (targeted for second quarter 2021) to correct the issue.

If you identify any of your patients received a notice in error, you may request retraction letter(s) by contacting your local Network Management Consultant.

We regret any frustration and respectfully ask for your understanding while we correct this issue. Continue to watch News and Updates and our Blue Review newsletter for updates.

Blue Essentials Access℠ and Blue Premier Access℠ Plan Reminder

Blue Cross and Blue Shield of Texas providers who sign a **Blue Essentials**℠ or **Blue Premier**℠ agreement **are also in-network** for **Blue Essentials Access** or **Blue Premier Access**.

The following are components of these plans.

Blue Essentials and Blue Premier plan(s):

- Select a Primary Care Provider (PCP) and obtain referrals for specialty services.

- When referrals are required, they must be initiated by the member's designated PCP and must be made to a participating physician or professional provider in the same provider network.

Blue Essentials Access and Blue Premier Access plan(s):

- Considered "open access" HMO plans
- No Primary Care Provider (PCP) selection or referrals are required when the member uses participating providers in the same network.

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

Prevention is Still Important During the COVID-19 Pandemic

Have your patients put off their office visits during the COVID-19 pandemic? Their wellness can't wait. Now is the time to encourage your patients to get caught up on their health – including needed vaccinations.
Download the Wellness Can't Wait Provider Toolkit to get all the resources you need to engage your patients today.

In this toolkit you'll find:

- Pre-written email, text, and letter templates to begin your patient outreach
- Telehealth tips to share with your patients
- Best practices

Other resources for your patients

We also encourage you to direct your patients to the Connect Community page for additional resources.

Register for Indices Training to Learn How it Can Help You Close Member Care Gaps

You can leverage Indices to access a range of insights about the BCBSTX members you are treating, including quality and risk metrics. Indices data is easy to navigate and can help:

- Improve quality of care by identifying gaps in care as reflected in claims and other regularly updated data. This may include wellness exams, screenings or other preventive care.
- Identify risks for chronic conditions and the severity of any conditions.

Use this flier to see our available trainings and sign up for a time that works for you.

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.

BEHAVIORAL HEALTH

2020 Behavioral Health Quality Improvement Program Evaluation Executive Summary

This Executive Summary provides an analysis and evaluation of the overall effectiveness and key accomplishments of the Behavioral Health (BH) Quality Improvement (QI) Program for Health Care Service Corporation (HCSC), Inc.

2020 Accomplishments

1. Launched Continuing Medical Education (CME) for providers across all the plan states and completed a series of three in depth trainings on Depression, Substance Abuse and Coordination of Care Amongst Providers.
2. Successfully insourced the Texas Health Maintenance Organization (HMO) product under the BH QI umbrella.
3. Federal Employee Program (FEP) Clinical Quality, Customer Service, and Resource Use (QCR) measures are on track to meet seven of the ten measures across the five states.
4. Updated Behavioral Health Quality Improvement Standard Operating Procedures (SOP).
5. Content was added to the BH landing page on the Connect Community site to provide members with access to BH content and information regarding multiple topics, including Postpartum Depression, caregivers and mental health and the impact of nutrition on mental health.

6. Engaged 12 facilities in the Federal Employee Program Follow-Up After Emergency Department Visit for Mental Illness (FUM)/Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Incentive Program.
7. Partnered in the successful completion of four Utilization Review Agent (URA) certificate renewals with BCBSTX and two with BCBSOK.
8. Transitioned all BH QI staff seamlessly to work from home during the COVID-19 pandemic with no deadlines or timeframes missed.

Program Focus for 2021

Based on the review of the 2020 program goals, an increased understanding of barriers to improvement, and attention to lessons learned during the year, the following primary areas for focus of the HCSC BH Quality Improvement Work Plan for 2021 include:
1. Measure, monitor, and continuously improve performance of behavioral health care in key aspects of clinical and service quality for members, providers, and customers;
2. Maintain a high level of satisfaction among providers and members;
3. Focus continuous quality improvement efforts on those priority areas defined in the annual BH QI Work Plan;
4. Continue to explore social determinants of health and focus on implementing new initiatives to address identified areas of concern, increase member resources and improve access;
5. Facilitate rounds, annual trainings and other activities as necessary to optimally manage behavioral health complaints and adverse incidents; and
6. Increase the rates of key HEDIS measures.

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

CPT® Category II Codes Can Help Close Care Gaps

Using the proper Current Procedural Terminology (CPT) Category II codes when filing claims can help streamline your administrative processes and ensure gaps in care are closed.

Read More

Overpayment of Multiple Surgical Procedures

On **June 1, 2021,** Blue Cross and Blue Shield of Texas (BCBSTX) will begin additional reviews of claims after payment to make sure they adhere to our reimbursement policy for multiple surgical procedures.

Key Point: Our payment policy states that when multiple procedures are performed by the same physician or physician group on the same patient in the same operative session, only the **primary procedure** will **pay 100%** of the allowed amount. **Secondary or subsequent procedures** will **pay at 50%.**

Multiple Surgical Procedure Guidelines

- **Primary procedure:** The surgical procedure with the **highest allowed amount** is the primary procedure and reimbursed at 100% of the allowed amount. If two procedures have the same allowed amount, **only one** will be considered primary. Other procedures are secondary or subsequent.
- **Secondary procedures:** Secondary procedures will be **reimbursed 50%** of the allowed amount.
- **Bilateral procedures:** If the surgical procedure for either side is the highest allowed amount, then one procedure will pay at 100% and the second at 50%, all other secondary procedures will also be reimbursed at

50%. If at least one other surgical procedure is the highest allowed amount, then the bilateral procedure (both sides combined) will be reimbursed at 75% and all other secondary procedures will be reimbursed at 50%.

For more information, refer to the **CPCP015 - Multiple Surgical Procedures - Professional Provider Services** on the Clinical Payment and Coding Policy page on the provider website for more detailed information.

What the Review Means?

If you submit claims with multiple billable units of the **same procedure,** for the **same member,** on the **same date of service,** at the **same location,** you may have been paid 100% for each procedure, despite our current payment policy. However, claims with dates of service on and after **June 1, 2021,** will be processed consistent with our payment policy. Some procedures may be exempt from this policy and pay 100% of the allowed amount.

If we overpay you, we'll **recoup** the amount overpaid against future claims. This could also **impact member cost-share,** so you may need to reimburse members.

Exclusions: Claims for members with the following benefit plans are excluded from this policy:

- BCBSTX is the secondary payer
- Medicare Supplement
- Medicaid

More information: If you have any questions, please call the number on the back of the member's ID card or contact your BCBSTX Provider Network Representative.

Telehealth Claim 'Place of Service'

Providers are responsible for accurately coding services performed on their claims. When submitting telehealth professional services using a HCFA 1500, the claims when billed with a telehealth procedure code or another CPT® or HCPCS procedure code with telehealth modifiers (G0, GT, GQ, or 95), need to be billed with place of service (POS) 02. **Starting May 1, 2021, if professional telehealth services are billed without POS 02, claims may be rejected and must be resubmitted with the correct POS.** If you have any questions, please contact your Network Management 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:

- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Effective 05/15/2021
- Neonatal Intensive Care Unit (NICU) Level of Care Authorization and Reimbursement Policy – Corrected effective date 04/05/2021

CLINICAL RESOURCES

Medical Record Data Collection for Quality Reporting begins February 1, 2021

Background

Blue Cross and Blue Shield of Texas (BCBSTX) collects annually performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS) and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS). HEDIS is the most widely used and nationally accepted effectiveness of care measurement available. Additionally, HHS requires reporting of QRS measures for accredited Qualified Health Plans. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule and patient authorization for release of information is not required. Texas state law (Chapter 108 of the Texas Health and Safety Code) requires Health Maintenance Organizations in Texas to report HEDIS data, by service area to the Department of State Health Services (DSHS) on an annual basis.

How Data is Collected

To meet these requirements, BCBSTX will be collecting medical records using Change Healthcare, an independent contracted third-party vendor, as well as BCBSTX staff. If you receive a request for medical records, we encourage you to reply within 3 to 5 business days. Cooperation with the collection of HEDIS and QRS data or any quality improvement activities are required under the providers' contractual obligation at no cost to BCBSTX or as stated within the provider's individual contract.

A representative from Change Healthcare, our contracted vendor or BCBSTX staff may be contacting your office or facility anytime between February 2021 through May 2021 to set up appointments for onsite visits or to set up an expected delivery date via fax, provider portal and if necessary, U.S. Mail.

What Providers Need To Do

As part of the request you will receive a letter introducing the background and authorizing agencies for the HEDIS and QRS data request, a medical record request list with members' names and other identifying demographics, and the medical record information needed for identified measures.

If you have any questions about medical record requests, please contact a representative that will be listed on the provider letter requesting the medical record information.

Change Healthcare is an independent third-party vendor that is solely responsible for the products or services they offer. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendors. If you have any questions regarding the services they offer, you should contact the vendor directly.

Predetermination of Benefits List

February 11, 2021

A predetermination of benefits is a voluntary request for written verification of benefits before rendering services. BCBSTX recommends submitting a predetermination of benefits request if the service may be considered experimental, investigational or unproven, as specified in BCBSTX Medical Policy.

To further assist providers in determining whether to submit a predetermination of benefits request, Blue Cross and Blue Shield of Texas (BCBSTX) has added a list of codes where predetermination may be available and is recommended. This list may be updated monthly. Providers are encouraged to check the list regularly for updates, located on the Predetermination of Benefits Request page of the provider website.

As a reminder, providers can submit a predetermination of benefits electronically using Availity's Attachments tool. If you don't have online access, you may fax and/or mail predetermination of benefit requests along with a completed Predetermination Request Form and pertinent medical documentation.

Please note that whether a guideline is available for any given treatment or a service or treatment has been predetermined for benefits, 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 the service was rendered.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

Get the Conversation Started on Colorectal Cancer

Your discussion is the number one influence on your patient's compliance.

Talk to your patients about the importance of having a screening and the different screening options available.

Talk to your patients about preventing colorectal cancer before it starts by finding and removing polyps, which can reduce their risk.

Talk to your patients about how early-stage colorectal cancer may have no symptoms but is highly treatable and beatable.

Start the conversation with all your patient's ages 50 to 75 who have an average risk of developing colorectal cancer. There are simple, affordable tests available. Start the conversation at an earlier age for those who have high-risk factors.

If Blue Cross and Blue Shield of Texas members have questions on which tests are covered, ask them to call Customer Service using the number on the back of their ID cards. Let your patients know they can find additional information on colorectal cancer at the American Cancer Society, the Colorectal Cancer Alliance and the National Cancer Institute.

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.

PHARMACY

- Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2021 – Part 1

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.

STANDARDS & REQUIREMENTS

Termination of Unused Provider Record ID

We may automatically cancel a Provider Record ID that does not have any claim dates of service within a 12-month period. Terminating a Provider Record ID will also result in termination of associated networks. Provider Record IDs are specific to billing/rendering NPIs and Tax Identification Numbers. If you have any questions, contact your Provider Network Representative.

Professional Provider Insurance Liability Limits

We require in-network office-based physicians and professional providers to maintain minimum amounts of insurance coverage for professional liability risk. Effective March 1, 2021, the new required minimum amounts for office based professional providers is $100,000 per occurrence and $300,000 aggregate. If you have any questions, contact your local Network Management Office.

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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