BLUE REVIEW℠

For Providers

DECEMBER 2023

BEHAVIORAL HEALTH

Training Resources for Behavioral Health Care

More than 120 million Americans live in areas experiencing a shortage in behavioral health care providers, according to the Health Resources and Services Administration. Even when providers are available, patients often rely on primary care physicians for behavioral health care, according to the American Academy of Family Physicians.

Below are resources that providers across disciplines may find helpful to **support patients presenting with behavioral health concerns.** Blue Cross and Blue Shield of Texas makes no endorsement of these resources and encourages providers to consider what care is best for their patients under their specific circumstances.

- Substance Abuse and Mental Health Services Administration Practitioner Training
- Providers Clinical Support System training to prevent and treat opioid use disorders
- Postpartum Support International's listing of psychiatric perinatal and pediatric mental health consultation lines

BCBSTX Webinars with Continuing Education Credit

We offer introductory behavioral health webinars at no cost to providers. **Register or sign in here** to view recordings of the following webinars. You will earn one continuing medical education (CME) credit or continuing education unit (CEU) per course, unless otherwise noted.

- Bipolar Disorder: Diagnosis and Treatment (1.5 CME/CEU)
- Comorbid Behavioral Health and Physical Health Conditions
- Depression in a Primary Care Setting
- Diabetes and Behavioral Health
- Differential Diagnoses of Depression: Assessment and Treatment
- Maternal Mental Health: Pregnancy and Postpartum
- Opioid Use Disorder
- Substance Abuse: Coordinating Care and Improving Follow-Up
- Suicide Prevention with the Military Community (1.5 CME/CEU)
- Synthetic Opioids and the Opioid Crisis

Reminder: New Enhancements for Behavioral Health Prior Authorizations

Just a reminder that we are making enhancements to our Behavioral Health request and review processes for some commercial members. Read our previous article for details on these ongoing enhancements.

CLAIMS & ELIGIBILITY

TRS Hospital Claim Analysis as Required by House Bill

Through Blue Cross and Blue Shield of Texas (BCBSTX), the Teacher Retirement System (TRS) provides affordable comprehensive medical coverage to school district employees and retirees across the state of Texas.

During the 88th session, the Texas legislature passed the General Appropriations Act (House Bill 1) which included a rider directing TRS to complete a review of hospital claims that exceeded $100,000 during the 2022 state fiscal year (September 1, 2021 – August 31, 2022).

You may receive a formal medical records request from BCBSTX, on behalf of TRS, requesting medical and billing records for identified claims. As a state agency providing services to Texas school districts, their employees, retirees, and dependents, TRS appreciates your cooperation in providing comprehensive and affordable healthcare services to school districts and their retirees across Texas. If you have any questions, please feel free to contact Blue Cross and Blue Shield of Texas (BCBSTX) at 800-451-0287, between the hours of 8 a.m. and 6 p.m., Central Time, Monday through Friday.

New BlueApprovRSM Tool Now Expedites Prior Authorization and Recommended Clinical Reviews for Behavioral Health services and More

Blue Cross and Blue Shield of Texas (BCBSTX) continues to streamline the prior authorization and recommended clinical review (RCR) process to reduce your workload with **BlueApprovR**SM. This new tool in Availity® Essentials will now help you expedite approvals for behavioral health, medical and surgical services and specialty pharmacy drugs for many of our commercial members.

BlueApprovRSM **tool offers End-to-End Efficiencies**

Registered Availity Essentials users have free, 24/7 access to BlueApprovR tool to:

- Request RCRs and prior authorization for inpatient and outpatient behavioral health, medical surgical services and specialty pharmacy drugs
- Secure real-time approvals for certain services and begin treatment right away
- Easily attach medical records
- Check approval status of your request

What if I am Prior Authorization exempt?

Providers with active prior authorization exemptions are encouraged to submit a notification through BlueApprovR for services or procedures for which you have a prior authorization exemption. You will also be able to submit recommended clinical reviews through BlueApprovR before moving forward with some services or procedures which are not on the required prior authorization list. Learn more here.

Note: your RCR submissions will follow the same path through BlueApprovR as Prior Authorization requests. Also, your RCR submission via BlueApprovR replaces the need to FAX or to attach forms in Availity.

Use BlueApprovR to Request Prior Authorization for these Types of Care

- Behavioral Health
- Specialty Pharmacy Drugs
- Inpatient Acute Care
- Long-term Acute Care
- Inpatient Rehab
- Skilled Nursing Facility
- Outpatient Hospice
- Inpatient Hospice
- Home Health
- Outpatient Service

How to Submit Prior Authorization and Recommended Clinical Review Requests through Availity Essentials

- In Availity, select **Payer Spaces** from the navigation menu, then **BCBSTX**
- On your Payer Spaces page, select the **Applications** tab and click **BlueApprovR**
- Users will be redirected to **BlueApprovR** to complete the request

Other Prior Authorization Request Methods:
Providers may submit a recommended clinical review utilizing the same submission process as a prior authorization using the Availity® Authorizations and Referrals tool.

Note: This new tool is currently not available for our Federal Employee Program,® Employees Retirement System of Texas, Teachers Retirement System of Texas or Medicare Advantage members. Please use your existing process for requesting prior authorization and recommended clinical review for these members.

Don't forget – benefits will vary based on the service being rendered. Always check eligibility and benefits first for BCBSTX members to confirm if prior authorization is required. This step also will alert you if your request must be submitted through a vendor, rather than BCBSTX.

Provider Resources

- Learn more about how to access and use BlueApprovR at our Provider Tools web page.
- Continue to watch News and Updates for future program updates and training opportunities.

New BlueApprovR℠ Tool Expedites Prior Authorization and Recommended Clinical Review for some Medical/Surgical Services

Blue Cross and Blue Shield of Texas (BCBSTX) continues to streamline the Prior Authorization and Recommended Clinical Review (RCR) process to reduce your workload with **BlueApprovR**. Effective Sept. 11, 2023, this new tool in Availity® Essentials helps you expedite approvals for some medical and surgical services for many of our commercial members.

BlueApprovR offers End-to-End Efficiencies
Registered Availity Essentials users have free, 24/7 access to BlueApprovR to:

- Request RCRs and prior authorizations for some inpatient and outpatient medical/surgical services
- Secure real-time approvals for certain services and begin treatment right away
- Easily attach medical records
- Check approval status of your request

What if I'm Prior Authorization Exempt?
Providers with active prior authorization exemptions are encouraged to submit a notification through BlueApprovR for services or procedures for which you have a prior authorization exemption. You will also be able to submit recommended clinical reviews through BlueApprovR before moving forward with some services or procedures that are not on the required prior authorization list. Learn more here.

Note: Your RCR submissions will follow the same path through BlueApprovR as prior authorization requests. Also, your RCR submission via BlueApprovR replaces the need to fax or to attach forms in Availity.

Use BlueApprovR to request prior authorization for these types of care:

- Specialty Pharmacy
- Inpatient Acute Care
- Long-Term Acute Care
- Inpatient Rehab
- Skilled Nursing Facility
- Outpatient Hospice
- Inpatient Hospice
- Home Health
- Outpatient Service

How to submit Prior Authorization and Recommended Clinical Review requests through Availity Essentials:

- In Availity, select **Payer Spaces** from the navigation menu, then **BCBSTX**.
- On your Payer Spaces page, select the **Applications** tab and click **BlueApprovR**.
- Users will be redirected to **BlueApprovR** to complete the request.

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- Providers may submit a recommended clinical review utilizing the same submission process as a prior authorization using the Availity Authorizations and Referrals tool.

Note: This new tool is currently not available for our Federal Employee Program® (FEP®), Employees Retirement System of Texas, Teachers Retirement System of Texas, or Medicare Advantage members. Please use your existing process for requesting prior authorization and recommended clinical review for these members.

Don't forget: Benefits will vary based on the service being rendered. Always check eligibility and benefits first for BCBSTX members to confirm if prior authorization is required. This step also will alert you if your request must be submitted through a vendor, rather than BCBSTX.

Provider Resources
Learn more about how to access and use BlueApprovR at our Provider Tools web page.

For More Information
Continue to watch News and Updates for future program updates and training opportunities.

See Updates to Claim Editing Changes for Emergency Department Services

Blue Cross and Blue Shield of Texas (BCBSTX) will enhance our claims editing and review process with Cotiviti for **emergency department (ED) evaluation and management (E&M)** for some of our commercial members. These editing enhancements for facility and professional claims will help ensure accurate billing and proper reimbursement.

As we told you earlier this year, for dates of service beginning Nov. 1, 2023, we will edit applicable **professional claims** to help ensure accurate billing and proper reimbursement. Now, for dates of service beginning Dec. 15, 2023, we will edit applicable **facility claims** to help ensure accurate billing and proper reimbursement.

What's changing: when we review your claim your reimbursement may be processed at a lower level of service if we cannot validate the level of E&M services billed. We will follow the American Medical Association guidelines for level of service and medical decision making.

What happens next: if you agree with the level of service reimbursed, no further action is needed. If you do not agree with the level of service reimbursed, you may submit additional medical records to support your claim.

Learn More: For more information on revisions to our ED claims editing process, please review our Clinical Payment and Coding Policies web page – see our revised CPCP003 Emergency Department Evaluation and Management (E/M) Services – for Facility Services policy and our new CPCP042 Emergency Department Evaluation and Management (E/M) Services Coding – for Professional Services policy.

Cotiviti, INC. is an independent company that provides medical claims administration for BCBSTX. References to other third-party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly.

Introducing Claim Reconsideration Requests via Availity® Essentials

Blue Cross and Blue Shield of Texas (BCBSTX) is excited to announce a convenient new way to submit claim reconsideration requests online for situational finalized claim denials (including BlueCard® out-of-area claims).

A ***claim reconsideration*** is a request to review and/or reevaluate a claim that has been finalized. Starting mid-October, you can submit reconsideration requests electronically, using Availity's Dispute Claim capability, which is anchored off the enhanced Claim Status tool. This method of inquiry submission is at no cost, **preferred over faxed/mailed claim disputes**, as it allows you to upload supporting documentation and monitor the status – all online.

Please note: This electronic option is not currently available for Texas Medicaid or Medicare Advantage claims.

We encourage you to begin using the new method for claim reconsideration requests now, as the Claim Inquiry Resolution (CIR) tool will be **modified to only accommodate certain claim scenarios**. The claim reconsideration option should be used to inquire on a previously processed claim.

Using this new online offering allows you to:

- Manage status
- Upload supporting documentation with your submission
- View and print the confirmation and decision
- Generate a Dashboard view of claim reconsideration request activity
- View uploaded documents after attaching them to the request*

***Note:** Uploaded attachments may take minutes to hours before they are viewable in the request.*

Steps to submit claim reconsideration requests online:

1. Log in to Availity Essentials
2. Select Claims & Payments from the navigation menu, then choose Claim Status
3. Search and locate the claim using the Member or Claim Number options
4. On the Claim Status results page, select Dispute Claim (if offered and applicable)
5. Select Reconsideration as the Dispute Reason
6. Complete the Dispute Request form
7. Upload supporting documentation
8. Review and submit your claim reconsideration request

For help with obtaining enhanced claim status online, refer to the Claim Status Tool user guide. Availity Administrators must assign users the **Claim Status role** in Availity Essentials to ensure users can access and submit electronic claim reconsiderations online. If your provider organization is not yet registered with Availity, you can sign up today at Availity, at no charge. For registration help, contact Availity Client Services at 800-282-4548.

For More Information

Watch for the **Claim Reconsideration Requests User Guide** coming soon to the Provider Tools section of our website. If you need further education or assistance, contact our Provider Education Consultants.

Fee Schedule Updates

Reimbursement changes and updates for commercial HMO and PPO practitioners are posted on the BCBSTX website under the “Reimbursement Schedules and Related Information” / Professional Schedules section.

- Changes resulting in a decrease will not become effective before (at least) 90 days from the posting date. The specific effective date will be noted for each change. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website.
- The Drug CPT®/HCPCS fee schedule is updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year.
- The National Drug Code fee schedule is updated monthly.

ClaimsXten™ Quarterly Update Effective Dec. 4, 2023

Blue Cross and Blue Shield of Texas (BCBSTX) will implement its fourth quarter code updates for the ClaimsXten auditing tool on or after Dec. 4, 2023.

These Quarterly code updates aren't considered changes to the software version. Code updates may include additions, deletions and revisions to:

- Current Procedural Terminology (CPT®) codes
- Healthcare Common Procedure Coding System (HCPCS) codes

When applicable, BCBSTX may also post advance notice of significant changes, like implementation of new rules, in the News and Updates section of our Provider website and the Blue Review monthly newsletter.

Use **Clear Claim Connection™ (C3)** to determine how certain coding combinations may be adjudicated when we process your claim. C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software.

Please note that C3 doesn't contain all of our claim edits and processes. Its results don't guarantee the final claim decision.

For more information, refer to the Clear Claim Connection page in the Education and Reference/Provider Tools section of our provider website for more information on C3 and ClaimsXten. It includes a user guide, rule descriptions and other details.

CLINICAL RESOURCES

Clinical Payment and Coding Policy Updates

Our website's Clinical Payment and Coding Policies 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 and does not address all reimbursement-related issues. We may add and modify clinical payment and coding policies. The following policies were added or updated:

- CPCP006 Preventive Services Policy Update Effective 10/1/2023
- CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services Update 10/01/2023
- CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services Effective 12/01/2023 Revised
- CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services Effective 01/25/2024

Updates to Clinical Practice and Preventive Care Guidelines

We've updated our Clinical Practice Guidelines and Preventive Care Guidelines. The guidelines help direct our quality and health management programs and improve member care. They may help guide your decision-making as you care for our members. We update them no less than every two years or when new significant findings or major advancements in evidence-based care are established.

EDUCATION & REFERENCE

Chronic Kidney Disease Management Strategies for Primary Care Providers

Blue Cross and Blue Shield of Texas (BCBSTX) invites **primary care providers** (PCPs) to an **online learning series on chronic kidney disease (CKD) management strategies.** The courses offer continuing medical education (CME) credit at **no cost to you**. We're pleased to offer this 12-part series through the National Kidney Foundation® (NKF), an independent organization dedicated to the awareness, prevention and treatment of kidney disease.

How to Access the Modules

We've emailed contracted BCBSTX PCPs a link to register for the series through the NKF learning management system. If you missed or didn't receive an email, you can find registration instructions in Availity® Essentials in BCBSTX Payer Spaces in the Resources section.

Course Offerings

- Earn **0.5 CME credit** for each of the following modules completed:
- Strategies for Slowing Progression in CKD
- Blood Pressure Management in Patients with CKD
- Nutritional Management in Kidney Disease: Opportunities and Challenges
- CKD and Cardiovascular Risk Management in Primary Care
- Strategies to Improve Outcomes in Diabetic Kidney Disease
- Evaluation and Diagnosis of Chronic Kidney Disease
- Women's Health and CKD from the Primary Care Perspective
- Medical Management of Advanced CKD from the Primary Care Perspective
- Management of Geriatric Patients with CKD from the Primary Care Perspective
- Addressing Health Inequities: An Opportunity to Improve Outcomes in Kidney Disease
- Kidney Replacement Therapy from the Primary Care Perspective
- Medication Management in Patients with CKD

You may complete the modules in any order and take as many as you choose.

More about CKD

Kidney diseases are a leading cause of death in the U.S., according to the Centers for Disease Control and Prevention. About 37 million adult Americans are estimated to have CKD, and most are undiagnosed.

BCBSTX tracks the quality measure Kidney Health Evaluation for Patients with Diabetes (KED) to help improve quality of care. KED applies to members ages 18 to 85 with diabetes (type 1 or type 2) who received a kidney health evaluation. An evaluation is defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year.

Join Us for a Webinar on Coding for Vascular Disease

Join our Coding Compliance team for a webinar on coding and guidelines for vascular disease. The webinar is free to providers and coding professionals. We are offering it:

- Dec. 15, 2023, from 12 to 12:30 p.m. CT. Register here.

If you're unable to view the registration site, you may need to clear your web browser history.

The webinar will include information from the Official ICD-10-CM Coding Guidelines, the American Hospital Association Coding Clinic and the Centers for Medicare & Medicaid Services. Topics include:

- Coding for peripheral vascular disease, deep vein thrombosis, pulmonary embolism and vascular aneurysm
- Risk adjustment updates
- ICD-10-CM guidelines and case studies
- Closing gaps in care for patients

This webinar doesn't offer continuing education credits.

HEALTH & WELLNESS

To support quality care, we provide information to providers and members to encourage discussions on health topics. Watch for more about health care quality in our website's News and Updates section and our *Delivering Quality Care* web page.

Encourage Annual Eye Exams for Members with Diabetes

People with diabetes are at a higher risk of vision loss and eye diseases, but 60% don't get annual eye exams, according to the Centers for Disease Control and Prevention (CDC). Early diagnosis and proper treatment can greatly **lower the chance of blindness** from diabetic retinopathy. You may play an important role in supporting our members with diabetes by encouraging an annual retinal or dilated eye exam by an eye care specialist.

In its Standards of Care in Diabetes 2023 for retinopathy, the American Diabetes Association recommends annual dilated retinal exams by an ophthalmologist or optometrist for members with any signs of retinopathy. See our preventive care and clinical practice guidelines for more information on diabetes.

Monitoring Our Members' Care

We track Eye Exam for Patients with Diabetes (EED), a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). EED captures the percentage of our members ages 18 to 75 with diabetes (type 1 and type 2) who have a retinal eye exam by an eye care professional during the measurement year to screen or monitor for diabetic retinal disease.

To help close gaps in care for this measure, consider the following:

- In early stages of retinopathy, people often don't experience any symptoms. Discuss the importance of annual eye exams with our members who have diabetes, including members who are planning to be pregnant or are pregnant. We've created information that may help.
- Consider building care gap alerts for eye exams in our members' electronic medical records and sending them reminders.
- We encourage eye care specialists to communicate exam results to our members' primary care providers to help coordinate care.

We track additional quality measures for our members with diabetes:

- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes, Blood Pressure Control for Patients with Diabetes and Kidney Health Evaluation for Patients with Diabetes: Learn more

- Statin Therapy for Patients with Diabetes: Learn more
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD): Learn more

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Colorectal Cancer Screenings Goal: 80% in Every Community – "Pulling It All Together"

The final article in a 4-part series regarding colorectal cancer (CRC) screenings.

Thank you for your continued support and interest in colorectal cancer screenings for our members. Please refer to the June 2023 Blue Review publication for first article titled, ***Colon Cancer Screenings Goal: 80% In Every Community[1]*,** our second article published in August titled ***Colorectal Cancer Screening Options and Statistics – Get the Conversation Started Today***, and our third article published in October titled ***Overcoming Barriers to Colorectal Cancer Screenings***.

We need your help to reach this goal!

Even though some screening methods are not appropriate or feasible for all patients, having a conversation with your patients about the screening options available and encouraging colorectal cancer (CRC) screenings are most likely to result in your patients getting screened. Colorectal cancer screening is recommended for adults ages 45 through 75 who are at average risk for colorectal cancer and who are asymptomatic. Some patients may need to be screened for colorectal cancer at an earlier age. It is also important to be aware that some screening methods may not be covered, and an out-of-pocket cost may result.

What Actions Can You Take to Make a Difference?
Have the conversation with your patients to discuss CRC risks and the best screening method for them. You are the biggest influence whether your patients receive CRC screening or not.

Colorectal Cancer Screening options[2]:

- Colonoscopy - Screening interval every 10 years.
- Flexible sigmoidoscopy - Screening interval every 5 years
- CT colonography - Screening interval every 5 years.
- Stool based tests - This type of screening includes:
    - FIT or immunologic Fecal Occult Blood Test (iFOBT). FIT tests may be one or two sample tests. Screening interval every year.
    - Guaiac based stool tests or gFOBT - Screening interval every year.
    - Stool DNA with FIT testing, also known as Cologuard® - Screening interval every 3 years.

The best test is the one that gets done!

Use a system within your practice to identify your patients ages 45-75 who need CRC screening and start that conversation.

How Far Away Are We from Reaching this Goal?
In 2022, the Healthcare Effectiveness Data and Information Set (HEDIS®) BCBSTX Commercial PPO result of 53.37 percent was well below the NCQA Quality Compass National PPO Average of 63.40 percent.

With your influence, we can raise the CRC screening rate, and meet the 80% colorectal cancer screening rate in every community goal.

References:
[1] https://nccrt.org/80-in-every-community-2/#1686669856662-9b5ce79e-8269
[2]https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening

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Coordinating Care after Hospital Discharges to Help Reduce the Chances of Readmissions

When our members receive inpatient hospital care, it's important for hospital care teams to share information with primary care providers (PCPs) to coordinate care after discharge. **Hospital discharge summaries** can help our members transition from inpatient care, according to the American College of Physicians and others. Care coordination and planning can in turn help reduce the chances of hospital readmissions, according to the National Committee for Quality Assurance (NCQA).

If you provide care to our members during or after a hospital discharge, consider the following tips to support care coordination.

For Hospital Care Teams

- Give PCPs timely access to **hospital discharge summaries.** Discharge summaries should include information on:
- Course of treatment
- Diagnostic test results
- Follow-up plans
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes and most commonly known side effects

For Primary Care Providers

- Obtain the member's hospital discharge summary and schedule a timely follow-up visit to discuss discharge instructions. Consider telehealth services when available and appropriate.
- Perform a medication reconciliation to compare hospital medication orders to the medications the member has been taking. This is done to prevent drug interactions, duplications, or other errors.
- Talk with our members about unique risks and barriers they may face that might have played a role in hospitalization. Our Health Equity and Social Determinants of Health page has information that may be helpful.

How We Can Help

- Let our members know we offer help and information in their language at no cost. To speak to an interpreter, members may call the customer service number on their member ID card.
- We have the potential to provide Medicaid members with free non-emergency transportation services.
- Blue Cross and Blue Shield Federal Employee Program® (FEP®) members may call 1-800-462-3275 to connect with a case manager after discharge.
- Blue Cross and Blue Shield TX Medicaid members may call 1-877-214-5630 STAR/CHIP and 1-877-301-4394 STAR Kids to connect with a service coordinator after discharge.

Tracking our members' progress

We track Plan All-Cause Admissions, which is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from NCQA. This captures the number of acute inpatient and observation stays during a measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. The measure applies to Medicare Advantage members ages 18 and older, and to other members ages 18 to 64.

As part of the Blue Cross and Blue Shield of Texas (BCBSTX) provider satisfaction survey, we also track responses from PCPs and specialists about the timely sharing of hospital discharge summaries. The survey results help us identify opportunities to improve coordination of care.

Overcoming Barriers to Colorectal Cancer Screenings

The third of a four-part series regarding colorectal cancer (CRC) screenings

Thank you for your continued support and interest in colorectal cancer screenings for our members. Please refer to the June 2023 Blue Review publication for first article titled, Colon Cancer Screenings Goal: 80% In Every Community and our second article published in August 2023 titled Colorectal Cancer Screening Options and Statistics – Get the Conversation Started Today.

The series now continues with article three, **Overcoming Barriers to Colorectal Cancer Screening**.
Patient Concerns

Embarrassment/Awkwardness

- Patients feel embarrassed about bowel functions and/or tests that involve stool collection.
- Inform patients that there are several screening options available, including simple take home tests that can be completed in the privacy of their own home.

Gaps in Knowledge: Facts people may not know about Colorectal Cancer and Colorectal Cancer Screenings

- Even if patients feel fine, being asymptomatic does not equate to an absence of cancer.
- Let patients know that many people diagnosed with colon cancer do not have any symptoms or a family history, which is why screening is so important even when they feel healthy.
- Most people diagnosed with CRC have no family history. The risk of having CRC is higher when a close relative has had it.
- More advanced CRC are being seen in younger people.
- Colorectal cancer is estimated to become the leading cause of cancer-related deaths ffor 20-49-year-olds by 2030.[1]

Additional Gaps in Knowledge

- Be mindful of social determinants of health such as the patients' low health literacy, language barriers, transportation, financial insecurity or no available companion. Discuss the variety of CRC screening options, in a way your patients can understand as well as individual considerations that may impact CRC screening test selection.
- Once a CRC screening option is agreed upon, explain the expectations and process. Assure that medications for discomfort will be provided for CRC screening procedures. Patient brochures and information are available.[2]

Concerns Regarding Costs and/or Interruption of Daily Life Responsibilities

- Although CRC screenings are a preventive measure, there may be affiliated out-of-pocket costs. Loss of work and/or lack of transportation may be a concern with a flexible sigmoidoscopy or colonoscopy.
- Inform patients that preventing colorectal cancer or finding it early does not have to be expensive. There are simple, affordable tests available.
- Encourage patients to contact their BCBSTX customer service representatives to discuss benefits and coverage.

Provider Concerns

Limited Patient Visit Time

- Addressing acute or chronic conditions may take precedence over preventive care during a visit.
- Inaccurate EMR reminders, lack of interoperable EHRs and trackable documentation inhibit an optimal clinic workflow. Office systems that "flag" patients needing CRC screenings are advantageous.
- Train your staff to identify patients with gaps in preventive care to allow for focused and efficient use of your time.

Familiarity with Recommended CRC Screening Options

- Various factors determine which option is best for each patient.
- Structure didactics for staff; educate staff on latest CRC guidelines and evidence-based screening options eligibility.
- Stocking Fecal Immunochemical Testing (FIT) kits in the office, to dispense during visits, can be effective. When patients agree to FIT testing, allow them to open the kit, handle the materials and complete the paperwork. The mystery will be removed if they can visualize the test and ask questions. They will also be more likely to complete the CRC screening if they feel confident in the process.

Culturally Competent

- Is your staff culturally competent? Use preferred language messaging. Use our free Language Line translation service during the office visit if necessary.
- Ask questions to ensure the patient understands you.
- Having printed materials available in the waiting room may encourage conversations.

Resources to Follow Up on Positive CRC Screenings

You may be concerned that patients with positive CRC screening results may not have access to gastroenterologists or cancer treatment specialists.

Review the availability of local resources to alleviate this concern or have patients call the number on the back of their member ID card to discuss resources.

References:

[1] https://nccrt.org/80-in-every-community-2/#1686669856662-9b5ce79e-8269

[2] https://www.nccn.org/patientresources/patient-resources/guidelines-for-patients/guidelines-for-patients-details?patientGuidelineId=61

MEDICARE ADVANTAGE PLANS

Medical Records Reminder for Out-of-Area Medicare Advantage Members

If we need medical records for Blue Cross Group Medicare Advantage (PPO)SM members, you will receive requests from Blue Cross and Blue Shield of Texas or our vendor, Change Healthcare, as part of the Blue Cross and Blue Shield National Coordination of Care program. In addition, you may receive requests from EXL Health for select inpatient, diagnosis-related group claims for any out-of-area Blue Cross Medicare AdvantageSM members. Please respond promptly to our requests so that we can provide timely service to those Medicare Advantage members.

Behavioral Health Mid-Level Fee Schedule Increase - Blue Cross Medicare Advantage (PPO)SM, Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage Dual Care (HMO SNP)SM

Blue Cross Blue Shield of Texas (BCBSTX) is pleased to announce a significant development concerning reimbursement rates for **Behavioral Health (BH) mid-level providers;** effective January 1, 2024. The rate increase will be implemented for the services of the **below BH mid-level providers**, aligning them with 100% of the Medicare fee schedule, by the applicable specialty:

Anesthesia Assistant Certified	Nutritionist
Advanced Nurse Practitioner	Physical Therapist
Certified Nurse	Physical Therapy Assistant
Certified Registered Nurse Anesthetist (CRNA)	Occupational Therapist
Dietician	Occupational Therapy Assistant
Licensed Clinical Social Worker (LCSW)	Registered Nurse (RN)
Licensed Genetic Counselor	Registered Nurse First Assistant
Licensed Marriage and Family Therapist (LMFT) - **Eff 1.1.24**	Respiratory Therapist
Licensed Master Social Worker	Skilled Nurse
Licensed Professional Counselors (LPC) - **Eff 1.1.24**	Speech Therapist
Licensed Physician Assistant	Speech Therapy Assistant
Mental Health Intensive Outpatient Program (IOP) - **Eff 1.1.24**	

This decision reflects BCBSTXs' commitment to recognizing the invaluable contributions of healthcare providers and their essential role in delivering exceptional care to our Medicare Advantage members. Fee schedule links are available via Availity® by selecting the Claims & Payments menu, Fee Schedule Listing, and then choose the appropriate Additional Fee Schedules for Medicare.

How to Use the Availity Fee Schedule Listing Tool: Note: Availity Administrators must assign the "Provider Fee Schedule" role for users to gain access to this tool at no cost.

1. Log in to Availity®
2. Select Claims & Payments from the navigation menu
3. Select Fee Schedule Listing
4. Select BCBSTX as the payer
5. Select your organization and Tax ID number
6. Enter the Billing National Provider Identifier (NPI) and Rendering NPI (if applicable)
7. Select the Network, Place of Service, and Provider
8. Enter the procedure code(s) and modifier(s)

If you are not yet registered:

1. Sign up today at Availity, at no charge. If you need registration assistance, contact Availity Client Services at **1-800-282-4548**.
2. For navigational assistance, refer to the Availity Fee Schedule User Guide.
3. **Note:** If you do not have Availity access, you may continue to submit your requests using the Professional Fee Schedule Request forms located on our provider website.

Providers with questions or in need of further clarification regarding this rate adjustment are encouraged to contact your dedicated Medicare Advantage Representative .

Category Removals from eviCore and other Updates to Prior Authorization Codes for Medicare Advantage Members, Effective Jan. 1, 2024

What's Changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Medicare members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

Medicare: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website. The revised lists can be found on the Prior Authorization Lists for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM page.

Changes include:

- Jan. 1, 2024 – **Removal of the Medical Oncology care category** previously reviewed by eviCore healthcare (eviCore)
- Jan. 1, 2024 – **Removal of the Radiation Oncology care category** previously reviewed by eviCore
- Jan. 1, 2024 – Addition of Radiation Therapy codes to be reviewed by BCBSTX

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

Medicare Advantage Members Transitioning to BCBSTX Kidney Care Program

In January 2024 we're launching a specialized care coordination program for eligible Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM members who have chronic or end-stage kidney disease. Our Kidney Care Program will replace the Somatus kidney care program, a service currently provided by vendor Somatus, Inc.®.

Program Transition

Medicare Advantage members who currently use Somatus will transition to our program from January through March 2024. During the transition, Blue Cross and Blue Shield of Texas (BCBSTX) and Somatus care coordinators will work together to support members. Members affected by the transition will receive a letter with details.

BCBSTX Care Coordination

As part of our Kidney Care Program, BCBSTX care coordinators collaborate with providers to coordinate services and help members follow a plan of care. Our goal is to support our members as they work with you to manage their disease and improve health outcomes. The program is free of charge.

Call the Customer Service number on the BCBSTX member ID card if you have questions or to refer a Medicare Advantage member to the Kidney Care Program.

Somatus is an independent company that provides care management services for certain BCBSTX members with CKD and ESKD. Somatus is wholly responsible for its own products and services. BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Blue Cross Medicare Advantage HMO℠ and Blue Cross Medicare Advantage Dual Care (HMO SNP) ℠ Behavioral Health Services Update

Effective January 1, 2024, Magellan will no longer be contracted with Blue Cross Blue Shield of Texas (BCBSTX) for Behavioral Health **(BH)** Services for both **Blue Cross Medicare Advantage HMO and Blue Cross Medicare Advantage Dual Care (HMO SNP)**. We want to assure you that BCBSTX is committed to ensuring a smooth transition during this period.

Note: There will be no changes for Blue Cross Medicare Advantage PPO℠.

IMPORTANT DETAILS:

1. **Transition Period**: BCBSTX will honor all authorizations and referrals on file with Magellan for up to **180** days from the effective date of **January 1, 2024**. This means that any ongoing authorizations and referrals will be honored during this transition period, ensuring that your patients' care remains uninterrupted.
2. **Contracting Opportunities**: If you are a behavioral health provider (who is not currently contracted directly with BCBSTX and would like to be, we encourage all **(BH)** provider types to take the next steps. You can begin the contracting and credentialing process by following the Join My Network link provided on our website.
3. **Refer To**: The Blue Cross Medicare Advantage Quick Reference Guide for additional contacts and resources.

We understand that this change may raise questions or concerns, and we are here to support you throughout this transition. Please feel free to reach out to your dedicated Medicare Advantage Network Team for any assistance or clarification you may need.

In addition, we will be hosting two HMO Behavioral Health Insourcing 30-minute seminars select your preferred date and time below to register for an upcoming session:

- December 4, 2023,12:00 p.m. CST Registration Link
- January 22, 2024, 12:00 p.m. CST Registration Link

Thank you for your dedication to delivering quality behavioral health services to our members, and we appreciate your understanding during this transition period.

2024 Expansion Blue Cross Medicare Advantage (PPO)℠, Blue Cross Medicare Advantage (HMO)℠ and Blue Cross Medicare Advantage Dual Care (HMO SNP)℠

Effective **Jan. 1, 2024**, Blue Cross Blue Shield of Texas (BCBSTX) announces that **Blue Cross Medicare Advantage (PPO), Blue Cross Medicare Advantage (HMO)** and **Blue Cross Medicare Advantage Dual Care (HMO SNP)** networks are expanding its service areas across Texas. The expansion continues to build on strong networks already in place in Texas and is part of our commitment to providing members with access to affordable health care.

Blue Cross Medicare Advantage (PPO) Expansion Areas:
Andrews, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Carson Castro, Cochran, Coke, Coleman, Concho, Crane, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Dickens, Donley, Ector, Edwards, Fisher, Floyd, Foard, Frio, Gaines, Garza, Gillespie, Glasscock, Hale, Hall, Hansford, Hardeman, Hartley, Haskell, Hockley, Howard, Hutchinson, Irion, Jeff Davis, Kent, Kimble, King, Kinney, Knox, Lamb, Live Oak, Loving, Lubbock, Lynn, Marion, Martin, Menard, Midland, Mitchell, Montague,

Moore, Motley, Oldham, Pecos, Presidio, Reagan, Red River, Reeves, Roberts, Runnels, San Augustine, Schleicher, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Terry, Upton, Wheeler, Winkler, Yoakum, and Zapata counties.

Blue Cross Medicare (HMO) Advantage Expansion Areas:
Anderson Andrews, Armstrong, Bailey, Baylor, Bee, Borden, Brewster, Briscoe, Carson, Castro, Cherokee, Cochran, Coke, Coleman, Concho, Crane, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Delta, Dickens, Donley, Erath, Fisher, Floyd, Foard, Frio, Gaines, Garza, Gillespie, Glasscock, Hale, Hall, Hansford, Hardeman, Harrison, Hartley Haskell Henderson Hockley Howard, Hutchinson, Irion, Jackson, Jeff Davis, Jim Wells, Kent, Kimble, King, Kinney, Kleberg, Knox, Lamb, Live Oak, Loving, Lubbock, Lynn, Marion, Martin, Menard, Midland, Mitchell, Montague, Moore, Motley, Nacogdoches, Oldham, Panola, Pecos, Presidio, Rains, Reagan, Reeves, Roberts, Runnels, San Augustine, Schleicher, Shelby, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Terry, Upton, Victoria, Winkler, Yoakum, Young, and Zavala counties.

Blue Cross Medicare Advantage (HMO SNP) Expansion Areas:
Anderson, Andrews, Armstrong, Bailey, Baylor, Bee, Borden, Brewster, Briscoe, Carson, Castro, Cherokee, Cochran, Coke, Coleman, Concho, Crane, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Delta, Dickens, Donley, Erath, Fisher, Floyd, Foard, Frio, Gaines, Garza, Gillespie, Glasscock, Hale, Hall, Hansford, Hardeman, Harrison, Hartley, Haskell, Henderson, Hockley, Howard, Hutchinson, Irion, Jackson, Jeff Davis, Jim Wells, Kent, Kimble, King, Kinney, Kleberg, Knox, Lamb, Live Oak, Loving, Lubbock, Lynn, Marion, Martin, Menard, Midland, Mitchell, Montague, Moore, Motley, Nacogdoches, Oldham, Panola, Pecos, Presidio, Rains, Reagan, Reeves, Roberts, Runnels, San Augustine, Schleicher, Shelby, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Terry, Upton, Victoria, Winkler, Yoakum, Young, and Zavala counties.

Remember to view the Blue Cross Medicare Advantage HMO SNP provider training here.

Plan highlights for both include:

- Cost-free SilverSneakers® gym membership
- Some plans offer supplemental vision and dental
- Dallas Choice Premier PPO plan offers a supplemental hearing aid allowance
- New Flexible Medicare Advantage PPO Plan

Have questions?
Call **1-972-766-7100**, Email Texas Medicare Advantage Network or reference the Medicare Advantage Provider Quick Reference Guide.

† SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company.

HMO Special Needs Plan provided by Blue Cross and Blue Shield of Texas, which refers to GHS Insurance Company (GHS), an Independent Licensee of the Blue Cross and Blue Shield Association. GHS is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in GHS' plan depends on contract renewal.

Survey Assesses Medicare Advantage Members' Health Outcomes

The Centers for Medicare & Medicaid Services (CMS) sends a Health Outcomes Survey (HOS) to a sample of our members from August through November. The survey asks members in Blue Cross Medicare Advantage and prescription drug plans to rate their last six months of care. If you get questions from members who have received the survey, **please encourage them to respond**. The survey covers health care topics our members may discuss with you, such as:

- Maintaining or improving physical health, including managing pain and exercise habits
- Maintaining or improving mental health, including energy levels, mood swings and sleeping habits
- Preventing falls

HOS results identify opportunities to improve health care plans. Results also affect the CMS Star Ratings, which rate Medicare Advantage plans on a scale from one to five stars. Our goal is to achieve the highest possible Star rating for our plans.

NETWORK PARTICIPATION

MyBlue Health℠ Network Expansion

Blue Cross and Blue Shield of Texas (BCBSTX) is expanding the **MyBlue Health℠** network, effective **Jan. 1, 2024,** for Comal, McLennan, and Rockwall Counties. MyBlue Health members in these areas will access care through providers contracted in the MyBlue Health network.

Note these additional counties have no impact on the current MyBlue Health network benefits applicable to:

Jan. 1, 2024	**Jan. 1, 2023**	**Jan. 1, 2022**	**Jan. 1, 2020**
Comal, McLennan, and Rockwall	Cameron, Collin, Denton, El Paso (The Valley), Hidalgo, and Tarrant	Bexar, Travis, and Williamson	Dallas and Harris

MyBlue Health members must choose a Primary Care Physician (PCP). Members can choose a family practitioner, internist, pediatrician, physician assistant (PA) or advanced practice registered nurse (APN), and/or obstetrician/gynecologist as their PCP.

In Comal, McLennan, and Rockwall Counties, some MyBlue Health members may choose a **MyBlue Health Select PCP** within the following practice groups which may result in a lower copayment for scheduled PCP office visits as indicated in their schedule of copayments and benefit limit:

Comal County	BHS Physicians Network and CentroMed
McLennan County	Providence Health Alliance
Rockwall County	Texas Health Physicians Group

Members covered by MyBlue Health can be identified through their **BCBSTX ID card:**

- **MyBlue Health** is displayed on the ID card.
- MyBlue Health members have a unique network ID: **BFT**
- The 3-character prefix is on the ID card: **T2G**

Patient eligibility and benefits should be checked prior to every scheduled appointment through the Availity® Essentials Provider Portal or your preferred web vendor. Eligibility and benefit quotes include participant confirmation, coverage status and other important information, such as applicable copayment, coinsurance, and deductible amounts. It's strongly recommended that providers **ask to see the participant's** ID card for current information and **photo ID** at every visit to guard against medical identity theft. When services may not be covered, participants should be notified they may be billed directly.

If you have any questions, please contact your Network Management Representative. Additional information regarding **MyBlue Health** will be available in future Blue Review and on our provider website.

PHARMACY

Pharmacy Program Quarterly Update, Part 1: Changes Effective Jan. 1, 2024

Review important pharmacy benefit reminders, drug list and dispensing limit changes, and Utilization Management program changes. Read more.

PRIOR AUTHORIZATION

New CPT Codes for COVID-19 Vaccines and Vaccine Administration

The American Medical Association (AMA) has updated its COVID-19 vaccine coding guidance. It released six new Current Procedural Terminology (CPT®) codes for Pfizer's and Moderna's vaccines and their administration.

The codes were effective as of Sept. 11, 2023. See the AMA website for current vaccine codes. The AMA announced that on Nov. 1, 2023, it will delete COVID-19 vaccine product and administration codes that end in "A" for products that are no longer FDA-authorized, except for the Novavax vaccine product code. Providers should discontinue use of the deleted codes for services provided after Nov. 1. The six new codes and the Novavax product code will remain in effect after Nov. 1.

COVID-19 coverage

Blue Cross and Blue Shield of Texas continues to cover FDA-authorized COVID-19 vaccines at the **member's preventive benefit level**. This includes the newest versions of the vaccines approved by the FDA. Some groups may not cover preventive services, including COVID-19 vaccines. Check eligibility and benefits for details for each member. Learn more on our Provider website.

FEP® Updates to Prior Approval Requirements and Benefits

As of January 1, 2024, the following changes will be in effect for FEP policy types:

1. For Standard and Basic, Hearing Aids will require Prior Approval and will NOT be covered with a post service review. Blue Focus will continue to have hearing aids not covered.
2. All genetic testing will require Prior Approval.
3. Proton Beam Therapy, Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy require prior approval.
4. Certain High-Cost High Dollar Drugs will require Prior Approval in addition to all Gene Therapy and CAR-T drugs.

5. All transplants require Prior Approval, regardless of policy type, except corneal.
6. Gender Affirming Care is being broadened to include breast augmentation and certain facial surgeries. All Gender Affirming Services still require Prior Approval.
7. We now provide coverage for Artificial Insemination; Prior Approval is required.
8. Benefits for drugs associated with Artificial Insemination (AI) procedures, where the procedure has been prior approved, may be covered.
9. In vitro fertilization (IVF) related drugs are limited to three cycles annually, prior approval required, and must be completed through the pharmacy benefit.
10. For Standard members, we now provide coverage for Assisted Reproductive Technology (ART) procedures and services, limited to $25,000 annually for some infertility diagnosis and Prior Approval required.
11. We no longer require written consent in a case management program prior to admission for inpatient care provided by a Residential Treatment Center (RTC) or Skilled Nursing Facility (SNF).
12. We now provide coverage for marital and family counseling.
13. For eligible members who do not opt out, prescription drug benefits will now be provided under a new FEP Medicare Prescription Drug Program (Medicare Part D).

FEP Resources

- Learn more on how to submit a request via Availity® Essentials
- Call **800-441-9188** for questions regarding FEP prior authorizations or you may utilize the Automatic Interactive Voice Response (AIVR)
- Fax numbers for prior authorizations **877-404-6455 or 888-368-3406** (fax along with a Recommended Clinical Review (Predetermination) form).
- For FEP expedited appeals only, the fax number is **972-766-9776**.
- For additional assistance please contact Customer Service **800-442-4607** or use contact number on back of the member's card.

In addition to the details provided above, visit fepblue.org for more information about our FEP members, including the benefit brochure.

Musculoskeletal, Cardiology Expansion and other Prior Authorization Code Changes for Commercial Members, Effective Jan. 1, 2024

What's new: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its lists of codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes. These changes are based on updates from Utilization Management prior authorization assessment, Current Procedural Terminology (CPT®) code changes released by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) changes from the Centers for Medicaid & Medicare Services.

Changes include:

- **Jan. 1, 2024** – **Expansion of the Musculoskeletal Joint & Spine category to include arthroscopy codes** to be reviewed by Carelon Medical Benefits Management (Carelon)
- **Jan. 1, 2024** – **Expansion of the Cardiology** category reviewed by Carelon
- **Jan. 1, 2024** – Addition of Specialty Pharmacy codes to be reviewed by BCBSTX
- **Jan. 1, 2024** – Addition of Medical Oncology drug codes to be reviewed by Carelon
- **Jan. 1, 2024** – Addition of Genetic Testing lab codes to be reviewed by Carelon

More Information: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website, Revised lists can be found on the Prior Authorization Lists **for** Fully Insured **and** Administrative Services Only **(ASO) Plans.**

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

New Location in Availity® to Access Prior Authorization Exemption Communications as of Sept. 7, 2023

Effective Sept. 7, all communications for prior authorization (PA) exemptions are now available in a new location in the Provider Correspondence Viewer (PCV) application under the secure Payor Spaces section of the Availity® Essentials website, including:

- The new PA Exemption notices effective 09/01/2023
- All previously issued exemptions (Effective 10/1/2022 and 3/1/2023)
- Maintain or Rescission Audit Review Notices
- All future communications of any kind

Accessing your communications in PCV is the most convenient method to access **all notices**. If you not currently registered for Availity, go to Availity Essentials or contact Availity Client Services at **1-800-282-4548** to get access. Refer to our PCV page for information on how to access PCV and a User Guide. The previous Prior Authorization Exemption Status Viewer is now retired.

Note, if you submitted a request by **07/31/2023** for another preferred method of receiving your PA exemption communications, (i.e., email or postal mail), your Sept. 1, 2023, notice will also be sent by your preferred method. If received after that date, your request will be used for future communications, and you will need to refer to Availity for your 9/1 communication. However, all letters regardless of your preference are available on PCV.

More Information
Please refer to Prior Authorization Exemptions on our Utilization Management page.

STANDARDS & REQUIREMENTS

Fee Schedules Update Effective February 1, 2024

Blue Cross and Blue Shield of Texas (BCBSTX) is implementing changes in the maximum allowable professional and ancillary fee schedules for Blue Choice PPO℠, Blue Essentials℠ (including HealthSelect℠ of Texas Network), Blue Premier℠, Blue Advantage HMO℠, Blue High Performance Network®, MyBlue Health℠ and PAR Plan networks (collectively referred to as "Networks") effective February 1, 2024.

Additional details and files are posted on the BCBSTX provider website under the Standards & Requirements tab then select General Reimbursement Information. To access this area, please obtain

the password from your Network Management Office. General reimbursement information policies and fee schedule information will be posted under **"Reimbursement Changes/Updates"** in the **"Reimbursement Schedules"** section.

To request professional fee schedule(s), please utilize the Professional Fee Schedule Request Form. **Be sure to indicate your request is for schedule(s) effective 02/01/2024.**
If you have any questions, please contact your Network Management Office.

Contact Us

View our quick directory of contacts for BCBSTX.

Verify and Update Your Information

Verify your directory information every 90 days. Use the Provider Data Management feature on Availity® or our Demographic Change Form. You can also use this form to submit email addresses for you and your staff to receive the *Blue Review* each month.

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.

Material presented is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment. The fact that a service or treatment is described is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through BCBSTX.

eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX. CPT copyright 2021 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

ClaimsXten and Clear Claim Connection are trademarks of Change Healthcare, an independent company providing coding software to BCBSTX. Change Healthcare is solely responsible for the software and all the contents.

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.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Primeto 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.

Change Healthcare is an independent third-party vendor that is solely responsible for the products orservices they offer.

HealthSmart RX is an independent company that has been contracted by BCBSTX on behalf of TRS to provide TRS patient support services for certain covered drugs. HealthSmart RX does not offer Blue Products or Services.

BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors

HEDIS is a registered trademark of NCQA.

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 certificateof 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, limitationsand 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 LegalReserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

bcbstx.com/provider