BLUE REVIEW℠

For Providers

DECEMBER 2024

BEHAVIORAL HEALTH

Updates Coming to Behavioral Health Substance Use Disorder Criteria for Utilization Management

We use clinical criteria from the American Society of Addiction Medicine's Treatment for Addictive, Substance-Related, Co-Occurring Conditions when reviewing requests to determine medical necessity. On Jan. 1, 2025, Blue Cross and Blue Shield of Texas will update our substance use medical necessity criteria for adults from ASAM Criteria 3.0 to ASAM's new Criteria 4.0. ASAM Criteria 3.0 will continue to be used for medical necessity criteria for adolescents.

The ASAM criteria are designed to support multi-dimensional assessments and treatments. There is a greater emphasis on the need for integrated care, addressing both the mental and physical health disorders present in patients with addictions.

If you have further questions, please call the member services number on the member's benefit card. As a helpful resource, learn more about ASAM's Treatment for Addictive, Substance-Related, Co-Occurring Conditions.

CLAIMS & ELIGIBILITY

Prior Authorization Code Updates for Medicare Members, Effective Jan. 1, 2025

What's Changing: Blue Cross and Blue Shield of Texas is changing prior authorization requirements for Blue Cross Medicare Advantage members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association. 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)℠ and Blue Cross Medicare Advantage (HMO)℠ page.

Changes effective January 1, 2025, include:

- **Removal of Medical Oncology and Supportive Care codes previously** reviewed by eviCore
- **Medical Oncology drug codes previously** reviewed by eviCore 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® 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.

Reminder: Medical Transportation Utilization Management Via Alacura Effective Jan. 1, 2025

As we previously posted, Alacura Medical Transportation Management will manage prior authorization, recommended clinical review and retrospective claim reviews for air and ground medical transportation on certain fully insured and Administrative Services Only groups* effective Jan. 1.

Alacura will manage:

- Air (Interfacility transfer for both fixed wing and rotor flights)
- Ground (reviewing level of care from basic life support to advance life support and urgency level for emergency and non-emergency transportation)
- Locating available ambulances, beds at the receiving hospital and other logistics of your patient's transport including transports by an in-network provider when possible.

Refer to our Utilization Management page for links to code lists that require prior authorization or are applicable to RCR for medical transportation.

***Alacura will not manage:**

- Members of the fully insured account group #212824
- BCBSTX Medicare Advantage and BCBSTX Medicaid
- 911/scene of accident or residence-based pickups

What do I need to do?

- Register for one of the following training sessions:
  - Wednesday 11/20 – 9:00 am -10:00 am
  - Wednesday 12/11 – 2:00 pm - 3:00 pm
  - Thursday 12/19 – 11:00 am -12:00 pm
  - Thursday 1/9 –2:00 pm - 3:00 pm
- As of Jan. 1, 2025, once the transport decision is made for our member, check eligibility and benefits to determine if Alacura manages medical transportations and notify Alacura if applicable. Ambulance providers can also check with Alacura before picking up the patient to ensure transport will be approved.

Contact Alacura:

- By phone (quickest channel) at **866-671-4834**
- By fax at **866-671-4995**
- Online at https://alacura.my.site.com/preauth/s/
- By email at Texas.UM@alacura.com

If you have any questions or if you need additional information, please contact your local BCBSTX Network Management Office.

Notification of Annual Benefit Updates

BCBSTX annually updates member files with benefit changes. As always, we encourage you to obtain your eligibility and benefit information using Availity® or your preferred electronic vendor. In the event you need to contact BCBSTX Provider Customer Service, please recognize that hold times may be longer than normal at the beginning of the year. Deferring eligibility and benefit information requests to a later date is appreciated for patients who are not scheduled for appointments.

Important Benefit Changes for Fully Insured Texas Group Plans

Review important benefit changes for Fully Insured group plans, effective Jan. 1, 2025, including:

- Outpatient lab claims
- Claims for services performed in an outpatient setting
- Any claims that meet criteria relevant to one or more of the applicable lab services included in this article

Read more.

New Laboratory Claims Review for Certain ASO Groups - Jan. 1, 2025

Beginning Jan. 1, 2025, Blue Cross and Blue Shield of Texas will implement new reimbursement policies for certain laboratory, services, tests and procedures for some Administrative Services Only members. You can view our applicable Laboratory Management Clinical Payment and Coding Policies here. A list of impacted ASO groups is coming soon on our website.

Affected claims: This lab program includes a review of claims prepayment and post-service for the following outpatient laboratory claims:

- Outpatient laboratory claims with dates of service beginning Jan. 1, 2025
- Claims for services performed in an outpatient setting (typically office, hospital outpatient or independent laboratory)
- Any claims that meet criteria relevant to one or more of the applicable laboratory services
- Applicable to specific ASO group members

Ordering providers should review the applicable Laboratory Management Clinical Payment and Coding policy when requesting lab services.

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:

- Annual Review: CPCP029 Medical Record Documentation Updated
- CPCP036 Paravertebral Facet Injection Procedure Billing & Coding Policy Updated Effective 02/13/2025
- CPCP008 Psychological and Neuropsychological Testing Updated Effective 02/13/2025
- CPCP020 Drug Testing Clinical Payment and Coding Policy Updated Effective 02/13/2025
- CPCP011 Applied Behavior Analysis – Effective 02/01/2025

EDUCATION & REFERENCE

SmartRx Assist Changes Its Name to HelpScript

Effective Nov. 22, 2024, HealthSmartRx has changed its name to HelpScript.

HelpScript offers assistance for certain eligible Teacher Retirement System of Texas participants with enrolling in pharmaceutical manufacturer copay assistance programs to eligible participants who are specific provider-administered specialty drugs.

The manufacturer copay assistance ensures continued access to these drugs with a significantly reduced copay, which can improve adherence and clinical outcomes. This copay assistance applies only to the cost of the provider administered drug(s) and does not apply to office visits or any other associated cost.

What do I need to do: Providers don't have to do anything. You will continue to follow your normal processes, use the same phone numbers and web addresses, including the same provider portal link.

More Information

- Review the TRS participant HelpScript FAQs
- If you have questions, call **1-833-798-6741** or visit HelpScript

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

MEDICARE ADVANTAGE PLANS

Medicare Prescription Payment Plan Launching Jan. 1, 2025

Effective Jan. 1, 2025, we will offer a new payment option for members with a Blue Cross Medicare Part D plan or a Medicare Advantage plan with Part D coverage. The Medicare Prescription Payment Plan offers enrollees the option to pay out-of-pocket prescription drug costs in the form of monthly payments over the plan year instead of all at once at the pharmacy.

Who may benefit: While this program is available to anyone with Medicare Part D, members who have high drug costs earlier in the calendar year may be more likely to benefit by spreading out their expenses over the year. Refer to the Centers for Medicare & Medicaid Services' fact sheet for more information.

How you can help: Members may opt into the program beginning Oct. 15, 2024, for a Jan. 1, 2025, effective date. If your patients have questions, have them call the number on their member ID card.

NETWORK PARTICIPATION

MyBlue Health℠ Network Expansion

Blue Cross and Blue Shield of Texas is expanding the MyBlue HealthSM network, effective Jan. 1, 2025, for Jefferson and Nueces 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, 2025	Jan. 1, 2024	Jan. 1, 2023	Jan. 1, 2022	Jan. 1, 2020
Jefferson, Nueces	Comal, McLennan, Rockwall	Cameron, Collin, Denton, El Paso, Hidalgo, Tarrant, Travis, Williamson	Bexar, Travis, Williamson	Dallas, 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 Jefferson and Nueces 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:

Jefferson County	**Baptist Physician Network**
Nueces County	QuickCare

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 Changes Effective Jan. 1, 2025 – Part 1

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

STANDARDS & REQUIREMENTS

Follow CMS Guidelines for Appointment Wait Time Standards

To ensure timely access to medical care for our members, follow the Centers for Medicare and Medicaid Services guidelines for Qualified Health Plan appointment wait time standards for behavioral health services, routine primary care and non-urgent specialty care.

Impacted health plans: Wait time standards apply to our members with MyBlue Health℠ and Blue Advantage HMO℠ health plans.

According to CMS guidelines as of Jan. 1, 2025: Ensure that our members seeking an appointment are able to schedule an appointment within the time frames below **at least 90% of the time:**

Provider Specialty Type	Appointments Must Be Available Within
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-urgent)	30 business days

For more information refer to CMS's Wait Time Standards FAQ.

UTILIZATION MANAGEMENT

How to Submit Photos to Accompany Prior Authorization or Recommended Clinical Review Requests

When you need to submit images to support a utilization management request, use the options below to send us photos. Photocopies sent via fax are typically low resolution and may not be dependable to support your case. The preferred method for submitting prior authorization or recommended clinical review requests is electronically.

If you submitted your original prior authorization or RCR request electronically: Send photos and other supporting documentation to us using the appropriate online option.

- **BlueApprovR℠** – For requests submitted via our BlueApprovR tool for some **commercial** members, we'll email you to request photos if needed to complete clinical review. See our BlueApprovR provider tools page for more information.
- **Authorization & Referrals tool via Availity® Essentials -** After submitting an authorization via Availity, if the request pends for clinical review, select "Add Clinical Documentation" to attach supporting documentation. You may add up to 10 attachments (.pdf, TIFF, JPEG or XML). See our instructional Availity Authorizations provider tools page for more help.

- **eviCore® healthcare for Prior Authorization (Government Programs) -** Images can be attached in the request on the eviCore portal. To upload images in eviCore, select "View Uploads, Letters and Faxes Tab" in the upper navigation menu.
- **Carelon Medical Benefits Management -** During the review, Carelon may request diagnostic imaging results, such an X-ray, CT, MRI, etc., of the pertinent region performed within the last twelve months. Login to Carelon's provider portal for more information.

To support prior authorization or RCR requests initiated by phone or fax: Send photos via secured email to us at photohandling@bcbsil.com. **Add photos to your email as attachments, such as JPEG or PDF.** (Don't copy and paste photos into the body of your email.)
In the body of your email, include:

- Member's first and last name
- Member's date of birth
- Member ID number, including the three-character prefix
- Group number
- Case number from Blue Cross and Blue Shield of Texas

Prior Authorization Code Changes for Commercial Members Effective Jan. 1, 2025

What's new: Blue Cross and Blue Shield of Texas updated its lists of codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes effective 01/01/2025. These changes are based on updates from Utilization Management prior authorization assessment, Current Procedural Terminology (CPT®) code changes released by the American Medical Association or Healthcare Common Procedure Coding System changes from the Centers for Medicaid & Medicare Services.

Changes Effective Jan. 1, 2025, include:

- Addition of Medical Oncology codes to be reviewed by Carelon
- Addition of Medical Oncology drug codes to be reviewed by Carelon
- Removal of Medical Oncology codes previously reviewed by Carelon
- Addition of Specialty Pharmacy drug codes to be reviewed by BCBSTX

More information: Refer to Prior Authorization Lists on the Utilization Management page of our provider website, Revised lists can be found on the Prior Authorization Lists for Fully Insured and Administrative Services Only 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.

Site-of-Care Utilization Management Review for Advanced Imaging Jan. 1, 2025

Effective Jan. 1, 2025, Carelon Medical Benefits Management will do a medical necessity review **including site of care when you request eligible computed tomography, computed tomography angiography, magnetic resonance imaging and magnetic resonance angiography imaging services** that require a prior authorization or are applicable for a recommended clinical review in a hospital-based outpatient setting for certain commercial members. These additional reviews will **help our members get the right care in the right setting**.

Carelon will review your request for medical necessity and determine if the service requires an outpatient hospital setting, or if there are available freestanding alternatives. Carelon will use its "Site of Care for Advanced Imaging" clinical guidelines to conduct its review. You may request a peer-to-peer review from Carelon before or after the determination.

For Advanced Imaging Facilities: If your facility bills as a freestanding imaging center, or bills with the following place of service designations, **we recommend you register with *Opti*Net® by Dec. 1, 2024:**

- Place of service codes 11, 49 or 81 are designated as a Freestanding Imaging Facility / Physician Group
- Place of service codes 19 or 22 are designated as an Outpatient Hospital Department

OptiNet is Carelon's online assessment tool that collects modality-specific data from imaging providers. For more information, refer to our updated prior authorization or recommended clinical review code lists on our Utilization Management page.

Always check eligibility and benefits first through Availity Essentials or your preferred vendor portal, prior to rendering services. This step will confirm prior authorization requirements or if service is eligible for recommended clinical review and if managed by BCBSTX or a utilization management vendor.

Even if prior authorization isn't required for a commercial member, you still may want to submit a voluntary recommended clinical review request. This step can help avoid post-service medical necessity review. Learn more about Recommended Clinical Review.

Services performed without required prior authorization or optional RCR that do not meet post service medical necessity or site of care criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Note: These changes do not apply to **Federal Employee Program®** or **Medicare Advantage or Medicaid** members.

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.

Alacura Medical Transportation Management, LLC. is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide utilization management services for members with coverage through BCBSTX.

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 registeredtrademark 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