BLUE REVIEW℠

For Providers

JANUARY 2024

CLAIMS & ELIGIBILITY

Advisory on Telemedicine and Telehealth Services – Using Place of Service Codes on Commercial Claims

What's changing: We're updating our telemedicine and telehealth **commercial** claims filing guidelines following recommendations from the Centers for Medicare & Medicaid Services.

When filing commercial claims, follow these place of service code recommendations from CMS:

- **POS 10** is for use on claims for "Telehealth Provided in Patient's Home"
- **POS 02** is for use on claims for "Telehealth Other than in Patient's Home"

The above place of service code changes designate where the patient is located when receiving services through telemedicine and telehealth.

This notification applies to claims for commercial Blue Cross and Blue Shield of Texas members.
More Information: Continue to visit the News and Updates page on the provider website and the Blue Review newsletter for further updates regarding telehealth and telemedicine. Visit the CMS website for more information on modifications to the POS codes for telemedicine and telehealth.

Three New ClaimsXtenTM Rules to be Implemented March 2024

Note: See also Disclosure Notice page.

On or after **March 1, 2024**, we will update the ClaimsXten software database to better align coding with the reimbursement of claim submissions.

These are the changes:

Bundled Service	This rule identifies claim lines containing procedure codes indicated by the Centers for Medicare & Medicaid Services to be always bundled when billed with any other procedure. According to the CMS National Physician Fee Schedule Relative Value File, this procedure has a status code indicator of "B," which is defined as: "Payment for covered services is always bundled into payment for other services not specified." This rule is appropriate for professional claims only.

CMS Add-on Without Base Code Facility	This rule identifies claim lines containing a Current Procedural Terminology or Healthcare Common Procedure Coding System assigned add-on code when billed without acceptable supporting primary procedure/base code by the same practitioner for the same patient on the same date of service, per CMS. According to CMS, add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. An add-on code is eligible for payment if its related primary procedure/base code is also eligible for payment to the same practitioner for the same patient on the same date of service. This rule is appropriate for outpatient facility claims only.
Ancillary Procedures	This rule identifies claim lines billed by the same or a different provider either on the same day or different day (depending on the procedure code) after a non-covered service. This rule can consider both facility and non-facility claims. Before denying an ancillary service, the rule checks for other covered services that may have been performed on the same day as the non-covered procedure. If found, the rule will allow the ancillary service. This rule is appropriate for professional claims and outpatient facility claims only.

To determine how coding combinations may be evaluated during claim adjudication, use Clear Claim Connection™ (C3). Refer to our Clear Claim Connection page for more information on ClaimsXten and C3.

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:

- CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services Update 12/01/2023
- Annual Review: CPCP008 Psychological and Neuropsychological Testing Update Effective 12/07/2023
- Annual Review: CPCP024 Evaluation and Management (E/M) Coding – Professional Provider Services Update Effective 12/08/2023
- CPCP004 NICU Level of Care Authorization and Reimbursement Policy Update Effective 03/06/2024
- CPCP030 Point-of-Care Ultrasound Updated Effective 03/06/2024
- CPCP020 Drug Testing Clinical Payment and Coding Update Effective 03/07/2024
- CPCP033 Telemedicine and Telehealth/Virtual Health Care Services Policy Update Effective 03/08/2024

HEALTH & WELLNESS

Remind Our Members about Cervical and Breast Cancer Screenings

The new year is an opportunity to remind our members to schedule their screenings for cervical cancer and breast cancer. Regular screening tests can detect problems early when they're easier to treat.

Recommended Screenings

The U.S. Preventive Services Task Force recommends:

- Screening all women for cervical cancer starting at age 21
- Screening women ages 50 to 74 for breast cancer every two years. You may want to discuss with members the risks and benefits of starting screening mammograms before age 50.

See our preventive care guidelines for more information.

Addressing Health Disparities

According to the American Cancer Society:

- Native American and Hispanic women have the highest rates of cervical cancer.
- Black women are more likely to die from breast and cervical cancer than other racial or ethnic groups.

Other non-medical drivers of health, such as education levels and poverty, are also linked to different health outcomes. See our Health Equity and Social Determinants of Health page for more information on health equity and how you can help.

Closing Gaps in Care

Cervical Cancer Screening and Breast Cancer Screening are Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance. We track data from HEDIS measures to help assess and improve our members' care.

Cervical Cancer Screening tracks the following:

- Women ages 21 to 64 who had cervical cytology performed within the last 3 years
- Women ages 30 to 64 who had either:
    - Cervical high-risk human papillomavirus (hrHPV) testing within the last 5 years or
    - Cervical cytology/hrHPV cotesting within the last 5 years

Breast Cancer Screening assesses the percentage of women ages 50 to 74 who had at least one bilateral mammogram in the past two years.

Tips to Consider

- Talk with our members about risk reduction and prevention.
    - We've created resources on cervical cancer and breast cancer screening that may help.
    - The Centers for Disease Control and Prevention recommends human papillomavirus (HPV) vaccines for all people up to age 26 to protect against cervical cancers. We have a tip sheet on coding and documenting for HPV and related cancers.
- Document screenings in the medical record. Indicate the date and result.
- Document medical and surgical history in the medical record, including dates.
- For members who have had a hysterectomy, document the type of hysterectomy and date of surgery. If the member has not had a hysterectomy with removal of cervix, they will need to continue to receive their cervical cancer screening. A documentation of hysterectomy alone is not sufficient to remove the member from the CCS measure. **There must be documentation of absence of cervix.**
- Follow up with members if they miss their appointment and help them reschedule.

MEDICARE ADVANTAGE PLANS

Care Guidelines for Medicare Advantage Members' Availability and Access Standards

The Centers for Medicare and Medicaid Services' revised guidelines for appointment availability and access should be followed to ensure timely access to medical care for Medicare Advantage members. Under CMS's Time Standards (42 CFR 422.112) the revised guidelines codify wait time standards to reflect business days instead of weekdays.

CMS applies these standards to primary care and behavioral health services and substance use disorder services as follows:

- Routine and preventive care within 30 business days
- Urgent, but non-emergent care within 24 hours of request
- Services that are not emergency or urgently needed, but requires medical attention — within 7 business days (revised from one week)

For more information refer to CMS's Access to Services (42 CFR 422.112).

Hospitals Must Provide Medicare Outpatient Observation Notice

Hospitals and Critical Access Hospitals (CAH) are required to give the standardized Medicare Outpatient Observation Notice (MOON) to our Blue Cross Medicare Advantage℠ members who are under outpatient observation for more than 24 hours. **The notice explains why the members aren't inpatients and what their coverage and cost-sharing obligations will be.**

To Complete the MOON:

- Download the notice from the Centers for Medicare & Medicaid Services (CMS) website. Forms in English, Spanish and large print are available.
- Fill in the reason the member is outpatient rather than inpatient.
- Explain the notice verbally to the member if they are in observation more than 24 hours.
- Have the member sign to confirm they received and understand the notice. If the member declines, the staff member who provided the notice must certify that it was presented.
- Document all member communications regarding the MOON process in members' records.

The notice **must be completed no later than 36 hours after observation begins or sooner** if the patient is admitted, transferred or released.

Learn more from CMS instructions.

Patients in the Qualified Medicare Beneficiary Program Should Not Be Billed

If you participate in Blue Cross Medicare Advantage℠ plans, you may not bill our members enrolled in the Qualified Medicare Beneficiary program, a federal Medicare savings program.

QMB patients are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a state Medicaid benefit, QMB covers the Medicare Advantage premiums, deductibles, coinsurance and copayments of QMB beneficiaries. **QMB beneficiaries are not responsible for Medicare Advantage cost-sharing, or out-of-pocket costs.**

For services you provide to QMB patients, you must:

- Bill both Medicare Advantage and Medicaid
- Accept Medicare Advantage payments and any Medicaid payments as payment in full

Tips to Avoid Billing QMB Patients

Please ensure that you and your staff are aware of the federal billing law and policies governing QMB. It is against federal law for any Medicare provider to bill QMB patients, whether or not the provider accepts

Medicaid. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB patients for Medicare Advantage cost-sharing.

To avoid billing QMB patients, please take these precautions:

- Identify QMB patients by looking for **Blue Cross Medicare Advantage Dual Care℠** on member ID cards
- Check the Texas Medicaid portal to confirm QMB beneficiary status.
- Understand the Medicare Advantage cost-sharing billing process
- Be sure your billing software and staff remove QMB patients from Medicare Advantage cost-sharing billing and related collections efforts

Questions? Call Customer Service at 1-877-774-8592 to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.

Prior Authorization Code Changes for Medicare Members, Effective January 1, 2024

What's Changing: Blue Cross and Blue Shield of Texas 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. 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 include:

- Jan. 1, 2024 – **Removal of Magellan Electro Convulsive Therapy codes previously** 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.

Reminder: Prior Authorizations via eviCore for Blue Cross Group Medicare Advantage Plans

Blue Cross and Blue Shield of Texas (BCBSTX) is expanding members enrolled in Blue Cross Group Medicare Advantage (PPO)℠ programs effective Jan. 1, 2024. As a reminder, Blue Cross Group Medicare Advantage members may require prior authorization (PA) from eviCore healthcare® for certain services as shown below. Services performed without authorization may not be reimbursed for these healthcare services and you may not seek reimbursement from members.

Authorization is required for:

- Advanced Radiology Imaging
- Musculoskeletal – Pain/Joint/Spine
- Outpatient Sleep
- Outpatient Specialty Drug
- Lab Management Solutions – Molecular and Genomic Lab Testing

Note: Effective 01/01/2024 outpatient Medical Oncology and Radiation Therapy do not require eviCore PA. However, certain Radiation Therapy services will require PA via BCBSTX Medical Management. Services performed in conjunction with an inpatient stay, 23-hour observation, or emergency room visit are not subject to authorization requirements.

Use Availity® Essentials or your preferred vendor to check eligibility and benefits before rendering services. This step will also help you determine if your services require prior authorization through **BCBSTX** or **eviCore**.**When services require prior authorization via eviCore, submit the request as follows:**

- Log onto **(preferred method):** eviCore Healthcare Web Portal
- Call**: 1-855-252-1117** (7 am – 7 pm local time, M-F)
- Fax: **1-800-540-2406**

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please submit a request online at eviCore and indicate the procedure is NOT routine/standard. Providers can also request urgent requests by calling the toll-free number at **1-855-252-1117**. Be sure to tell the representative the request is for medically urgent care.

We recommend ordering physicians request authorization and pass the approval information to the rendering facilities at the time of scheduling. Authorizations contain approval numbers and one or more CPT codes specific to the services authorized. If the service requested and/or performed is different than what was initially authorized, the rendering facility must contact eviCore to make revisions to the authorization prior to claim submission.

Have questions about requesting authorizations? Attend on online orientation session!
The orientation schedule and program training resources are available on the eviCore resources site then select Blue Cross Blue Shield of Texas from drop down list.

eviCore healthcare's Clinical Guidelines and request forms are available on the eviCore website. Please call Client and Provider Services department at **1(800) 646-0418** (Option 4) if you have any questions or need more information.

Update Your Records: New Medicare Advantage Open Access PPO Members and ID Cards

New Medicare-eligible retirees have joined our **Blue Cross Group Medicare Advantage Open Access (PPO)℠** plans for retirees of employer groups and **Blue Cross Medicare Advantage Flex (PPO)℠** plan for individuals. These are open access, national PPO plans without network restrictions.

If you're a Medicare provider, you may treat these members regardless of your contract or network status with Blue Cross and Blue Shield of Texas. That means you don't need to participate in BCBSTX Medicare Advantage networks or in any other BCBSTX networks to see these members.

The **only requirements** are that you agree to see the member as a patient, accept Medicare assignment and submit claims to the Plan.

Check for New Member ID Cards

As with all our members, it's important to ask to see the member's ID card before all appointments, and to check eligibility and benefits. All Medicare Advantage members receive new ID cards Jan. 1. Newly enrolled members also have new ID numbers.

Please update your records with **new ID numbers**. Use the **entire member ID number**, including the alpha prefix, to verify benefits and successfully process claims.

You can identify these members by the **plan type** listed on their ID card: **Blue Cross Group Medicare Advantage Open Access (PPO)** or **Blue Cross Medicare Advantage Flex (PPO).**

If you have questions, call the customer service number on the member's ID card.

Open Access PPO Retiree Groups

On Jan. 1, 2024, approximately 11,000 retirees from **The Texas A&M University System** joined our Blue Cross Group Medicare Advantage Open Access (PPO) plan called **65 Plus Medicare Advantage Plan (PPO).**

Medicare providers may see these members and retirees of other employer groups that joined or soon will join the Blue Cross Group Medicare Advantage Open Access (PPO) plan:

- Baptist General Convention of Texas
- Buckner International Group
- City of Austin
- City of Hurst
- City of Irving
- Ector County
- Nautilus Hyosung America Inc.
- Oncor Electric Delivery Company LLC
- Plumbers Local Union Number 68
- Sempra Texas Holdings Corp.
- Southwestern Baptist Theological Seminary
- Southwestern Health Benefit Fund
- Tarrant County Appraisal District
- University of Texas System (UT CARE™ Medicare PPO)
- Vistra Energy
- The Weir Group
- Zachry Holding

Flex and Open Access Advantages
These plans cover the same benefits as Medicare Advantage Parts A and B plus additional benefits per plan. Members' coverage levels are the same inside and outside their plan service area nationwide for covered benefits.

- **Blue Cross Group Medicare Advantage Open Access (PPO)** is available to retirees of employer groups. It includes medical coverage and may include prescription drug coverage. Plan members may have to pay deductibles, copays and coinsurance, depending on their benefit plan.
- **Blue Cross Medicare Advantage Flex (PPO)** is available to individuals. It includes medical coverage and prescription drug coverage. It doesn't require member cost share.

Referrals aren't required for office visits. Prior authorization may be required for certain services from Medicare Advantage-contracted providers with BCBSTX.

For Reimbursement
Follow the billing instructions on the member's ID card. When you see these members, you'll submit the claims to the Plan and not Medicare.

- **If you're a Medicare Advantage-contracted provider with any Blue Cross and Blue Shield Plan,** you'll be paid your contracted rate. You're required to follow utilization management review requirements and guidelines.
- **If you're a Medicare provider who isn't contracted for Medicare Advantage with any BCBS Plan,** you'll be paid the Medicare-allowed amount for covered services. You may not balance bill the member for any difference in your charge and the allowed amount.* You aren't required to follow utilization management guidelines. However, you may request a review to confirm medical necessity.

* Blue Cross Group Medicare Advantage Open Access (PPO) members may be responsible for cost share for supplemental dental services from non-contracted Medicare providers.

Providers not contracting with BCBSTX are under no obligation to treat Blue Cross Medicare Advantage Flex (PPO) or Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations.

PHARMACY

BCBSTX's Approach to Managing GLP-1 Agonist Medications

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to providing its members access to safe, appropriate, and cost-effective health care within their plan benefits. To ensure the appropriate use of GLP-1s as indicated for diabetes, we are making it easier for providers to bypass our prior authorization (PA) process for some of our members with diabetes.

What this means: In June 2023, we implemented 'smart' automation technology at the pharmacy counter to assist with PA review requirements for GLP-1 drugs covered by the pharmacy benefit. The technology reviews documented medical diagnosis of Type 2 diabetes and claims history for other diabetes medications like insulin. When applicable members have a pharmacy claim for a GLP-1 diabetes drug and BCBSTX has documentation of both the Type 2 diabetes diagnosis and claims history for other diabetes medications, members are flagged as having met the PA criteria and a PA request is not needed. The applicable members only need a prescription for their medicine. Medical chart notes are only required in cases where we do not have a member's diabetes diagnosis and other diabetes medication history on file.

What's changing: Beginning Jan. 1, 2024, applicable commercial plan members using a GLP-1 diabetes drug who do not have a diabetes diagnosis and other diabetes medication history on file will be required to go through the PA process. This will apply to both group members with prescription drug benefits administered by Prime Therapeutics and members who purchase individual and family plans, who have the PA program as part of their pharmacy benefits.

- If your patient does not have a Type 2 diabetes diagnosis in their medical claims history and prescription history for other diabetes drugs, you may need to submit documentation of the missing information to meet the new PA criteria. Coverage of a GLP-1 diabetes drug may not be approved without documentation of a diabetes diagnosis.
- Note: If your patient has an existing PA approval for a GLP-1 diabetes drug, the PA will remain in effect until the expiration date stated on the PA approval notice. You, or your patients, may receive a PA notification alert to re-submit the request in advance as part of our notification process.

Starting in 2024, Medicare members will also need PA approval for GLP-1 coverage consideration to treat Type 2 diabetes. If a diagnosis of Type 2 diabetes is already on file with us, this request may not be needed.

What's next: BCBSTX and Prime Therapeutics continue to monitor market changes and pharmacy dispensing and medication utilization. Pharmacy clinical management strategies will be adjusted as needed to best support our members while managing the total cost of care.

Updated: 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.

Introducing Smart RxAssist via HealthSmartRx®

Blue Cross Blue Shield of Texas (BCBSTX) is working with HealthSmartRx (HSRx), an independent company, to implement the Smart RxAssist program for certain eligible Teacher Retirement System of Texas (TRS) participants effective **October 16, 2023**.

What Is Smart RxAssist? Smart RxAssist offers assistance with enrolling in pharmaceutical manufacturer copay assistance programs to eligible participants who are prescribed 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 costs.

Enrollment is optional for eligible TRS participants and participation is voluntary for providers. The resulting payments from the copay assistance, TRS participant's cost sharing, and the health plan will equal the Allowable Amount that applies today. Participants who choose to participate are required to enroll in the Smart RxAssist program per their group benefits for in-scope provider-administered drugs.

HealthSmartRx Smart RxAssist Process:

- If your patient has not yet enrolled in Smart RxAssist, an HSRx Patient Advocate will reach out to your patient by phone to facilitate enrollment and answer any questions they may have.
- Your office may be contacted by HSRx via phone or fax for enrollment and/or to provide documentation required by the manufacturer for the copay assistance program.
- Once your patient is enrolled, an HSRx Patient Advocate will contact your office to provide additional details on copay assistance claim submission and how you will receive copay assistance funds from the manufacturer.
- If required, initiate prior authorization and follow utilization review requirements in the Provider Manual. You will receive notification if the prior authorization is approved.
- Submit a medical claim to BCBSTX for primary payment.
- Follow applicable manufacturer program reimbursement procedures to obtain copay assistance funds.

More Information

- Review the TRS participant Smart RxAssist FAQs.
- If you have questions, call **1-833-798-6741** or visit SmartRxAssist.

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.

Oral Oncology Pharmacy Network Transitioned to IntegratedRx™

What's new? As of Oct. 1, 2023, the Prime Therapeutics® oral oncology pharmacy network has transitioned to the IntegratedRx™ network of specialty pharmacies.

What is IntegratedRx™? IntegratedRx™ is a clinically integrated program that allows members to receive their oral oncology and other select medications at their health care provider's clinic or hospital pharmacy. The doctor and pharmacist are part of the same team and have direct communication. Members have access to more than 400 clinic-based pharmacies for oncology and more than 10 clinic-based pharmacies for cystic fibrosis.

Finding a specialty pharmacy: Providers learn more by reviewing the updated list of BCBSTX's in-network specialty pharmacy vendors. Members can view the specialty network list by logging into their Blue Access for Members℠ or MyPrime.com accounts.

More information: Call the number on your patient's member ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

BCBSTX contracts with Prime Therapeutics to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics. MyPrime.com is an online resource offered by Prime Therapeutics. The relationship between BCBSTX and the specialty pharmacies is that of independent contractors.

Monitoring Children Using ADHD Medication

Medication for attention-deficit/hyperactivity disorder can help manage symptoms in children, according to the Centers for Disease Control and Prevention. Providers who prescribe ADHD medication to children should monitor them to ensure medications are prescribed and managed correctly, according to the National Committee for Quality Assurance. NCQA recommends following up with children who are newly prescribed ADHD medication and who remain on medication long term.

Supporting Quality Care

We track the NCQA quality measure Follow-Up Care for Children Prescribed ADHD Medication. This measure captures the percentage of children ages 6 to 12 who had:

- Initiation phase: One follow-up visit with a provider with prescribing authority within 30 days of the first prescription
- Continuation and maintenance phase: Two or more follow-up visits with a provider in the nine months (270 days) after the initiation phase. The child also remains on the ADHD medication for at least 210 days

Visits for both phases can be by telehealth when appropriate and depending on the member's benefits. For tips to close gaps in care for this measure, see our tip sheet.

PRIOR AUTHORIZATION

TRS is Moving Certain Services to Recommended Clinical Review

Effective March 1, 2024, Blue Cross and Blue Shield of Texas (BCBSTX) is moving certain inpatient services from prior authorization to the Recommended Clinical Review Option (RCR) for Teacher Retirement System of Texas (TRS) participants.

RCR will be available for:

Elective Inpatient Medical/Surgical Facility Admissions Including Transfers:

- Acute Care / Hospital Hospice, Maternity, Medical, Surgical, Transplant
- Hospice Care
- Long Term Acute Care / Sub-acute
- Rehabilitation Facility
- Skilled Nursing Facility

Elective Behavioral Health and Chemical Dependency Facility Admissions:

- Inpatient
- Residential Treatment Center (RTC)

Key Points

Refer to the Availity Attachments: Submit Recommended Clinical Review Requests Online.
RCR requests are optional medical necessity reviews conducted before services are provided. Submitting a request prior to rendering services informs you of situations where a service may not be covered based upon medical necessity.

Claims for services for which the RCR option is available will be subject to retrospective review if a provider elects not to submit a request for RCR.

Submitting a recommended clinical review evaluates the medical necessity of a service but does not guarantee the service will be covered under the participant's benefit plans. The terms of the participant's plan control the available benefits.

RCR Process

RCR requests can be submitted using Availity Authorization and Referrals tool or by calling the authorization number on the back of the participant's ID card.

For More Information
Learn more about our utilization management process, including prior authorization and recommended clinical review in the Utilization Management section of our provider website. Follow our News and Updates page for future updates.

Prior Authorization Code Changes for Commercial Members Effective April 1, 2024

What's new: Blue Cross and Blue Shield of Texas 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 effective April 1, 2024, include:

- Addition of Genetic Testing codes reviewed by Carelon Medical Benefits Management
- Addition of Infusion Site of Care codes to be reviewed by BCBSTX
- Addition of Medical Oncology drug codes to be reviewed by Carelon
- Removal of Medical Oncology drug codes previously 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.

STANDARDS & REQUIREMENTS

Reminder: Serving our Blue High Performance Network® (BlueHPN®)

Thousands of BlueHPN members have access to quality and affordable health care in the Austin, Dallas-Fort Worth-Arlington, Houston and San Antonio areas.

BlueHPN is an exclusive provider network with participation from Blue Cross and Blue Shield Plans nationwide. BlueHPN members **must stay in network** to receive benefits. There are **no out-of-network** benefits except for emergency, accident and urgent care scenarios.

Here are some tips as you serve these members:

How to Recognize Blue HPN Members
You can identify BlueHPN members by their member ID card. Look for the Blue High Performance Network name on the front along with the initials "BlueHPN" in a suitcase. This logo indicates that BlueHPN rates apply.

Check Eligibility and Benefits First
Use Availity® Essentials or your preferred vendor to check eligibility and benefits for all BCBSTX members before every scheduled appointment. Eligibility and benefit quotes include membership confirmation, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information on applicable prior authorization requirements.

Emergent Care
Members have access to BlueHPN providers as well as non-BlueHPN providers in an emergency situation.

Treating BlueHPN Members
You may work in multiple locations or for multiple medical groups with multiple tax identification numbers (TINs) or national provider identifiers (NPIs). Because BlueHPN members do not have out-of-network benefits, please make sure you're rendering care at an in-network facility under the TIN or NPI that is contracted with BlueHPN.

Referring to Specialists
When BlueHPN members need to see a specialist or another health care provider, refer them to participating BlueHPN providers to **ensure they receive in network benefits**. Check BCBSTX's online Provider Finder® or call the number on the member's ID card to identify other providers in BlueHPN.

Claim Filing
BlueHPN follows the same claims filing process as our commercial members. Submit local and out-of-area BCBS member claims to BCBSTX as you typically would. See the Claim Filing Tips page for more details.

Joining BlueHPN
Visit our BCBSTX contracting web page for details on joining the BlueHPN network.

Questions? Call the Customer Service number on the member's ID card.

Medical Policy Updates

New or revised medical policies, when approved, may be posted on our provider website on the 1st or 15th of each month. Medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date is noted for each medical policy.

To streamline the medical policy review process, you can view draft medical policies and provide feedback online. When there are draft medical policies to review, they will be available around the 1st or the 15th of each month with a review period of approximately two weeks.

Related Information
Refer to the Recommended Clinical Review Option page for information on submitting a request for review of your services prior to rendering services related to a medical policy. Also, other policies and information regarding payment can be found on the Clinical Payment and Coding Policies page.

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.

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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.

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