BLUE REVIEW℠

For Providers

JUNE 2024

BEHAVIORAL HEALTH

Behavioral Health Consultations During Medical Hospitalization Can Improve Outcomes

Updated May 21, 2024

Coexisting physical and behavioral health conditions can be difficult to manage. Studies have found that people hospitalized for physical health conditions who also have mental illness are more likely to be readmitted than people who don't have mental illness. Proper follow-up care for behavioral health after a hospitalization is often lacking, according to the National Committee for Quality Assurance.

Behavioral health consultations during a hospital stay can help our members who have physical and behavioral health conditions. Addressing behavioral health care with timely follow-ups can help **reduce hospital readmissions** and improve health outcomes, according to NCQA.

We encourage hospital staff/attending providers to discuss behavioral health with our members during a hospital stay and **to consider consultations and follow-up care coordination** when appropriate.

Tips for Behavioral Health Consultations and Follow-up Care

To help improve outcomes for our members receiving inpatient care, we encourage hospital staff/attending providers to consider the following:

- Discuss with our members and their medical teams how medical and behavioral health diagnoses are important and **can be intertwined**.
- Facilitate **behavioral health consultations** for our members when they're admitted to a medical unit for a medical concern and also exhibiting behavioral health symptoms.
- Coordinate care with our members' medical and behavioral health providers and social support to help ensure **timely follow-ups**. A behavioral health follow-up within 30 days after discharge can be in the form of:
    - Behavioral health inpatient admission
    - Partial hospitalization program
    - Intensive outpatient program
    - Behavioral health outpatient appointment

Coding for Behavioral Health Consultations

When a member receives a psychiatric consultation while medically inpatient and receives a secondary behavioral health diagnosis, include the following on claims:

- The behavioral health diagnosis
- The correct Current Procedural Terminology (CPT®) codes for a psychiatric consult

Below is information from the American Medical Association about coding for behavioral health consultations (pages 24 and 28). Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter.

CPT code	Threshold Time	Description
99221	At least 40 minutes of total time on the date of the encounter	**Initial hospital inpatient or observation care**, per day, for the evaluation/management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making
99222	At least 55 minutes of total time on the date of the encounter	**Initial hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99223	At least 75 minutes of total time on the date of the encounter	**Initial hospital inpatient or observation care, per day,** for the E/M of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99231	At least 25 minutes of total time on the date of the encounter	**Subsequent hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making
99232	At least 35 minutes of total time on the encounter on a single date	**Subsequent hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99233	At least 50 minutes of total time on the date of the encounter	**Subsequent hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

Resources

- Preventive Care Guidelines
- Clinical Practice Guidelines
- ImmTrac2 Texas Immunization Registry
- Quality Improvement Toolkits and Tip Sheets for Medicaid providers
- Texas Health Steps for Medical Providers

CLAIMS & ELIGIBILITY

Claim Processing Enhancements for ERS Effective Sept. 1, 2024

Effective Sept. 1, the following updates will be made related to claim processing for **Employee Retirement System of Texas** participants:

- **Cotiviti**
  - **Diagnosis Code Guideline Policy** added to identify multiple scenarios where a diagnosis submitted for a procedure or service is reported in an inappropriate position on professional and/or facility claim line(s).
  - **Anatomical Modifiers** edit will focus on coding the appropriate modifier based on the area or part of the body the procedure is performed and will apply to professional claims and facility claims.
  - **Emergency Room Evaluation & Management** edits to identify miscoded facility and professional claims that were billed at high intensity levels (4 & 5).

- **MultiPlan out-of-area or out-of-network rate negotiations**
    - We will negotiate charges for covered health care services from out-of-network health care providers to reduce the amount a participant may be liable for and/or help protect participants from balance billing.

For additional information, contact your Blue Cross and Blue Shield of Texas Network Management office.

Electronic Claim Review and Ensuring the Correct Use of our Claim Review Form

Electronic claim review through Availity® Essentials is fast and easy and is the preferred method of submission.

If you're unable to submit electronically, you can submit by paper, using our Claim Review Form, Blue Cross and Blue Shield of Texas must have all the information requested to complete a proper claim review. **Effective August 1, 2024, we'll return any incomplete form without conducting the claim review.**

Here are some **helpful tips** when submitting a claim review form:

- These requests are only to be used for **review of a previously adjudicated claim**.
- Don't attach the original claims to a review form, rather, you'll reference the claim number in the appropriate field on the form
- Don't use this form to submit a corrected claim, instead, use our Corrected Claim Form
- Don't use this form to respond to an additional information request. Use the Additional Information Form.
- If you submit this form as a request for a second review, you must provide information not previously submitted for the review to be eligible.

Reminder: Electronic submission is your fastest path to an efficient claim review at Availity® Essentials. Be sure to provide all required information as we won't review electronic inquiries received with incomplete information.

Submit a Claim Review Online, Fast

To submit an online claim review request via Availity Essentials:

- First, perform a **Claim Status** search utilizing the Member or Claim tab;
- Second, use the **Dispute Claim** or **Message This Payer** option to request a claim review;
- Third, complete all needed information.

More information: Learn more at our Claim Filing Tips web page.

ClaimsXten™ Quarterly Update Effective Aug. 19, 2024

Blue Cross and Blue Shield of Texas will implement its third quarter code updates for the ClaimsXten auditing tool on or after Aug. 19, 2024.

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 our 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.

Access MCG Care Guidelines Clinical Criteria via Availity®

Blue Cross and Blue Shield of Texas uses some, but not all, clinical criteria from MCG Care Guidelines when reviewing requests to determine medical necessity. Our clinical rationale outlined in some provider correspondence and in some Clinical Payment and Coding Policies will guide you to the specific MCG Care Guidelines, when applicable.

As a helpful resource, you can now access MCG guidelines through your Availity Essentials login**.**

How to access MCG Guidelines through Availity

- Log onto Availity Essentials
- Select on **Payer Spaces** on the upper navigation bar
- Select **BCBSTX** to navigate to our payer space
- Select the **Resources** tab
- Select **MCG Guidelines** and then follow the prompts

Search for related **MCG Guidelines** by opening any category link and searching for services by name and topic using the "control + F" key board function.

Remember: BCBSTX does not rely on all MCG Care Guidelines to support our utilization management decision making.

Fee Schedule Updates

Reimbursement changes and updates for commercial HMO and PPO providers are posted under the Standards and Requirements / General Reimbursement Information / Reimbursement Schedules and Related Information section on our provider website.

Changes resulting in a decrease do not become effective until at least 90 days from the posting date. The specific effective date is noted for each change that is posted. To view this information, visit the General Reimbursement Information section on our provider website. The Drug CPT®/HCPCS Fee Schedule is updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule is updated monthly.

ClaimsXten™ Quarterly Update Effective June 17, 2024

Blue Cross and Blue Shield of Texas will implement its second quarter code updates for the ClaimsXten auditing tool on or after June 17, 2024.

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 codes

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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: CPCP032 Intraoperative Neurophysiology Monitoring (IONM) Coding and Reimbursement Policy
- Annual Review: CPCP036 Paravertebral Facet Injection Procedure Coding & Billing Policy Updated
- Annual Review: CPCP005 Home Health Care/Private Duty Nursing Policy Updated
- Annual Review: CPCP018 OP Facility and Hospital Claims: Revenue Codes Requiring Supporting CPT, HCPCS and/or NDC Codes Updated
- Annual Review: CPCP019 Home Infusion Updated
- CPCP029 Medical Record Documentation Updated – Effective 07/24/2024

CLINICAL RESOURCES

PeriPAN Perinatal Mental Health Toolkit for Obstetric Clinicians

Blue Cross and Blue Shield of Texas encourages providers in obstetrics and gynecology and related disciplines to use the PeriPAN Perinatal Mental Health Toolkit for Obstetric Clinicians. This toolkit, which is available at no cost, offers perinatal care providers and other specialists with actionable information to build capacity for preventing, identifying, treating, and monitoring perinatal mood and anxiety conditions.

Select the link below to access the toolkit and learn more information.

- **LInk to toolkit:** PeriPAN Perinatal Mental Health Toolkit for Obstetric Clinicians
- **View** video for more information about the importance of screening for depression pre- and post-natal

Questions or comments: If you have any questions or comments, please contact Behavioral Health Quality Improvement.

EDUCATION & REFERENCE

Helping Our Members Manage Diabetes

About 38 million Americans have diabetes, according to the Centers for Disease Control and Prevention. Because symptoms can develop slowly, one in five of them don't know they have it. You may play an important role in supporting our members through **regular screenings, tests and office visits**.

Monitoring Our Members' Care
We track Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance related to diabetes care, including:

Hemoglobin A1c Control for Patients with Diabetes captures the percentage of our members ages 18 to 75 with diabetes (type 1 and type 2) whose HbA1c level during the measurement year is:

- Less than 8.0%, indicating controlled
- Greater than 9.0%, indicating uncontrolled. A lower rate on this measure indicates better performance

Eye Exam for Patients with Diabetes tracks members ages 18 to 75 with diabetes (type 1 and type 2) who have a retinal eye exam by an eye care professional to screen or monitor for diabetic retinal disease.

Blood Pressure Control for Patients with Diabetes captures members ages 18 to 75 with diabetes (type 1 and type 2) whose blood pressure was controlled (<140/90 mm Hg).

Kidney Health Evaluation for Patients with Diabetes tracks members ages 18 to 85 with diabetes (type 1 and type 2) who received a kidney health evaluation during the measurement year. An evaluation includes a blood test for kidney function (estimated glomerular filtration rate) and a urine test for kidney damage (urine albumin-creatinine ratio).

Statin Therapy for Patients with Diabetes tracks members ages 40 to 75 who have diabetes and do not have clinical atherosclerotic cardiovascular disease, and who received and adhered to statin therapy.

Tips to Close Gaps in Care

- Identify care gaps and schedule lab tests before office visits to review results and adjust treatment plans if needed.
- Monitor blood pressure status at each visit and adjust medications as needed for control.
- Document medication adherence to angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers when applicable.
- **Repeat abnormal lab tests later in the year** to document improvement.
- Encourage members with diabetes to have annual retinal or dilated eye exams by an eye care specialist.
- For our members on statin therapy, discuss the proper dose, frequency and the importance of staying on the medication.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.

Resources
Information on **Current Procedural Terminology (CPT®) Category II codes** is available in Availity® Essentials in Payer Spaces in the Resources section. It includes information on coding for HbA1c Control for Patients with Diabetes and Blood Pressure Control for Patients with Diabetes.

We've created information that may help you **discuss diabetes with our members**. For more information on diabetes, see our preventive care and clinical practice guidelines.

Reminder: Sanitas Medical Center Name Changes to Innovista Medical Center
We value your partnership in patient care and want to remind you of a change that has occurred at all Sanitas Medical Center locations in Texas. As of April 1, 2024, all clinics are now rebranded as Innovista Medical Center.

HEALTH & WELLNESS

BCBSTX 2023 Marketplace Member Satisfaction with Providers Results

Earlier this year we shared **CAHPs and the QHP Enrollee Experience Survey** now we're providing you collection feedback on patient experiences with QHPs available through the Health Insurance Marketplace 2023. QHP Enrollee surveys give patients the opportunity to provide feedback on the experience with their health plan and its contracted providers. Focusing on a positive patient experience will have many important benefits to your practice:

- Patient retention
- Compliance with physician recommendations
- Patient's overall wellness and health outcomes
- Preventive care addressed more timely

The QHP Enrollee Experience Survey is a valuable measurement tool to assess service gaps and develop specific improvement strategies. A random sample of eligible members enrolled for at least six months are surveyed through mail, phone, and web-based modes. The survey gauges experience with cultural competence, how well doctors communicate and takes approximately 12 minutes to complete with an emphasis on domains where providers have the most impact:

- Access to care
- Care coordination
- Ratings of specialist, personal doctor, healthcare
- Flu vaccination for adults (age 18–64)
- Medical assistance with smoking and tobacco use cessation

Key findings:

- **Overall Health Plan Rating** has not changed significantly since last year. The response decreased from 18% in 2022 to 13% in 2023

Key drivers – performing well:

- Rating of Health Care, Specialist and care coordination informing doctors about specialty care needs and outcomes

Measures of improvement:

- Cultural Competence
- Flu Vaccinations for Adults Ages 18-64
- Advising Smokers and Tobacco Users to Quit
- Discussing Cessation Medications

Measures to make improvements in:

- Rating of Personal Doctor
- Getting Needed Care
- Getting care, tests, or treatment, Getting specialist appointment
- Care coordination – Obtained help from Doctor's office to manage care

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The Need for Better, Improved Continuity and Coordination of Care

Electronic Health Record systems are capable of facilitating the timely distribution of integrated and organized patient health information. These can reduce the fragmentation that can surround the continuum of care. Reducing fragmented care leads to better continuity and coordination of care. Leveraging this tool in every episode of care allows for:

- notification to all authorized providers when a patient has been in the hospital or seen in the Emergency Department
- every provider involved in a patient's care to have the same up-to-date information including medications, allergies, and other medical conditions
- timely follow up with the patient

Technology has advanced to give us better availability and accuracy of patient information. This improved information sharing is especially important for patients:

- getting emergency treatment
- seeing multiple providers
- transitioning between care settings

Blue Cross Blue Shield of Texas annually surveys a sample of our providers about their satisfaction. The BCBSTX Provider Satisfaction Survey includes questions about PCPs' satisfaction with inpatient hospital discharge summaries and emergency department visit summaries. In 2023, overall satisfaction with continuity of care remained unchanged. Receipt of summaries of care from care setting to provider increased 8-percentage points from the ED and increased 1-percentage point from the Inpatient setting. There was a 4-percentage point increase in adequate information about medications at discharge and was the only question that met our goal of 85%. There were improvements in the timeliness of receipt of summaries, but this area still needs some improvement. The results demonstrate opportunities for improvement, most importantly making sure the PCP receives an inpatient discharge summary and an ED visit summary.

BCBSTX Provider Satisfaction Survey Results

Survey Questions	Goal 85%	2022	2023
Overall satisfaction with continuity of care		78%	78%
When your patients are seen by the following, are you sent summary information following the discharge or visit?			
Inpatient Setting		69%	70%
Emergency Dept.		59%	67%
When you receive the summary information, does it reach your office in a timely manner (within 10 business days)?			
Inpatient Setting		78%	83%
Emergency Dept.		71%	75%
When you receive hospital discharge information, does it contain adequate information about medications at discharge?		86%	90%

If every episode of care is captured electronically and every effort is made to identify all providers involved in the care of a patient, authorized information sharing can be critical in avoiding miscommunication or delays in care. EHRs are an invaluable resource that may improve patient outcomes by providing better quality of care and better continuity and coordination of care between care settings and providers.

MEDICARE ADVANTAGE PLANS

Closing Gaps in Care for Group Medicare Advantage (PPO) members

Through the Blue Cross and Blue Shield **National Coordination of Care program**, you may receive medical record requests from us for **Blue Cross Group Medicare Advantage (PPO)℠** members. These include members with coverage with Blue Cross and Blue Shield of Texas as well as Group MA PPO members enrolled in other BCBS plans who are living in Texas. This data helps us monitor for gaps in our members' care.

What This Means for Medicare Providers

If we need medical records for Group MA PPO members, you will receive requests only from BCBSTX or a vendor, Advantmed. We may request medical records for:

- Risk adjustment gaps related to claims submitted to BCBSTX
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Centers for Medicare & Medicaid Services Star Ratings

Please respond quickly to requests related to risk adjustment, HEDIS and other government-required activities as your contract requires. You don't need patient-authorized information releases to fulfill medical records requests and risk adjustment gaps through this program.

Important Reminders

- Use Availity® Essentials or your preferred vendor to verify members' eligibility and benefits before every appointment. Eligibility and benefit quotes include membership verification, coverage status, prior authorization requirements, provider's network status for the patient's policy and applicable copayment, coinsurance and deductible amounts.
- Ask to see the member's ID card and a photo ID to help guard against medical identity theft.
- Notify members that they may be billed directly when services may not be covered.

Questions? Call the customer service number on the member's ID card.

Preventive Services Reminder: Zero Copay for Blue Cross Medicare Advantage℠

We want to remind you that there are no copays for preventive services for Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO)℠. Blue Cross Medicare Advantage covers a full range of preventive services to help patients stay healthy, detect problems early and determine when treatment is necessary. Please let members know which of these services is right for them and encourage them to set appointments for preventive services.

Access the Centers for Medicare & Medicaid Services Medicare Learning Network's Medicare Preventive Services for more detailed information.

Additionally, you should check eligibility and benefits electronically through Availity, or your preferred web vendor.

PHARMACY

Pharmacy Program Quarterly Update Changes Effective July 1, 2024 – Part 1

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

STANDARDS & REQUIREMENTS

Physician Performance Insights Coming Soon from PEAQ℠

In July, physicians eligible for our Physician Efficiency, Appropriateness, and Quality Program can view their Physician Performance Insights in Availity Essentials. PPI reports show how physicians compare to their peers and include information on improving performance. Read more.

UTILIZATION MANAGEMENT

Changing Prior Authorization to Recommended Clinical Review Effective Sept. 1 for TRS Participants

What's Changing

Effective Sept. 1, 2024, Blue Cross and Blue Shield of Texas will be moving prior authorization to **Recommended Clinical Review Option for outpatient services** for **Teacher Retirement System of Texas** participants as indicated below:

Outpatient Services previously requiring PA by **BCBSTX moving to RCR**: (As a reminder, inpatient services were changed to RCR effective 03/01/2024)

- Cardiology -Lipid Apheresis
- Ear, Nose and Throat
- Gastroenterology
- Neurology
- Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw)
- Pain Management
- Wound Care
- Home Health Services including but not limited to home private duty nursing (PDN), home infusion therapy (HIT)
- Home Hemodialysis
- Home Hospice
- Non-Emergent Air Ambulance
- Transplant Services, Transplant Evaluations and Transplants
- Durable Medical Equipment > $5000 applicable to medical necessity review per benefit language (less than $5000 medical necessity review not needed)
- Outpatient Physical Therapy/Occupational Therapy/Speech Therapy
- Mental Health and Substance Use Disorder Services
    - Applied Behavior Analysis
    - Electroconvulsive Therapy
    - Intensive Outpatient Treatment
    - Partial Hospitalization
    - Psychological Testing/Neuropsychological Testing
    - Repetitive Transcranial Magnetic Stimulation
- Specialty Pharmacy Medications that are covered by Medical Benefits
    - Infusion Site of Care
    - Medical Oncology & Supportive Care (through Carelon)
    - Provider Administered Drug Therapies

Carelon Medical Benefits Management will handle RCR for the following services:

- Advanced Imaging / Radiology
- Cardiology
- Molecular Genetic Lab Testing
- Musculoskeletal - Joint, Spine Surgery, Musculoskeletal - Pain
- Radiation Therapy / Radiation Oncology
- Sleep

Providers are encouraged to submit an RCR for services that previously required prior authorization to prevent post service medical necessity reviews. Refer to the RCR page for a list of applicable services.

Recommended Clinical Review Key Points

- 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.
- 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.
- 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.

For more information: Refer to the RCR page for information on RCR services and how to submit requests for services managed by BCBSTX or Carelon.

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.

Utilization Management Update Including Change to Recommended Clinical Review Effective Sept. 1, 2024, for ERS Plans

What's changing: Blue Cross and Blue Shield of Texas will be making the following changes effective Sept. 1, 2024, for the Employee Retirement System of Texas (ERS) medical plans, including HealthSelect of Texas® and Consumer Directed HealthSelect℠:

- Moving all services previously requiring prior authorization, as well as other certain services needing medical necessity review, to **Recommended Clinical Review (RCR).**
    - RCR allows providers to submit requests for medical necessity review before the services are provided. RCR will replace post-service review for medical necessity when an RCR is completed. This includes concurrent reviews.
    - RCR is an optional medical necessity review 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 or other plan rules.

- **Carelon Medical Benefits Management** will handle RCR for the following services:
    - Advanced Imaging (such as CT scan, nuclear stress test, MRI, PET scan with the exception of MRI of the breast)/cardiology imaging
    - Musculoskeletal (Joint/Spine), pain
    - Genetic/molecular testing
    - Radiation (oncology) therapy for cancer
    - Medical oncology specialty drugs and supportive care

Important: Medical necessity does not guarantee payment. Eligibility and other plan requirements must be met. You can access the HealthSelect of Texas and Consumer Directed HealthSelect documents at: healthselect.bcbstx.com/medical-benefits.

Coming soon: Refer to the updated ERS RCR Services List for the most current services applicable for an RCR and how to submit the requests.

Note: Providers may continue to request medical necessity review of additional services even when not included on the RCR Services List.

Effective Sept. 1, 2024, providers submitting RCR requests for services for ERS participants will have the option of submitting the request electronically via BlueApprovR℠ or the Availity® Authorization & Referrals tool.

More information: Be sure to check eligibility and benefits and confirm if a service is eligible for RCR through Availity® Essentials or your preferred vendor.

Learn more about ERS processes, including RCR on the Utilization Management section of our provider website. Follow our News and Updates page for future updates.

Utilization Management Decisions

We're dedicated to serving our customers through the provision of health care coverage and related benefit services. Utilization Management determinations are made by licensed clinical personnel based on the:

- Benefits policy (coverage) of a member's health plan
- Evidence-based medical policies and medical necessity criteria
- Medical necessity of care and service

All UM decisions are based on appropriateness of care and service, and existence of coverage. We prohibit decisions based on financial incentives nor do we specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The criteria used for UM determinations are available upon request. Please call the Customer Service or Health Advocate number on the back of the member's ID card.

Prior Authorization Code Changes for Commercial Members Effective July 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 or Healthcare Common Procedure Coding System changes from the Centers for Medicaid & Medicare Services.

Changes effective July 1, 2024, include:

- Addition of Specialty Pharmacy codes to be reviewed by BCBSTX
- Replacement of Medical Oncology codes reviewed by Carelon
- Addition of Medical Oncology codes to be reviewed by Carelon
- Addition of Genetic Testing codes to be reviewed by Carelon
- Removal of Genetic Testing codes previously reviewed by Carelon
- Addition of Cardiology 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.

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

Change Healthcare is an independent third-party vendor that is solely responsible for the products or services 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 certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits.

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

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

bcbstx.com/provider