BLUE REVIEW℠

For Providers

NOVEMBER 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.

The American Society of Addiction Medicine is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide utilization management support for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

CLAIMS & ELIGIBILITY

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.

Texas Senate Bill 1040 Prohibits Organ Transplants Associated with China

What's changed: Per Senate Bill 1040, effective September 1, 2023, which applies to plans delivered, issued for delivery or renewed on or after Jan. 1, 2024, Blue Cross and Blue Shield of Texas prohibits coverage of a human organ transplant if the operation is performed or if the organ was procured by a sale or donation originating, in China or a country known to have participated in organ harvesting. "Organ harvesting" is the removal of one or more organs from a living person by means of coercion, abduction, deception, fraud, or abuse of power or a position of vulnerability.

Why the change: This prohibition helps to combat the practice of forcibly harvesting organs from living persons for transplant without free, voluntary consent and curb illicit transplant tourism and prevent residents of this state from unknowingly involving themselves in forced organ harvesting. For additional details, refer to Texas Senate Bill 1040.

What's not covered: BCBSTX will not cover the transplant procedure or post-transplant.

This change applies:

- Fully insured BCBSTX plans
- Medicaid
- Individual health benefit plans offered by BCBSTX
- ERS
- TRS
- UT/TAMU

Check eligibility and benefits: 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 through Availity® Essentials or your preferred vendor.

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

ClaimsXten™ Quarterly Update Effective Dec. 9, 2024

We will implement fourth quarter code updates for the ClaimsXten auditing tool on or after Dec. 9, 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

When applicable, we 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 tools page for a user guide, rule descriptions and other details.

Register for a Coding Webinar on Coagulation Defects and Other Hematological Disorder

Join our Coding Compliance team for a webinar on coding and documentation for coagulation defects. The webinar is free for providers and coding professionals.

We'll review ICD-10-CM documentation and guidelines, coding case study samples and tips on closing gaps in care for members. This is an informational webinar – it doesn't offer continuing education credits.

Coding Webinar for Coagulation Defects and Other Hematological Disorders
Select your preferred session date to register now:

- Oct. 25, 2024 (noon to 12:30 p.m., CT)
- Nov. 22, 2024 (noon to 12:30 p.m., CT)
- Dec. 13, 2024 (noon to 12:30 p.m., CT)

Visit our website for more training opportunities.

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:

- CPCP006 Preventive Services Policy Update, Effective 10/01/2024
- Annual Review: CPCP032 Intraoperative Neurophysiology Monitoring (IONM) Coding and Reimbursement Policy
- Annual Review: CPCP042 Emergency Department Services Evaluation and Management - E/M Coding - Professional Services

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EDUCATION & REFERENCE

Check ID Cards for New Coupe Health Plan Members

As a reminder, providers in our commercial PPO network and Blue High Performance Network® can treat members with our new Coupe Health benefit plan in coming months. This plan streamlines the payment process for your office and our members. Read more.

HEALTH & WELLNESS

Risk Identification and Outreach Program Supports Member Safety

You may receive information about certain commercial members' care as part of our Risk Identification and Outreach Program. Our multidisciplinary RIO team collaborates with providers on initiatives to enhance safety, such as safely managing opioid medications and facilitating follow-up care.

If RIO contacts you by fax, email, or phone, you can help support our members' care by reviewing the information and providing any details requested.

Interventions based on data: RIO's medical and behavioral health professionals, physicians, pharmacists, and clinical data analysts develop targeted interventions based on claims data. They reach out to members and providers to discuss or facilitate:

- **Opioid education**, such as pain management options, safe dosing, naloxone usage, medication storage and disposal, and risks of long-term opioid use after surgery
- **Follow-up care for a recent diagnosis of depression** that is untreated, such as psychotherapy

and/or pharmacological treatment
- **Follow-up care for multiple emergency room visits** with primary care physicians or specialists

If you have questions, contact RIO@bcbstx.com or call 1-888-372-2159.

Encourage Annual Eye Exams for Members with Diabetes

Early detection and treatment can greatly lower the chance of vision loss for our members living with diabetes. Learn about the important role annual eye exams play and tips for closing gaps in care. Read more.

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 Oct. 1, 2024 – Part 2

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

30-Day Supply Limit: Select Commercial Members Have New Pharmacy Benefit for GLP-1 and/or Anti-Obesity Drug Therapy

Starting Sept. 1, 2024, an optional 30-day supply limit pharmacy benefit program is available for some employer groups with Prime Therapeutics. Two benefit options are available as part of the program: GLP-1 30-Day Max and Anti-Obesity 30-Day Max.

This new program aims to reduce drug waste and cost of care associated with GLP-1 and/or anti-obesity drug therapy.

The program limits fills to 30 days for all applicable GLP-1 and/or anti-obesity drugs (oral and injectable). The benefit may involve the following drug products: Mounjaro, Ozempic, Orlistat, Phentermine HCL, Qsymia, Saxenda, Trulicity, Wegovy and Zepbound.*

The categories and medications included may vary according to employer group selections. Program details and applicable prior authorization requirements are based on the member's pharmacy benefits.

Which members are affected? This program is an employer group option that may apply to some of our commercial members. Always check eligibility and benefits first for each member at every visit. This step confirms membership and other details, such as prior authorization requirements and prescription drug fill limitations, if applicable.

- For services/drugs under the member's medical benefit, check eligibility and benefits electronically via Availity® Essentials or your preferred vendor prior to rendering care.
- For drugs under the member's pharmacy benefit, call the number on the member's ID card before prescribing.

If your patients have questions, they can call the number on their member ID card for Blue Cross and Blue Shield of Texas, log on to Blue Access for Members℠ or visit MyPrime.com.

GLP-1 New to Therapy: We previously announced an optional pharmacy benefit program for members beginning GLP-1 therapy. It became available April 1, 2024, for some employer groups with Prime Therapeutics.

UTILIZATION MANAGEMENT

Medical Transportation Utilization Management for Some Members Updated Effective Jan. 1, 2025

What's changing? Effective Jan. 1, 2025, Alacura Medical Transportation Management will manage air and ground medical transportation, prior authorization, recommended clinical review and retrospective claim reviews for our fully insured members and certain Administrative Services Only groups*. Medical Management at Blue Cross and Blue Shield of Texas will no longer manage these services as of 11:59 pm on Dec. 31, 2024.

***Alacura does not manage:**

- BCBSTX Medicare Advantage and BCBSTX Medicaid
- 911/scene of accident or residence-based pickups
- Alacura manages:
- 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)
- Easy workflows and simple administrative processes to help with locating available ambulances, beds at the receiving hospital and other logistics of your patient's transport
- Assurance that members are transported by an in-network provider where possible while proving cost effectiveness of member benefits.

For more information and a full list of codes refer to the Prior Authorization Services for Fully Insured members and certain Administrative Services Only groups and the Recommended Clinical Review Options as follows:

- Prior Authorization Services List for Other ASO Groups Effective 01/01/2024
- Prior Authorization Procedure Codes List for Other ASO Plans Effective 01/01/2025
- 2024 Recommended Clinical Review, Post Service Review and Non-Covered Procedure Code List for Fully Insured Accounts (Includes Services Effective 01/01/2025)

What do I need to do? Facilities and providers need to contact Alacura immediately once the transport decision is made. Ambulance providers will want to check that Alacura has been engaged for patient facility transports before picking up the patient to ensure transport will be approved. Nurses are available 24/7/365 for real-time verbal assessments.

How do I contact Alacura effective Jan. 1, 2025?

- 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

Check Eligibility and Benefits

Providers should check eligibility and benefits through Availity® Essentials or their preferred vendor. This may also indicate if a service requires a prior authorization, recommended clinical review. or retrospective review.

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

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

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.

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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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 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

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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.

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