BLUE REVIEW℠

For Providers

JANUARY 2025

SPOTLIGHT

Removal of Dermatology Referral Requirement for HealthSelect of Texas Effective 01/01/2025

Effective Jan. 1, 2025, HealthSelect of Texas® In Area medical plans will no longer require participants to get a referral from their primary care providers to obtain services from **in-network dermatologists**. Blue Cross and Blue Shield of Texas is working to ensure all eligibility and benefit systems and plan documents reflect this change. If you have any questions, please contact Provider Customer Service at **(800) 451-0287**.

Eligibility and other plan requirements must still be met. You can access the HealthSelect documents at: https://healthselect.bcbstx.com/medical-benefits.

CLAIMS AND ELIGIBILITY

Remind Billing Agencies to Correctly Submit Claim Review Requests

If your billing agency requests claim reviews **through** Availity® Essentials (preferred electronic method) or with our claim review form, we encourage you to share the following submission tips with them.

Electronic submission: For faster processing, use Availity Essentials. No claim form is needed. Follow these steps:

- Perform a **Claim Status** search using the Member or Claim tab in Availity Essentials
- Use the **Dispute Claim** or **Message This Payer** option to request a claim review.

Claim Forms:

- Remember, we will return incomplete requests received without conducting the claim review.
- Reference the **claim number** in the appropriate field on the claim review form, rather than attaching the original claim to the form. And complete the form in its entirety.
- To submit a corrected claim, use our corrected claim form, not the claim review form.
- To respond to an additional information request, use our Additional Information form, not the claim review form.
- If you submit the claim review form as a request for a second review, you must provide information not previously submitted for the review to be eligible.

For more Information, refer to our claim status page.

ClaimsXten™ Quarterly Update Effective March 17, 2025

We will implement first quarter code updates for the ClaimsXten auditing tool on or after March 17, 2025.

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

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.

When applicable, we may also post advance notice of significant changes, like implementation of new rules in News and Updates and Blue Review.

For more information, refer to the Clear Claim Connection page for a user guide, rule descriptions and other details.

CLINICAL RESOURCES

Records Needed to Support Quality Care for Medicare Advantage Members

Medicare Advantage providers may receive medical record requests from Blue Cross and Blue Shield of Texas or our vendor Advantmed from **January through June 2025**. We collect data for Healthcare Effectiveness Data and Information Set (HEDIS®) measures on the quality of our members' care and health outcomes.

How you can help: Either BCBSTX or Advantmed may contact you by fax or phone to provide details about the records needed and how to submit them to us. Please **promptly provide complete and accurate records.**

Patient authorization isn't required to release these records, as their collection and review is considered a component of health care operations under the Health Insurance Portability and Accountability Act of 1996.

The data we're seeking: We collect data related to chronic conditions such as diabetes and high blood pressure, and transitional care.

Other record requests throughout the year may include requests related to risk adjustment, focusing on chart reviews and the accuracy of risk-adjustable codes submitted to the Centers for Medicare & Medicaid Services.

Please contact your local Provider Network Office if you have questions.

Medical Records Collection for Federal Employee Program® Begins in February

Providers who care for our FEP® members may receive medical record requests from Blue Cross and Blue Shield of Texas or our medical record retrieval vendor from **February through April 2025**. We collect data for Healthcare Effectiveness Data and Information Set (HEDIS®) measures to gather information on FEP members' care. This data helps us ensure compliance with Federal Employees Health Benefits Program requirements.

How you can help: Either BCBSTX or the medical record retrieval vendor Advantmed will contact you by fax, phone or email to provide details about the medical records needed and how to submit them. Please **provide complete and accurate records** within **five business days** of the request.

Patient authorization isn't required to release these records, as their collection and review is considered a component of health care operations under the Health Insurance Portability and Accountability Act of 1996.

The data we're seeking: We collect data for HEDIS measures developed by the National Committee for Quality Assurance, including:

- High Blood Pressure Control
- Diabetes Care
- Glycemic Status Assessment (previously known as Hemoglobin A1c)
- Blood Pressure Control
- Eye Exam
- Cervical Cancer Screening
- Childhood Immunizations
- Immunizations for Adolescents
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

If you have questions, contact FEP Quality Improvement at **888-907-7918**.

Follow-Up Care Is Recommended for Children Prescribed ADHD Medication

Attention-deficit/hyperactivity disorder is one of the most common behavioral health disorders affecting children, according to the Centers for Disease Control and Prevention. ADHD medication can help manage symptoms including hyperactivity, impulsiveness and inattention, according to the CDC. The National Committee for Quality Assurance recommends pediatricians with prescribing authority monitor children using ADHD medication to ensure it is prescribed and managed correctly.

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 ADHD medication for at least 210 days.

Visits can be by telehealth when appropriate and depending on the members' benefits.

For more information on ADHD, watch our video on improving ADHD medication compliance. Refer to our tip sheet for tips to close gaps in care for this measure.

Resources

For Texas Medicaid Provider Quality Improvement, review the following resources ranging from quality measures data to current vaccine schedules:

- Preventive Care Guidelines
- Clinical Practice Guidelines
- ImmTrac2
- Quality Improvement Toolkit and Tip Sheets
  Texas Health Steps for Medicaid Providers

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 40 to 74 for breast cancer every other year.

See our preventative care guidelines for more information.

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 gather this information to help improve our members' care.

Cervical Cancer Screening tracks the following:

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

Breast Cancer Screening assesses the percentage of women ages 40 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 screenings that may help.
- The Centers for Disease Control and Prevention recommends human papillomavirus vaccines for all people as early as 9 years of age 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. Documentation of hysterectomy alone is not sufficient to remove the member from the quality measure. **There must be documentation of absence of cervix.**
- Follow up with members if they miss their appointment and help them reschedule.

Resources

For Texas Medicaid Provider Quality Improvement, review the following resources ranging from quality measures data to current vaccine schedules:

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

Coding Reference for Quality Measures Is Available to Help Identify Gaps in Care

Using the proper Current Procedural Terminology (CPT®) Category II codes when filing claims can help streamline your administrative processes and ensure gaps in our members' care are closed.

A coding resource for you: We developed a quick reference on CPT II and ICD-10-CM codes related to these Healthcare Effectiveness Data and Information Set (HEDIS®) measures:

- Prenatal and Postpartum Care: Learn more
- Controlling High Blood Pressure: Learn more
- Blood Pressure Control for Patients with Diabetes: Learn more
- Hemoglobin A1C Control for Patients with Diabetes: Learn more

To access the coding resource

- Sign in to Availity® Essentials. If you don't yet have an Availity account, register here at no cost.
- Select the **Payer Spaces** section from the navigation menu. Then choose Blue Cross and Blue Shield of Texas.
- You can find the quick reference listed under **Resources.**

EDUCATION

Comparing Commercial and Retail BCBSTX Member Satisfaction with Providers

Results from the 2023 Qualified Health Plan Enrollee Experience Survey and the HMO and PPO Consumer Assessment of Healthcare Providers and Systems Survey were shared earlier this year. As a reminder while we prepare to survey our members starting in February 2025, these survey topics were identified as areas of improvement. and where providers have the most impact:

2023 BCBSTX Results (%)			
Survey Category/Topic	**QHP EES** **TX HMO**	**CAHPS** **TX HMO**	**CAHPS** **TX PPO**
Rating of Personal Doctor	69	83	73
Getting Care Needed · **Specialist appointments** · **Care, tests, or treatment**	69 58 80	78 75 80	80 75 85
Getting Care Quickly · **Urgent care**	76 75	77 78	82 85
How Well Doctors Communicate · **Dr. listened carefully**	91 90	93 93	95 95
Care Coordination	82	80	84
Flu vaccination for adults	51	45	49
Advising Smokers and Tobacco Users to Quit	64	58	61
How often were you advised to quit smoking or using tobacco by a provider in your plan?			
Discussing Cessation Medications	48	30	41

How often was medication recommended or discussed by a provider to assist you with quitting smoking or using tobacco? *Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.*			
Discussing Cessation Strategies	44	25	35
How often did your provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? *Examples of methods and strategies are telephone helpline, individual or group counseling, or cessation program.*			

Summary Rate scores are calculated using % Always/Usually or %Yes for composite measures and % 8,9,10 for rating questions – with 100% the highest possible score.

These surveys are valuable measurement tools to assess service gaps and other key factors where you have impact as you focus on positive patient experiences.

Our next article will focus on the Key Findings, Key Drivers and Opportunities for improvement identified from the 2024 QHP EES and CAHPS Surveys results.

Solutions and Results Monitoring for Gene Therapy Treatments to Launch in 2025

As of Jan. 1, 2025, we're launching **gene therapy solutions** for our commercial group members to support access to care while protecting against high treatment costs. To help track clinical outcomes, we may ask you for information about the effectiveness of these treatments prescribed for our members.

Gene therapy solutions involves:

- **Helping members navigate** through their complex care journey, including care coordination and case management support
- **Tracking outcomes** through results-based agreements with drug manufacturers to monitor treatments and help ensure clinical results are achieved
- **Protecting members and employer groups** against the financial risk of sudden high-cost gene therapy treatments

You should know: We may request outcomes information from you related to gene therapies including:

Luxturna	Onpattro
Zolgensma	Ambuttra
Zynteglo	Casgevy
Hemgenix	Lyfgenia
Vyjuvek	Lenmeld
Givlaari	

This list is subject to change. **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 utilization management vendors, if applicable.

If your patients have questions about their benefits, they can call the number on their member ID card or log in to Blue Access for Members℠.

Explore Learning Opportunities

We offer free webinars to providers who participate in our networks. Webinars include training on electronic tools and courses that offer continuing education credit. For new providers and staff, we offer orientation and reference materials.

MEDICAID

Stay Updated on Medicaid News

You can find information for STAR, STAR Kids and CHIP on our Medicaid News and Updates page.

Records Needed to Support Quality Care for Medicaid Members

Texas Medicaid providers may receive a request from Blue Cross and Blue Shield of Texas from February through June 2025 to collect data for Healthcare Effectiveness Data and Information Set (HEDIS®) measures. The data you provide helps us gather information on the **quality of our members' care and their health outcomes**.

How you can help: BCBSTX may contact you by fax or phone to provide details about the records needed and how you can return them to us. When requested, please **promptly provide complete and accurate records.**

Patient authorization isn't required to release these records, as their collection and review is considered a component of health care operations under the Health Insurance Portability and Accountability Act of 1996.

The data we're seeking: We collect data related to chronic conditions such as diabetes and high blood pressure, and transitional care.

Please contact our Texas Medicaid Quality Improvement Department via email TX_Medicaid_QI@bcbstx.com.

Other records requests: We also request medical records throughout the year for risk adjustment, focusing on chart reviews and the accuracy of risk-adjustable codes submitted to the Centers for Medicare & Medicaid Services.

MEDICARE

Funds to Be Recouped on Some Medicare Advantage Hospital and Ancillary Claims

We have recently identified some Medicare Advantage claims that have been paid incorrectly to hospitals and ancillary providers. These are claims that have been overpaid based on your contract, Centers for Medicare & Medicare Services guidelines or retroactive member updates.

What's next: We will begin a recoupment process to collect funds from the impacted claims billed with dates of service in the past 18 months. You will receive a letter if you have any claims that have been identified as being overpaid and will have 45 days to appeal before we move forward with a recoupment. Your explanation of benefits will list any claims that are recouped as part of this project.

You may choose to mail us a refund check instead of having recoupments applied to future claims. Mail a check along with the Provider Refund Form to:

Blue Cross and Blue Shield of Texas
Refund and Recovery
PO Box 120695
Dallas, TX 75312-0695

Additional Information: As a reminder, you may not balance bill members for any funds owed in these recoupments.

Please contact Provider Customer Service at **877-774-8592** if you have any questions or need assistance.

CMS Tracks High-Risk Medication Combinations with New Part D Quality Measures

In January 2025, the Centers for Medicare & Medicaid Services is adding two quality measures to its Star Ratings for Medicare prescription drug plans. These measures track potentially high-risk combinations of medications and will impact 2027 Star Ratings.

Concurrent Use of Opioids and Benzodiazepines measures the percentage of Medicare Part D beneficiaries ages 18 years or older with concurrent use of opioids and benzodiazepines. Combining these medications presents **serious health risks,** including the risk of overdose death, according to CMS.

- CMS defines concurrent use as overlapping days' supply for at least 30 cumulative days during the measurement period, which is the calendar year. CMS uses prescriptions' date of service and days' supply to determine concurrent use.
- Prescription claims may be for the same or different opioids.
- CMS excludes patients from this measure if they have cancer or sickle cell disease, are in hospice or receiving palliative care.

Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults tracks the percentage of Medicare Part D beneficiaries ages 65 years or older with concurrent use of two or more unique anticholinergic medications during the measurement period which is associated with an increased risk of cognitive decline in older adults.

- Concurrent use is defined as overlapping days' supply for at least 30 cumulative days during the measurement period.
- CMS excludes patients from this measure if they are in hospice care.

Here are samples of anticholinergic medications included in this measure. The list isn't all-inclusive.

Class	Anticholinergic medications	Alternatives
Antihistamine	cyproheptadine, diphenhydramine, hydroxyzine, meclizine	levocetirizine, azelastine nasal spray
Antiparkinsonian	benztropine, trihexyphenidyl	amantadine, carbi/levodopa, entacapone
Skeletal Muscle Relaxants	cyclobenzaprine, orphenadrine	methocarbamol, baclofen, tizanidine
Antidepressants	amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, paroxetine	bupropion, citalopram, fluoxetine, sertraline, escitalopram
Antipsychotics	chlorpromazine, clozapine, olanzapine, perphenazine,	aripiprazole, quetiapine, risperidone, ziprasidone
Antimuscarinics (Urinary Incontinence)	fesoterodine, oxybutynin, solifenacin, tolterodine, trospium	Myrbetriq, Gemtesa
Antispasmodics	clidinium-chlordiazepoxide, dicyclomine, scopolamine	glycopyrrolate
Antiemetics	prochlorperazine, promethazine	ondansetron

About Star Ratings: CMS rates Medicare Part D and Medicare Advantage plans on a scale from one to five stars based on multiple quality and performance measures.

Update Your Records for New Members of Blue Cross Group Medicare Advantage Open Access (PPO)SM

New Medicare-eligible retirees have joined our **Blue Cross Group Medicare Advantage Open Access (PPO)SM** plan for retirees of employer groups. This is an open access, non-differential national PPO plan 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 our Medicare Advantage or other networks to see these members.

The **only requirements** are that you agree to see the member as a patient, accept Medicare and submit claims to the member's Blue Cross and Blue Shield Plan

Texas retiree groups **recently joining** the Blue Cross Group Medicare Advantage Open Access (PPO) plan include Brazoria County, City of Laredo, and the Public Employee Benefits Cooperative.

The University of Texas System, Texas A&M University System and City of Austin retiree groups are **continuing** the Blue Cross Group Medicare Advantage Open Access (PPO) plan.

Check member ID cards: You can identify these members by the plan type − Blue Cross Group Medicare Advantage Open Access (PPO) − listed on their ID card. 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.

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

Nationwide coverage: Blue Cross Group Medicare Advantage Open Access (PPO) covers the same benefits as Medicare Advantage Parts A and B plus additional benefits depending on the plan. It includes medical coverage and may include prescription drug coverage.

Members' coverage levels are the same **inside and outside their plan service area nationwide** for covered benefits. Plan members may have to pay deductibles, copays, and coinsurance, depending on their benefit plan. Members may be responsible for cost share for supplemental dental services from non-contracted Medicare providers.

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 BCBSXX and not Medicare.

If you're a Medicare Advantage-contracted provider with any BCBS 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 but accepts Medicare assignment, 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.

NETWORK PARTICIPATION

Ensure Your Office Is Providing Your Most Current Information

When seeking care, our members may contact your office or search our online Provider Finder® for information such as your appointment availability for new patients, location and contact information. To ensure the information provided to our members is accurate, we encourage you to take the following steps:

Ensure all office staff members, including those at centralized offices for provider groups:
Have access to up-to-date information that aligns with information you've provided to us;
Can readily relay this information to our members or transfer them to the appropriate resource.

Regularly **verify your demographic data and update it** with Blue Cross and Blue Shield of Texas as soon as it changes. Federal law requires that directory information be verified every 90 days even if it hasn't changed. You can verify and update your information using:

The Provider Data Management feature in Availity® Essentials, or
Our Demographic Change Form if you're unable to use Availity Essentials

In addition, **Medicaid providers** must attest and are required by the Texas Health and Human Services Commission to update their information through the Provider Enrollment and Management System. To learn more, see PEMS.

Important data to regularly review includes your practice locations, phone number, specialty, languages spoken, language line availability, appointment availability (accepting new patients), website and telehealth capabilities. Learn more about verifying and updating your information with us.

If you have a National Provider Identifier: Update the National Provider Identifier Registry when your information changes.

Keep Your Contact Information Updated to Receive Recredentialing Reminders

Providers credentialed with Blue Cross and Blue Shield of Texas are required to recredential every three years. Keeping your information up to date with BCBSTX and CAQH allows us to obtain your recredentialing application and you to receive reminders at updated contact methods when there is a change.

To update and attest to your information for CAQH

- Report changes to your information in your CAQH ProView account.
- CAQH will send you reminders to review and attest to your data's accuracy.

To update and verify your information for BCBSTX

- Use the Availity® Essentials Provider Data Management feature or our Demographic Change Form to update your information when it changes. Also verify your directory information every 90 days.

Refer to our Verify and Update Your Information page to learn more.

Authorize BCBSTX within CAQH: You may authorize BCBSTX to obtain your recredentialing information within CAQH or **select "global authorization."** This allows us to complete the recredentialing process without you needing to take additional steps.

Refer to our Recredentialing page for more information on recredentialing.

PHARMACY

Preferred Drugs to Be Recommended Through Enhanced Prior Authorization

Effective Jan. 1, 2025, we will recommend some preferred drugs over other drugs according to our medical policies, when clinically appropriate. This will improve access to more affordable care for some of our **commercial and individual** members.

What's changing? When submitting a prior authorization request for certain drugs, you will receive a recommendation for preferred drugs that are **comparable and clinically appropriate**. Blue Cross and Blue Shield of Texas or Carelon Medical Benefits Management will process these prior authorization requests.

Before submitting a prior authorization request, you can learn which drugs are included in this process, and what preferred drugs will be recommended, by referring to our medical policies. (List of drugs subject to change.)

- For **Pegfilgrastim and biosimilars**, see Medical Policy number RX501.134, "Oncologic Uses of White Blood Cell Colony Stimulating Factors," for more information (medical policy disclosed Oct. 1, 2024).
- For **immunoglobulin therapy,** see Medical Policy number RX504.003, "Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])," for more information (medical policy disclosed Oct. 1, 2024).
- For **Rituximab and biosimilars**, see Medical Policy number RX502.030, "Rituximab and Biosimilars for Non-Oncologic Indications," (medical policy disclosed Oct. 1, 2024).

Always **check eligibility and benefits** first to confirm membership and other important information, including prior authorization requirements and utilization management vendors, if applicable.

For more details on prior authorization

- Refer to How to Submit a Prior Authorization or a Notification for step-by-step instructions on how to submit prior authorization requests.
- Review prior authorization support materials (commercial) including prior authorization code lists and links to our digital lookup tool to determine if the drugs you're recommending require prior authorization or are applicable to RCR.

STANDARDS AND REQUIREMENTS

Lab Management Clinical Payment and Coding Policies Updated for Certain Administrative Services Only Groups

What's Changing?

Effective Jan.1, **2025** Blue Cross and Blue Shield of Texas is updating certain reimbursement policies with newly published American Medical Association procedure codes for certain laboratory, services, tests and procedures for some Administrative Services Only members.

The Details:

The following policies have been updated with code changes:

- CPCPLAB002 Cervical Cancer Screening
- CPCPLAB011 Biomarker Testing for Autoimmune Rheumatic Disease
- CPCPLAB018 Helicobacter Pylori Testing
- CPCPLAB027 Testing for Diagnosis of Active or Latent Tuberculosis
- CPCPLAB030 In Vitro Chemoresistance and Chemosensitivities Assays
- CPCPLAB036 Serum Biomarker Testing for Multiple Sclerosis and Related Neurologic Diseases
- CPCPLAB045 Pathogen Panel Testing
- CPCPLAB053 β-Hemolytic Streptococcus Testing

What do I need to do?
Review in detail the above updated policies – Laboratory Management Clinical Payment and Coding Policies.

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

Clinical Payment and Coding Policy Updates

We periodically add and modify Clinical Payment and Coding Policies as part of our ongoing policy review. These policies provide billing, coding and documentation guidelines. Visit our CPCP page regularly to ensure you're up to date on any changes or new policies.

REMINDERS

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

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

Alacura will manage:

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

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

***Alacura will not manage:**

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

What do I need to do?

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

Contact Alacura:

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

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

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 Effective 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.

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

What's New: We are changing prior authorization requirements for Blue Cross and Blue Shield of Texas Medicaid members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association.

Changes effective Jan. 1, 2025, include:

- **Medical Oncology drug codes previously** reviewed by eviCore to be reviewed by BCBSTX
- **Addition of one Behavioral Health code to be** reviewed by BCBSTX

More Information: Refer to our updated **Prior Authorization Lists and Reports** on the Utilization Management section of our Medicaid provider website.

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

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

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

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

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

Changes effective January 1, 2025 include:

- **Removal of Medical Oncology and Supportive Care codes previously** reviewed by eviCore
- **Medical Oncology drug codes previously** reviewed by eviCore to be reviewed by BCBSTX

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

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Stay Informed

Watch News and Updates and this newsletter. If others in your practice would like to receive *Blue Review*, submit their email addresses through our Demographic Change Form.

Refer to our provider website for more information, including available training and online tools.

Verify Your Directory Details Every 90 Days

Your directory information must be verified every 90 days. It's easy and quick to get it done for all health plans in Availity Essentials, or you can use our Demographic Change Form. Learn more.

Contact Us

Refer to our directory of contacts for Network Representatives and other resources.

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.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. References to other third-party sources or organizations are not a representation, warranty or endorsement of such organization. The fact that a service or treatment is described in this material, 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.

Trademarks are the property of their respective owners.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a provider. 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.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations.

Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.

Medical policies are for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are encouraged to exercise their own clinical judgment based on each individual patient's health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Some benefit plans administered by BCBSTX, such as some self-funded employer plans or governmental plans, may not utilize medical policies. Members should contact the number on their member ID card for more specific coverage information.

Please note that checking of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, 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.

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 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.

Advantmed, LLC is an independent company that has contracted with BCBSTX to request medical records for HEDIS reporting. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services they offer.

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

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.

CAQH is the Council for Affordable Quality Healthcare, Inc., a not-for-profit collaborative alliance of the nation's leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH's participating organizations provide health care coverage for more than 300 million Americans.

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

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

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HEDIS is a registered trademark of NCQA.

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

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

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