Blue Choice PPOSM and Blue High Performance NetworkSM (BlueHPN)SM Provider Manual –Filing Claims – Ancillary Services

Important note:

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

The following topics are covered in this section:

In this Section

| Topic | Page |
|---|-----------|
| Ancillary Services Overview | F (f)— 3 |
| Prior Authorizations and Predeterminations | F (f)— 3 |
| Diabetic Education | F (f)— 3 |
| Durable Medical Equipment (DME) | F (f)— 4 |
| DME Benefits | F (f)— 4 |
| Custom DME | F (f)— 4 |
| Repair of DME | F (f)— 4 |
| Replacement Parts | F (f)— 5 |
| DME Rental or Purchase | F (f)— 5 |
| DME Prior Authorization | F (f)— 5 |
| Prescription or Certificate of Medical Necessity | F (f)— 6 |
| Life-Sustaining DME | F (f)— 7 |
| Life-Sustaining DME List | F (f)— 7 |
| Home Infusion Therapy (HIT) | F (f)— 8 |
| Services Incidental to Infusion and Injection Therapy Per Diem | F (f)— 10 |
| Home Infusion Therapy Schedule | F (f)— 10 |
| Imaging Centers | F (f)— 11 |
| Imaging Prior Authorization or Prenotification | F (f)— 11 |
| High Tech Procedures - AIM Specialty Health® | F (f)— 12 |



In this Section

The following topics are covered in this section:

| Торіс | Page |
|---|-----------|
| Imaging Center Tests Not Typically Covered | F (f)— 13 |
| Independent Laboratory Claims Filing | F (f)— 14 |
| Independent Laboratory Services | F (f)— 14 |
| Prior Authorization for Certain Outpatient Lab Services | F (f)— 14 |
| Independent Laboratory Policy | F (f)— 15 |
| Independent Laboratory – Non-Covered Tests | F (f)— 16 |
| Prosthetics & Orthotics | F (f)— 17 |
| Prosthetics & Orthotics –Healthcare Common Procedure Coding System (HCPCS) Code Description Non-Covered | F (f)— 17 |
| Radiation Therapy Center Claims Filing | F (f)— 21 |



Ancillary Services Overview

It is important that providers submit ancillary claims accurately and completely. To assist, Blue Cross and Blue Shield of Texas (BCBSTX) has provided the following information and guidelines. In addition, refer to the **Clinical Payment and Coding Policies** on the provider website for specific information.

Prior Authorizations and Predeterminations

Either BCBSTX Medical Management or AIM Specialty Health (AIM) may be responsible for prior authorization for certain ancillary services.

Providers should refer to **Utilization Management** or the **AIM Specialty Health** pages on the BCBSTX provider website and check eligibility and benefits through Availity® or their preferred vendor to determine prior authorization requirements and who to contact.

Predetermination for coverage is recommended for medical necessity to determine benefit coverage. Refer to the **Predetermination of Benefits** page on the provider website for more information. Providers can submit Predetermination requests electronically through the **Availity Attachments Tool** or fax completed Predetermination Forms to **1-888-579-7935**.

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 merely confirms the Medical Necessity of the service or admission, but does not guarantee payment. Payment will be determined after the claim is filed and is subject to the following:

- Eligibility
- Other contractual provisions and limitations, including, but not limited to:
 - Cosmetic procedures
 - Failure to call on a timely basis (Prior delivery of DME)
 - Limitations contained in riders, if any

Diabetic Education

Diabetic education must be administered by or under the direct supervision of a physician. The program should provide medical, nursing and nutritional assessments, individualized health care plans, goal setting and instructions in diabetes self-management skills.

Claims filing instructions: Must use diabetes as the primary ICD-10 diagnosis for the claim to be paid. The V code for the education/counseling would be listed as the secondary diagnosis.

- Use CMS-1500 (02/12) claim form
- Use POS "99" for the place of service
- Use diabetes as the primary ICD-10 diagnosis
- Use appropriate procedure codes for services rendered
- File with your National Provider Identifier (NPI) number



Durable Medical Equipment

Blue Choice PPO describes Durable Medical Equipment (DME) as being items which can withstand repeated use; are primarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home.

DME Benefits

Benefits should be provided for the DME when the equipment is prescribed by a physician within the scope of his license and does not serve as a comfort or convenience item.

Benefits should be provided for the following:

- 1. Rental Charge (but not to exceed the total cost of purchase) or at the option of the Plan, the purchase of DME.
- 2. Repair, adjustment, or replacement of components and accessories necessary for effective functioning of covered equipment.
- 3. Supplies and accessories necessary for the effective functioning of covered DME.
- **Benefits are subject to the subscriber's individual or group contract provisions.

Custom DME

When billing for "customized" DME or Prosthetic/Orthotic (P&O) devices, an item must be specially constructed to meet a patient's specific need. The following items do not meet these requirements:

- An adjustable brace with Velcro closures
- A pull-on elastic brace
- A light weigh, high-strength wheelchair with padding added

A prescription is needed to justify the customized equipment and should indicate the reason the patient required a customized item. Physical therapy records or physician records can be submitted as documentation. An invoice should be included for any item that has been provided to construct a customized piece of DME or any P&O device for which a procedure codes does not exist.

Repair of DME

Repairs of DME equipment are covered if:

- Equipment is being purchased or already owned by the patient,
- Medically Necessary, and
- The repair is necessary to make the equipment serviceable.



Replacement Parts

Replacement parts such as hoses, tubing, batteries, etc., are covered when necessary for effective operation of a purchased item.

DME Rental or Purchase

The rental versus purchase decision is between the patient and supplier. However, the rental of any equipment should not extend more than 10 months duration. If the prescription indicates "lifetime" need, the supplier should attempt to sell the equipment as opposed to renting.

DME Prior Authorization

Prior authorization determines whether medical services are:

- Medically necessary
- Provided in the appropriate setting or the appropriate level of care
- Of a quality and frequency generally accepted by the medical community
- Check eligibility and benefits through your Availity® or your preferred vendor to determine prior authorization requirements.



Prescription or Certificate of Medical Necessity

A prescription or Certificate of Medical Necessity (CMN) is required to accompany all claims for DME rentals or purchase. The prescription or CMN also must be signed by the member's attending physician/professional provider.

When a physician/professional provider completes and signs the CMN, he or she is attesting that the information indicated on the form is correct and that the requested services are Medically Necessary. The CMN must specify the following:

- Member's name
- Diagnosis
- Type of equipment
- Medical Necessity for requesting the equipment
- Date and duration of expected use

The Certificate of Medical Necessity is not required in the following circumstances:

- The claim is for an eligible prosthetic or orthotic device that does not require prior medical review;
- The place of treatment billed for durable medical equipment or supplies is inpatient, outpatient or office;
- The individual line item for durable medical equipment or supplies billed is less than \$500.00 and the place of treatment is in the home or other;
- The claim is for durable medical equipment rental and is billed with the RR modifier; or
- The claim is for CPAP or Bi-Pap and there is a sleep study claim in file with BCBSTX that has been processed and paid. Sleep study (Current Procedural Terminology (CPT®) codes include but are not limited to 95806-95811.

These guidelines apply to fully insured members as well as self-funded employer groups who have opted to follow these guidelines. However, this may not apply to members with the Federal Employee Plan benefits or those from other Blue Cross and Blue Shield plans. To determine if a Certificate of Medical Necessity is required, please call the telephone number listed on the back of your patient's member ID card.



Life-Sustaining DME

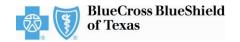
Life-Sustaining Durable Medical Equipment (DME) is paid as a perpetual rental during the entire period of medical need.

- The Vendor owns the DME. The Vendor is responsible for monitoring the functional state of the DME and initiating maintenance or repair as needed. The Vendor is likewise responsible for conducting the technical maintenance, repair and replacement of the DME. The rental payments to the Vendor from BCBSTX cover these services.
- When the period of medical need is over, possession of the DME returns to the Vendor.
- Attachments, replacement parts and all supplies and equipment ancillary to Life-Sustaining DME are considered included in the monthly rental payment. This includes refills of both gaseous and liquid oxygen.
- BCBSTX does not recognize or support member-owned DME previously obtained from another source.

Life Sustaining DME List

| HCPCS* Code | Description BCBSTX Life Sustaining DME |
|----------------|--|
| E0424 | Stationary compressed gas 02 |
| E0431 | Portable gaseous O2 and tubing |
| E0433 | Portable liquid oxygen sys |
| E0434 | Portable liquid O2 |
| E0439 | Stationary liquid O2 |
| E0441 | Stationary O2 contents, gas |
| E0442 | Stationary O2 contents, liq |
| E0443 | Portable 02 contents, gas |
| E0444 | Portable 02 contents, liquid |
| E0465 | Home vent invasive interface |
| E0466 | Home vent non-invasive inter |
| E0481 | Intrpulmnry percuss vent sys |
| E0618 | Apnea monitor |
| E0619 | Apnea monitor w/ recording feature |

^{*}HCPCS -Healthcare Common Procedure Coding System



Life Sustaining DME List, cont'd

| HCPCS Code | Description BCBSTX Life Sustaining DME |
|---------------|---|
| E1390 | Oxygen concentrator |
| E1391 | Oxygen concentrator, dual |
| E1392 | Portable oxygen concentrator |
| E1590 | Hemodialysis machine |
| E1592 | Auto interm peritoneal dialy |
| E1594 | Cycler dialysis machine |
| K0738 | Portable gas oxygen system |
| S8120 | O2 contents gas cubic ft |
| S8121 | O2 contents liquid lb |

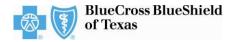
Home Infusion Therapy (HIT)

- Please make sure all claims are filed with your NPI number electronically or on a **CMS-1500** (02/12) claim form.
- Use Place of Service 12 (Home) when filing your claim.
- Reference the Home Infusion Clinical Payment and Coding Policy
- A service found on the HIT schedule, as well as the drugs used, will require prior authorization.

Note: All services/drugs that will be administered must be listed in the authorization or they will be denied.

- Providers should refer to "Factor Products" as identified in the Home Infusion Therapy Drug Schedule posted on the BCBSTX provider website. The codes are subject to change in accordance with the terms of the agreement.
- Nursing Visits: For nursing visits, prior authorize using CPT Codes 99601 and 99602.

For extended visits, prior authorize using CPT 99602.



Home Infusion Therapy (HIT), cont.

- Always bill using a valid procedure code (CPT, HCPCS and National Drug Code (NDC) for a drug and identify the appropriate number of units administered in Field 24g of the CMS-1500 (02/12) form. For example, if the procedure code defines the drug as 1 gram and you administered 20 grams, the CMS-1500 (02/12) form should reflect 20 units. Please note that J3490 should only be used if there is not a valid procedure code for the administered drug, in which case you would then bill using J-3490 and the respective NDC number.
- If billing for two or more concurrent therapies, use the appropriate modifiers:
 - **SH** Second concurrent administered infusion therapy
 - **SJ** Third or more concurrently administered infusion therapy
- Per diems not otherwise classified should only be prior authorized if the HIT services are not defined in an established per diem code.

The per diem for aerosolized drug therapy (S9061) does not include the cost of the nebulizer. The nebulizer must be purchased or rented through a PPO contracted Durable Medical Equipment supplier.

 The HIT per diems include supplies and equipment. For example, IV poles, infusion pumps, tubing, etc. Refer below to a list of HCPCS codes that will be considered incidental to the per diem code



Services
Incidental
to Home
Infusion
and
Injection
Therapy Per
Diem

| Miscellaneous Supplies and Services | | |
|---|-------------|--|
| A4206-A4210 | G0001 | |
| A4212-A4247 | Q0081-Q0085 | |
| A4454-A4455 | S9430 | |
| Vascular Catheters | | |
| A4300-A4306 | | |
| Enteral Nutrition Medical Supplies | | |
| B4034-B4086 | | |
| Parenteral Nutrition Solutions and Supplies | | |
| B4164- | B4164-B5200 | |
| Enteral and Parenteral Pumps | | |
| B9000-B9999 | | |
| Infusion Supplies | | |
| E0776- | -E0830 | |
| K0455 | K0455 S1015 | |

Home Infusion Therapy Schedule Codes and pricing are listed on the BCBSTX website under **Standards and Requirements** then **General Reimbursement Information**. Providers must verify codes and pricing prior to rendering services.

Updated 12-28-2020 Page F (f)—10



Imaging Centers

File claims electronically with BCBSTX or submit CMS-1500

- Must use CPT-4 coding structure
- Use POS "49" for place of service for electronic or paper claims
- Use the correct modifier appropriate to the service you are billing (i.e., total component, technical only, etc.)
- All "not other classified" procedure codes (NOCs) should be submitted with as much descriptive information as possible
- Must itemize all services and bill standard retail rates
- Must file with your NPI number
- Be sure to include NDC number for any oral or injectable radiopharmaceutical or contrast material used

Imaging Procedures Prior Authorization or Prenotification

BCBSTX is contracted with the AIM Specialty Health (AIM) for certain radiology services:

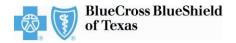
AIM may require prior authorization and post service medical necessity review for certain outpatient advanced imaging and cardiology related imaging services or a prenotification Radiology Quality Initiative (RQI) for certain outpatient high-tech diagnostic imaging services.

For details on specific services including specific procedure codes that require prior authorization or prenotification for the RQI program, refer to the AIM Specialty Health and Utilization Management pages on the BCBSTX provider website.

When prior authorization or prenotification RQI's are needed through AIM, ordering physicians for **Plan** patients must contact AIM to obtain a prior authorization or an RQI order request number.

Ordering physicians must write the order request number on the requisition for the imaging study. The ordering physician/professional provider is required to contact AIM, whether the ordering provider is the PCP or the specialist. The PCP will not be expected to obtain the order request number if a specialist orders the test. **The order request number must be on the performing provider's claim form UB-04 or CMS-1500s.**

When the ordering physician/professional provider submits the order through the AIM ProviderPortalSM, they will experience suggestions to include imaging sites that have an "A" score. Please note: The ordering provider will still be able to search for additional servicing providers in your network.



High Tech Procedures - AIM Specialty Health, cont. Performing providers (hospitals and freestanding imaging) may confirm that an order request number was issued as well as clinical guidelines and other educational resource by accessing AIM Specialty Health's (AIM) interactive website at http://www.aimspecialtyhealth.com.

When contacted, AIM will either issue an order request number or forward the case to a registered nurse or physician for review. AIM's physician reviewer may contact the ordering physician/provider to discuss the case in greater detail within two business days of receipt of the request. Ordering physicians must write the order request number on the requisition for the imaging study. Issuance of a order request number is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of a subscriber's health benefit plan.

The AIM process is based upon guidelines from medical organizations and medical literature. The guidelines are consistent with the clinical appropriateness criteria developed by the American College of Radiology (ACR). AIM promotes:

- Ordering the most appropriate outpatient diagnostic or advanced imaging for the diagnosis in question while minimizing unnecessary radiation exposure,
- Performing studies in the proper sequence, and
- Maximizing service to subscribers through the efficient use of their benefit plan.



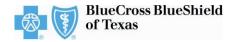
Imaging
Center Tests
Not Typically
Covered

Imaging center tests not typically covered may include but are not limited to:

- **70371** Speech evaluation complex
- **76000** Fluoroscopy, 1hr phys/qhp
- **76140** X-ray consultation
- **76511** Ophth US quant only
- **76512** Ophth US w/non quant A
- **76513** Echo exam of eye waterbath
- **76516** Echo exam of eye
- **76519** Echo exam of eye
- **76529** Echo exam of eye
- **77058–77079** MRI of the breast
- **78469** IO radiation TX management
- PET Scan

For more information, call the Medical Care Management Department at **1-800-441-9188.**

Updated 12-28-2020 Page F (f)—13



Independent Laboratory Claims Filing

- File claims electronically with BCBSTX or submit **CMS-1500** (02/12)
- Use CPT-4 coding structure
- Use place of service "81"
- Must file with your NPI number
- Must itemize all services and bill standard retail rates

Independent Laboratory Providers

Plan providers should refer members to in-network lab providers for outpatient lab services.

To locate participating labs in the Blue Choice PPO network, visit the Online Provider Directory through the BCBSTX website: https://www.bcbstx.com/find-a-doctor-or-hospital.

Prior
Authorization for
Certain
Outpatient
Lab
Services

BCBSTX is contracted with AIM Specialty Health to manage prior authorization services for certain lab services.

Refer to the <u>AIM Specialty Health</u> pages for information on specific services requiring prior authorization as well as how to prior authorize services.



Independent Laboratory Policy

- All not otherwise classified procedure codes (NOCs) should be submitted with as much descriptive information as possible.
- "STAT" charges are not reimbursable as a separate line item.
- The following diagnostic tests are not routinely covered without sufficient medical justification:
 - Amylase, blood, isoenzyme, electrophoretic
 - Autogenous vaccine
 - Calcium, feces, screening
 - Calcium saturation clotting time
 - Capillary fragility test (Rumpel-Leede)
 - Cephalin flocculation Congo red, blood
 - Chemotropism, duodenal contents
 - Chromium, blood
 - Circulation time, one test
 - Colloidal gold
 - Gastric analysis, pepsin
 - Gastric analysis, tubeless
 - Hormones, adrenocorticotropin, Quantitative, animal test
 - Hormones, adrenocorticotropin, Quantitative, bioassay
 - Skin test, lymphopathia verereum
 - Skin test, Brucellosis
 - Skin test, Leptospirosis
 - Skin test, Psittacosis
 - Skin test, Trichinodid
 - Thymol turbidity, blood
 - Zinc sulphate, turbidity, blood
- The following tests are the components of the Obstetrical (OB)
 Profile:
 - ABO type
 - Antibody screens for red cell antigens
 - CBC
 - RH type
 - Rubella titer
 - Serologic tests for syphilis
 - Sickle cell prep (when appropriate)



Independent Laboratory – Non Covered Tests

- Assay of Appolipoprotein
- Automated hemogram
- Candida enzyme immunoassay
- Captopril challenge test
- Cervigram (cervicography)
- Cystic disease protein test
- Cytomegalovirus screening in pregnancy patients
- EDTA formalin assay
- Glucose blood, stick test
- Glycated albumin test
- Human tumor stem cell drug sensitivity assay
- Lipoprotein cholesterol fractionation calculation by formula
- Neopterin RI acid test
- Nonprotein nitrogen (NPN) blood
- Provocative and neutralization testing for phenol and ethanol formaldehyde
- Radioimmunoassay (RIA) not otherwise specified
- RIA urinary albumin
- Sperm penetration assay
- Sublingual provocative testing
- Transfer factor test
- Travel allowance for specimen pickup
- Urinary albumin excretion rate

Providers should check eligibility and benefits through Availity® or their preferred vendor.



Prosthetics/ Orthotics

- File claims electronically with BCBSTX or submit **CMS-1500** (02/12)
- Must use Healthcare Common Procedure Coding System (HCPCS) coding structure
- Must use place of service B
- Need to submit complete documentation when using an NOC procedure code
- Must itemize all services and bill standard retail rates
- Must file with your NPI Number

Prosthetics & Orthotics - HCPCS Code Description - Non-Covered

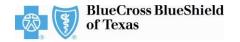
Prosthetics & Orthotics not typically covered may include but are not limited to:

| HCPCS Code | Description |
|---------------|---|
| N/A | Foot orthotics, bilateral |
| N/A | Foot orthotics, unilateral |
| N/A | Foot impressions, bilateral |
| N/A | Foot impressions, unilateral |
| N/A | Orthopedic Supports, cervical collar, immobilize slings |
| L3000 | Ft insert ucb berkeley shell |
| L3001 | Foot insert remov molded spe |
| L3002 | Foot insert plastazote or eq |
| L3003 | Foot insert silicone gel eac |
| L3010 | Foot longitudinal arch suppo |
| L3030 | Foot arch support remov prem |
| L3040 | Ft arch suprt premold longit |
| L3050 | Foot arch supp premold metat |
| L3060 | Foot arch supp longitud/meta |
| L3070 | Arch suprt att to sho longit |
| L3080 | Arch supp att to shoe metata |
| L3090 | Arch supp att to shoe long/m |



Prosthetics & Orthotics - HCPCS Code Description - Non Covered, cont.

| HCPCS Code | Description |
|---------------|------------------------------|
| L3100 | Hallus-valgus nt dyn pre ots |
| L3170 | Foot plas heel stabi pre ots |
| L3201 | Oxford w supinat/pronat inf |
| L3202 | Oxford w/ supinat/pronator c |
| L3203 | Oxford w/ supinator/pronator |
| L3204 | Hightop w/ supp/pronator inf |
| L3206 | Hightop w/ supp/pronator chi |
| L3207 | Hightop w/ supp/pronator jun |
| L3215 | Orthopedic ftwear ladies oxf |
| L3216 | Orthoped ladies shoes dpth i |
| L3217 | Ladies shoes hightop depth i |
| L3219 | Orthopedic mens shoes oxford |
| L3221 | Orthopedic mens shoes dpth i |
| L3222 | Mens shoes hightop depth inl |
| L3230 | Custom shoes depth inlay |
| L3250 | Custom mold shoe remov prost |
| L3251 | Shoe molded to pt silicone s |
| L3252 | Shoe molded plastazote cust |
| L3253 | Shoe molded plastazote cust |
| L3254 | Orth foot non-stndard size/w |
| L3255 | Orth foot non-standard size/ |
| L3260 | Ambulatory surgical boot eac |
| L3265 | Plastazote sandal each |



Prosthetics & Orthotics - HCPCS Code Description - Orthotics - Non-Covered cont.

| | B |
|---------------|------------------------------|
| HCPCS Code | Description |
| | |
| L3300 | Sho lift taper to metatarsal |
| L3310 | Shoe lift elev heel/sole neo |
| L3320 | Shoe lift elev heel/sole cor |
| L3330 | Lifts elevation metal extens |
| L3332 | Shoe lifts tapered to one-ha |
| L3334 | Shoe lifts elevation heel /i |
| L3340 | Shoe wedge sock |
| L3350 | Shoe heel wedge |
| L3360 | Shoe sole wedge outside sole |
| L3370 | Shoe sole wedge between sole |
| L3380 | Shoe clubfoot wedge |
| L3390 | Shoe outflare wedge |
| L3430 | Sho heel count plast reinfor |
| L3440 | Heel leather reinforced |
| L3450 | Shoe heel sach cushion type |
| L3455 | Shoe heel new leather standa |
| L3460 | Shoe heel new rubber standar |
| L3465 | Shoe heel thomas with wedge |
| L3470 | Shoe heel thomas extend to b |
| L3480 | Shoe heel pad & depress for |
| L3485 | Shoe heel pad removable for |
| L3500 | Ortho shoe add leather insol |
| L3510 | Orthopedic shoe add rub insl |
| L3520 | O shoe add felt w leath insl |
| L3530 | Ortho shoe add half sole |



Prosthetics & Orthotics – HCPCS Code Description – Orthotics – Non Covered, cont.

| HCPCS Code | Description |
|---------------|------------------------------|
| 55.05 | |
| L3540 | Ortho shoe add full sole |
| L3550 | O shoe add standard toe tap |
| L3560 | O shoe add horseshoe toe tap |
| L3649 | Orthopedic shoe modifica NOS |
| A6530 | Compression stocking BK18-30 |
| A6531 | Compression stocking BK30-40 |
| A6532 | Compression stocking BK40-50 |
| A6533 | Gc stocking thighlngth 18-30 |
| A6534 | Gc stocking thighlngth 30-40 |
| A6535 | Gc stocking thighlngth 40-50 |
| A6536 | Gc stocking full Ingth 18-30 |
| A6537 | Gc stocking full Ingth 30-40 |
| A6538 | Gc stocking full Ingth 40-50 |
| A6539 | Gc stocking waistIngth 18-30 |
| A6540 | Gc stocking waistIngth 30-40 |
| A6541 | Gc stocking waistIngth 40-50 |
| A6544 | Gc stocking garter belt |
| S9999 | Sales tax |

Providers should check eligibility and benefits through Availity or their preferred vendor.



Radiation Therapy Center Claims Filing

- Must use appropriate CMS-1500 claim form or electronic equivalent
 Note: Use UB-04 or electronic equivalent, if a facility; or
 Use CMS-1500 (02/12) if a free-standing facility
- Must bill negotiated rates according to fees stated in contract.
- May use CPT-4 code as part of description, but **must have correct** revenue codes if using UB-04.
- When the member's coverage requires a PCP referral, form locator 63 must be completed with a referral authorization number obtained from BCBSTX.
- Must file with your NPI number

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

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

CPT copyright 2021 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.