Texas Medicaid Claims Editing Enhancements Effective July 26, 2022

What's happening

Effective July 26, 2022, Blue Cross and Blue Shield of Texas (BCBSTX) will enhance our claims editing and review process to help ensure accurate coding and reimbursement of services. Below is a list of policies that will be affected once the new edits go into effect.

Medicaid – Allergy Services		
Topic	Description	
Allergy Services – Allergy Testing	Limit 86003 or 86008 (Allergen specific IgE; quantitative or semiquantitative,	
	crude allergen extract/ recombinant or purified component) to 30 units per	
	year when billed by any provider.	

Medicaid – Ambulatory Electroencephalogram (EEG)		
Topic	Description	
Ambulatory Electroencephalogram (EEG)	Limit 95700 (Electroencephalogram continuous recording) to three units per six months by the same provider ID.	
Ambulatory Electroencephalogram (EEG)	Limit any combination of 95717-95726 (Professional component ambulatory electroencephalogram) to three units per six months by the same provider ID.	
Ambulatory Electroencephalogram (EEG)	Limit any combination of 95705-95716 (Technical component ambulatory electroencephalogram service) to three units per six months by the same provider ID.	
Ambulatory Electroencephalogram (EEG)	Deny 95700 or 95705-95726 (EEG monitoring) when billed without an approved diagnosis on the claim.	
Medicaid – Behavioral Health Services – Outpatient Mental Health Services		
Topic	Description	
Outpatient Mental Health Services	Deny 90832-90838, 90846-90847 or 90853 (Psychotherapy) when billed without an approved diagnosis on the claim.	
Outpatient Mental Health Services	Deny 96116, 96121 (Neurobehavioral exam), 96130-96133 or 96136- 96137 (Psychological or neuropsychological testing) when billed without an approved diagnosis on the claim.	
Outpatient Mental Health Services	Deny 96116 or 96121 (Neurobehavioral testing) when billed on the same date of service as psychological testing or neuropsychological testing (96130-96133, 96136, 96137) by the same provider ID.	
Medicaid – Clinician-Administered Drugs		
Topic	Description	
Clinician-Administered Drugs - Azacitidine (J9025)	Deny J9025 when billed without an approved diagnosis on the claim.	
Clinician-Administered Drugs - Botulinum Toxin Type A and Type B	Deny J0586 when billed without an approved diagnosis on the claim.	
Clinician-Administered Drugs - Colony Stimulating Factors	Deny J2505 when billed on the same date of service as J1442.	
Clinician-Administered Drugs - Colony Stimulating Factors	Deny J1442, J1447, J2505, J2820, Q5101, Q5108, Q5110, Q5120, or Q5122 when billed without an approved diagnosis on the claim.	
Clinician-Administered Drugs - Infliximab (J1745, Q5103, Q5104)	Deny J1745, Q5103 or Q5104 when billed without an approved diagnosis on the claim.	

Medicaid – Diagnostic Doppler Sonography		
Topic	Description	
Diagnostic Doppler Sonography	Deny peripheral arterial Doppler studies when billed without an approved	
	diagnosis on the claim.	
Diagnostic Doppler Sonography	Deny peripheral venous Doppler studies when billed without an approved	
	diagnosis on the claim.	
Medicaid – Durable Medical Equipment (DME)		
Topic	Description	
Durable Medical Equipment and Supplies -	Deny certain DME and medical supplies when reported with modifier RR	
Modifier RR (Rental)	(Rental).	
	icaid – Evaluation and Management (E/M)	
Topic	Description	
Evaluation and Management – Preventive	Limit any combination of 99385-99387 or 99395-99397 (Adult preventive	
Medicine Services	medicine services) to one unit per year when billed by any provider and the	
	patient is 21 years of age or older.	
Evaluation and Management – Preventive	Deny 99385-99387 or 99395-99397 (Adult preventive medicine services) when	
Medicine Services	billed without an approved diagnosis on the claim and the patient is 21 years	
Finding and Management Drawnsking	of age or older.	
Evaluation and Management – Preventive Medicine Services	Deny 99385 or 99395 (Adult preventive medicine services) when billed without	
Wedicirie Services	an approved diagnosis on the claim and the patient is 18 years through 20	
Evaluation and Management – Preventive	years of age. Deny 99381-99384 or 99391-99394 (Child preventive medicine services) when	
Medicine Services	billed without an approved diagnosis on the claim.	
Wedicine Services	Medicaid – Hearing Services	
Topic	Description	
Hearing Services – Auditory Rehabilitation	Limit 92626 (Evaluation of auditory rehabilitation status) to one unit in 180	
	days when billed by any provider.	
Hearing Services – Auditory Rehabilitation	Deny 92630 or 92633 (Auditory rehabilitation) when billed with greater than 12	
	units in 180 days by any provider.	
	Medicaid – Laboratory Services	
Topic	Description	
Clinical Laboratory Improvement	Deny 83655 (Assay of lead) when billed without modifier QW (CLIA waived test)	
Amendment (CLIA) Waived Tests	and the place of service is office (02, 11, 15, 17, 20, 49, 50, 60, 65, 71, 72).	
Organ or Disease-Oriented Panels	Deny 80061 (Lipid panel procedure) when billed with 99381-99387 (Preventive	
	medicine evaluation and management services, new patient) or 99391-99397	
	(Preventive medicine evaluation and management services, established patient)	
	for more than one visit per rolling year by any provider.	
	Medicaid – Maximum Units	
Topic	Description	
Annual Maximum Units	Limit certain testing procedures to two units per year when billed by any	
	provider with the same bill type. (CMS-1450)	
	Medicaid – Obstetrics and Gynecology	
Topic AUDS)	Description (24.422.24.527)	
Non-invasive Prenatal Screening (NIPS)	Limit non-invasive prenatal screening procedure (81420, 81507) to one unit per	
	pregnancy (240 days) when billed by any provider unless a diagnosis of	
	pregnancy with abortive outcome has been billed on the claim with any service	
Antonartum and Fatal Invasive December	by any provider. Limit 50020 or 50025 (Fotal test) to one unit per day when hilled with Payenua	
Antepartum and Fetal Invasive Procedures	Limit 59020 or 59025 (Fetal test) to one unit per day when billed with Revenue	
	Code 0729 (Labor room/delivery other) by the same provider.	

Tobacco Use Cessation	Deny 99406 or 99407 (Smoking and tobacco use cessation counseling) when	
	billed without an approved diagnosis on the claim.	
Tobacco Use Cessation	Deny 99406 or 99407 (Smoking and tobacco use cessation counseling) when	
	billed in any combination more than once per day by any provider.	
Tobacco Use Cessation	Deny 99406 or 99407 (Smoking and tobacco use cessation counseling) when	
	billed in any combination more than eight units per rolling year by any	
	provider.	
Medicaid – Physical Therapy, Occupational Therapy and Speech Therapy		
Topic	Description	
Physical Therapy, Occupational Therapy	Limit 92521-92524, 92610, 97161-97163 or 97165-97167 (Therapy	
and Speech Therapy	evaluation services) to one unit every three years when billed by the same	
	provider ID and patient is 21 years of age or older.	
Medicaid – Podiatry Services – Clubfoot Casting		
Topic	Description	
Clubfoot Casting	Deny 29450 or 29750 (Application/wedging of clubfoot cast) when billed	
	without an approved diagnosis on the claim.	
Clubfoot Casting	Deny 29450 or 29750 (Application/wedging of clubfoot cast) when billed	
	without modifier LT or RT.	
Clubfoot Casting	Deny 29450 or 29750 (Application/wedging of clubfoot cast) when billed and	
	the patient is four years of age or older.	

Questions

For questions or additional information, please:

- Contact our BCBSTX Medicaid Provider Service Center at 1-877-560-8055 or
- Contact your BCBSTX Medicaid Provider Network Representative at 1-855-212-1615 or
- Submit via email to <u>TexasMedicaidNetworkDepartment@bcbstx.com</u>.

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. 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.

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