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 - Modifier RR (Rental)	*Deny certain DME and medical supplies when reported with modifier RR (Rental).*
Medicaid – Evaluation and Management (E/M)	
Topic	*Description*
Evaluation and Management – Preventive Medicine Services	*Limit any combination of 99385-99387 or 99395-99397 (Adult preventive 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 Medicine Services	*Deny 99385-99387 or 99395-99397 (Adult preventive medicine services) when billed without an approved diagnosis on the claim and the patient is 21 years of age or older.*
Evaluation and Management – Preventive Medicine Services	*Deny 99385 or 99395 (Adult preventive medicine services) when billed without an approved diagnosis on the claim and the patient is 18 years through 20 years of age.*
Evaluation and Management – Preventive Medicine Services	*Deny 99381-99384 or 99391-99394 (Child preventive medicine services) when billed without an approved diagnosis on the claim.*
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 Amendment (CLIA) Waived Tests	*Deny 83655 (Assay of lead) when billed without modifier QW (CLIA waived test) 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	*Description*
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 by any provider.*
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 and Speech Therapy	*Limit 92521-92524, 92610, 97161-97163 or 97165-97167 (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 TexasMedicaidNetworkDepartment@bcbstx.com.*