
DECEMBER 2017

## NOTICES & ANNOUNCEMENTS

### BlueOptions® Benefit Plan Design No Longer Offered Beginning Dec. 31, 2017

Effective Dec. 31, 2017, the BlueOptions benefit plan product will no longer be offered as a BCBSTX product. BlueOptions provided enhanced benefits to BCBSTX members who obtained care from Blue Choice PPO℠ physicians who were recognized through the BlueCompare℠ program for cost efficiency and quality performance. Blue Compare for Physicians, the program that measures quality for certain specialties, will continue to provide performance reporting to physicians and members. Please note that the elimination of this benefit plan does not affect any other networks. If you have questions, please contact your BCBSTX Network Representative.

---

### New Medical Record Retrieval Vendor for Blue Card Plan Member Records

The “risk adjustment” requirement under the Affordable Care Act (ACA) requires Blue Cross and Blue Shield of Texas (BCBSTX) to meet data submission and coding accuracy standards. Member medical records are necessary to help ensure that these requirements are satisfied.

Currently, BCBSTX works with Verscend to retrieve medical records for all Blue Card Plan members to support Healthcare Effective Data and Information Set (HEDIS®), the risk adjustment requirement under ACA and government programs.

Effective Jan. 1, 2018, Inovalon will replace Verscend as the new medical records retrieval vendor. Between now and Jan. 1, 2018, you may receive requests for medical records from both Verscend and Inovalon as the transition is completed on Jan. 1, 2018.

Both Verscend and Inovalon are independent companies and contractually bound to preserve the confidentiality of members’ protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Please note that patient authorized forms are not required for disclosures of members’ medical records to Verscend or Inovalon.

As set forth in your Agreement with BCBSTX, you are required to respond to requests for medical records from BCBSTX. Such compliance is also required for requests for medical records from BCBSTX’s designees, such as Verscend and Inovalon, in support of risk adjustment, HEDIS and government programs within the requested timeframe. BCBSTX is working diligently to ensure this process is followed.

For your convenience, medical records may be submitted in the following ways:

**Inovalon**

- Fax: 877-221-0604
- Email: EMRService@inovalon.com (send secure)
- Mail: Inovalon Document Processing, 7777 Market Center Ave, Suite E, El Paso, TX 79912

**Verscend**

- Upload the record image to Verscend's secure portal and enter your password that is included with your Verscend request. Select the files to be uploaded.
- Fax: 888-231-9601
- Mail: Verscend, 66 E. Wadsworth Park Dr., Draper, UT 84020

Providers are permitted to disclose PHI to BCBSTX without authorization from the member when both the provider and BCBSTX have or had a relationship with the member and the information relates to the relationship. See 45 CFR 164.506(c)(4). For more information regarding the HIPAA Privacy Rule, please visit hhs.gov/ocr/privacy.

If you have any questions about sending medical records to Verscend or Inovalon, contact your BCBSTX Network Representative.

*HEDIS is a registered trademark of NCQA*

---

## BCBSTX Celebrates LGBTQ Inclusion

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to promoting the health and wellness of our members and communities. Our commitment guides us in fostering greater access to care and working to lower the overall cost of care, while helping improve care quality and patient outcomes.

Our responsibility to an ever increasing, diverse member base led us to work with our lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) employees to understand the health care needs of the LGBTQ population. We are proud to inform you that this partnership resulted in the creation of the BCBSTX Values LGBTQ Inclusion resource web page. This resource underlines the importance of this dynamic community and supports our pledge, "To do everything in our power to stand with our members in sickness and in health."

We invite you to visit BCBSTX Values LGBTQ Inclusion and learn how you can join us in supporting the LGBTQ community. You will find examples of our internal and external commitments, as well as information on Health Professionals Advancing LGBT Equality (formerly known as the Gay & Lesbian Medical Association, GMLA). GLMA is an online provider directory where patients can search for primary care providers, specialists, therapists, dentists and other health care professionals that welcome LGBTQ individuals and families.

BCBSTX stands by our core values of integrity, respect, commitment, caring and excellence. We recognize the diverse worldviews that drive most health care choices in multicultural homes. To that end, we are committed to providing a variety of products and services that help meet the unique needs of our members by meeting them where they are and hope that you will join us.

---

## Fee Schedule Updates Effective Oct. 1

Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule used for Blue Choice PPO℠, Blue Essentials℠, Blue Premier℠, Blue Advantage HMO℠ and ParPlan effective Oct. 1, 2017. The changes include:

- The methodology used to develop the maximum allowable fee schedule for these plans will be based on 2017 Centers for Medicare and Medicaid Services (CMS) values as posted on their website for the services in which the BCBSTX reimbursement is based on CMS values.
- BCBSTX provides general reimbursement information policies, fee schedule request forms and fee schedule information on the General Reimbursement Information section of BCBSTX's provider website.
    - Reimbursement changes and updates will be posted under "Reimbursement Changes/Updates" in the Reimbursement Schedules section.
    - The specific effective date will be noted for each change that is posted.
- The conversion factor for certain surgical codes may vary by place of service for ambulatory surgical center and outpatient hospital.

- Blue Choice PPO, Blue Essentials, Blue Premier and Blue Advantage HMO:
    - Will consider the site of service where the service is performed.
    - The multiple procedure payment will be changing on the professional component of certain diagnostic imaging procedures. This change applies to services billed as professional component only or global for the procedures listed on the website. The highest priced procedure will be reimbursed at 100 percent of the allowable and each additional procedure – when performed during the same session on the same day – will be reimbursed at 95 percent (previously 75 percent) of the allowable.

If you would like to request a sample of maximum allowable fees or if you have any questions, please contact your Network Management office.

---

## Integration of Prime Therapeutics® and Walgreens® Specialty Pharmacy and Mail Order Services

Blue Cross and Blue Shield of Texas' (BCBSTX) pharmacy benefit manager (PBM), Prime Therapeutics LLC (Prime), and Walgreens announced a strategic alliance in August 2016 to create a first-of-its-kind model for pharmacy benefit management that aligns a national pharmacy chain, a leading PBM and health plans, including a long-term retail pharmacy agreement. As part of this alliance, Prime and Walgreens have formed a combined company for specialty pharmacy and mail order services, headquartered in Orlando, FL.

Teams have been working to unite each organization's mail service and specialty pharmacy operations. As of mid-August 2017, all BCBSTX members whose pharmacy benefits are administrated through Prime will have been integrated into the new combined company's pharmacy systems.[1] A summary of the changes you might experience from this integration are included below.

**Specialty Pharmacy Services**
As of July 15, 2017, BCBSTX members were integrated into the new specialty pharmacy system. The new company is nationally accredited by Accreditation Commission for Health Care and Utilization Review Accreditation Commission. Any additional accreditation and licenses will be pursued as needed. Additionally, a vast selection of previously labeled limited distribution products will be available through Prime Therapeutics Specialty Pharmacy.

**There are no changes to the way you submit a prescription. The following remains the same:**

- The name used when e-prescribing: Prime Therapeutics Specialty (as of April 5, 2017)
- The fax number used to send prescriptions
- The prior authorization process; patient prior authorization approvals on file were transferred and will follow the BCBSTX process for renewals
- The number you call to reach Prime Specialty Pharmacy: 877-627-MEDS (6337)
- The hours of operation: Monday-Friday, 7 a.m. – 7 p.m. CT

**For prescriptions coming to your location, you may notice changes in Prime Therapeutics' communications and packaging, including:**

- The use of the Prime Specialty Pharmacy and Walgreens names/logos may both appear on the packing receipt, enclosed information sheets, stickers on the box, etc.
- Cooler/cooler packaging and the box holding the medicine may look different
- The label affixed to the front of the box may show a dispensing location other than Orlando, FL

**Mail Order Services**
Covered 90-day supply mail order prescriptions are being filled by "PrimeMail by Walgreens Mail Service" home delivery program as of Aug. 18, 2017.

**There is a new way to submit a prescription electronically:**

- For patients with expired/no remaining refill prescriptions, you will need to provide a new prescription. If submitting this prescription electronically after Aug. 18, you will need to send it to Walgreens Mail Service in Tempe, AZ, or you can fax the prescription to 800-332-9581.

**Please Note:** Existing PrimeMail ePrescribing or fax methods you may currently be using can continue for the immediate future, but will be returned as "unable to fill" at some point later this year. Please take this opportunity to update any pharmacy information that may be stored in your patients' records. Also, if your patient has a current prior authorization approval on file, it was transferred over to the new mail order system and will follow the standard BCBSTX process for renewals.

Members with prescription history within the last 12-18 months were notified of the specialty pharmacy and/or mail order service changes. Full integration of all mail service and specialty pharmacy services are expected to be completed by the first quarter of 2018. More information about the new combined company, including the official name, will be shared in future *Blue Review* issues and/or in the News and Updates section of the BCBSTX provider website.

If your patients have questions about their pharmacy benefits, please advise them to contact the Pharmacy Program number on their member ID card. Members may also visit bcbstx.com and log in to Blue Access for Members℠ for a variety of online resources.

[1]Members with Medicare Part D or Medicaid coverage transitioned to the new mail order services as of earlier this year.

*Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime Therapeutics to provide pharmacy benefit management and other related services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSTX and contracting pharmacies is that of independent contractors. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.*

*Prime has entered into an agreement with Walgreens, an independently contracted pharmacy, to form a combined specialty pharmacy and mail order services company, owned by Prime and Walgreens.*

---

### Become a BCBSTX HealthSelect℠ of Texas Provider Today!

Are you currently providing or interested in providing healthcare services for Employees Retirement System of Texas (ERS) participants? ERS will utilize the Blue Essentials network to support its custom POS network for ERS HealthSelect of Texas℠ and Consumer Directed HealthSelect℠. If you are not currently an active Blue Essentials network provider, you need to apply for participation in Blue Essentials prior to September 1, 2017, as HealthSelect will access the Blue Essentials network. To ensure a seamless transition and have the optimum providers available, we are reaching out to increase awareness about this opportunity.

ERS participants in the HealthSelect Point of Service (POS) plan receive maximum benefits when care is provided or directed by an in-network Primary Care Provider. Participants have an out-of-network option available to them, but there could be a significant financial impact when utilizing out-of-network services. Open enrollment for ERS participants will take place from June 26 through July 28, 2017. To continue providing care to your ERS participants, we hope you will consider participating in our customized HealthSelect network. Please contact your local Network Management office to obtain an agreement to be a HealthSelect provider through the Blue Essentials network.

We value your participation in our existing networks and it is our earnest hope you consider being a part of the Blue Essentials network for the benefit of your current and future ERS patients.

---

## CLAIMS & ELIGIBILITY

### Zero Copay for Preventative Services Reminder

Are you up to date on preventive services benefits? Blue Cross and Blue Shield of Texas (BCBSTX) would like to remind you that there are no copays for preventative services for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠. Blue Cross Medicare Advantage covers a full range of preventive services to help keep patients healthy, help find problems early and determine when treatment is most effective.

Physicians should let members know which of these services is right for them. For a detailed list of the services with zero copay you may access: Are You Up-To Date on Your Preventive Services. In addition, you should check eligibility and benefits electronically through Availity™ or your preferred Web vendor.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized 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. If you have any questions, please call the number on the back of the member's ID card.

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.

---

## Coverage of Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease

**Applies to: Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM**

Original fee-for-service Medicare will continue covering the cost and reimbursement of SET for symptomatic peripheral artery disease in 2018. For 2019 and subsequent years, providers should plan to bill SET items and services to the beneficiaries' MA plan unless notified otherwise.

The Centers for Medicare and Medicaid Services (CMS) has determined the cost and reimbursement for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) will be covered for calendar years 2017 and 2018 only, by original fee-for-service Medicare. Providers should bill necessary SET items and services obtained by beneficiaries enrolled in MA plans to original fee-for-service Medicare. For 2019 and subsequent years, providers should plan to bill SET items and services to the beneficiaries' MA plan unless notified otherwise.

Consistent with §1862(a)(1)(A) of the Act, Medicare Administrative Contractors will consider whether SET for PAD services are reasonable and necessary and reimbursable by original Medicare for Medicare beneficiaries enrolled in MA plans in CY 2017 and 2018.

Please review the CMS guidance article as soon as possible.

---

## Processing Claims for Preventive Colonoscopies

Accurate claims billing is essential to receiving correct payment for a preventive care service like a diagnostic colonoscopy. The initial reason a procedure was performed determines whether it is covered without member cost-sharing. For example, when the initial reason for a colonoscopy is to screen for colorectal cancer, it is considered preventive under the United States Preventive Services Task Force (USPSTF) guidelines that drive ACA requirements. That procedure should be billed using the applicable CPT modifier 33. However, the CPT modifier 33, does not apply to non-preventive colonoscopies, such as those done to evaluate or follow up on signs, symptoms or pre-existing conditions.

Currently for HealthSelectSM of Texas, Consumer Directed HealthSelectSM of Texas, HealthSelectSM and Consumer Directed HealthSelectSM Out-of-State, the prior authorization requirement is waived for preventive colonoscopies performed by in-network providers when the intent of the procedure is preventive and billed with modifier 33, regardless of the findings.

### Tips on Using Modifiers for Preventive Services

Sometimes it can be difficult to know when to use which modifiers. Here are some tips that may help:

- If the purpose of the procedure is to screen for colorectal cancer and the service becomes diagnostic during the procedure, modifier 33 may be used.
- Modifier 33 is not used for non-preventive colonoscopies or other non-preventive procedures.
- A colonoscopy procedure will process at the no-cost sharing benefit level as long as modifier 33 is present.
- Colonoscopies not billed with one of the preventive modifiers will not be processed as a preventive screening.

**Frequently Asked Questions about Preventive Colonoscopies**

**1. What colonoscopy procedures is BCBSTX defining as preventive?**
A service associated with a screening colonoscopy must pay at the preventive benefit level. If a procedure is billed as a screening, colonoscopy benefits will be applied as preventive based on the intent of the test and not on the findings. If a problem is found during the screening and a procedure is performed to address the problem (such as polyp removal), the claim will still be paid as preventive with no cost sharing – as long as it has been billed with modifier 33. If the procedure is not billed as preventive, it will not be paid as a preventive screening.

**2. What services are considered part of the screening colonoscopy?**

- Colonoscopy screening procedure
- Pathology services
- Anesthesiology (if necessary)
- Outpatient facility fee

A service that is directly related to a screening colonoscopy is considered to be part of the screening colonoscopy.

**3. Will BCBSTX adjust a claim for a colonoscopy?**
If a member advises that a colonoscopy was intended to be preventive, BCBSTX will research the claims history and potentially adjust the claim, if applicable. There are a number of factors that could impact the way BCBSTX will reimburse for a colonoscopy procedure. Reasons that may lead to the claim being paid with member cost-sharing include number of visits; age limits; use of a non-network provider; procedure billed as diagnostic or medical; symptoms or history.

The provider may need to submit a corrected claim if they did not bill the colonoscopy as preventive when, in fact, it was a preventive procedure.

**4. What if a problem is found during the colorectal screening? Does it change the way the claim is paid?**
If a procedure is billed as a preventive screening, BCBSTX will assume that colonoscopy benefits should be applied based on the intent of the test and not on the findings. If a problem is found during the screening and a procedure is performed to address the problem (such as polyp removal), the claim will still be paid as preventive with no member cost sharing – as long as it has been billed using the appropriate preventive modifiers. If the procedure is not billed as preventive, it will not be paid as a preventive screening.

**5. For Texas plans that include a prior authorization requirement, how are colonoscopies handled?**
Providers should refer to the current preauthorization/prior authorization requirements lists to determine if authorization is required for colonoscopies.



For more information about the USPSTF recommendation on screening for colorectal cancer see http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm.



---

## Documentation Guidelines for Laboratory Audit and Review

To assist in prompt payment of claims and to insure payment integrity, Blue Cross and Blue Shield of Texas (BCBSTX) requires laboratory services to be properly documented. Incomplete or illegible records can result in a denial of payment for services.

**Submit Justification of Services**
For a claim to process and for BCBSTX benefits to be valid, there must be sufficient documentation in the provider's or hospital's records to verify that the services performed were medically necessary and required the level of care billed. If there is insufficient or no documentation, then there is no justification for the services or level of care billed, and request for payment may be denied. Additionally, if there is insufficient documentation for the claims that have already been adjudicated by BCBSTX, reimbursement may be considered an overpayment and the funds may be recovered.

**Laboratory claims** should be submitted to the state Blue Cross and Blue Shield Plan **where the sample was obtained** regardless of where the testing facility resides.

Each laboratory claim should have valid laboratory medical records documenting the services ordered and the results of the services performed. Laboratory medical records consist of a signed valid requisition and complete results of the tests performed. A valid requisition is one received from the patient's treating physician or qualified health care provider (i.e., the provider treating the patient and who will use the test results in the management of the patient's specific medical problem). Records should be complete, legible and include the following on the requisition:

- Complete patient identification
- Complete ordering provider identification (minimum full name and NPI#)
- Signature of ordering physician (must be legible) (signature on file, signature stamp and photocopies of signature are not acceptable)
- Facility and location where sample collected (state, office, home, hospital, residential treatment center)
- Type of sample (e.g., blood, serum, urine, oral swab)
- Date and time collected
- Date and time received in the lab
- Identity of individual who collected sample
- For urine testing, a temperature at time of collection may be relevant and aid in validity
- ICD-10-CM diagnosis codes received from ordering provider (specificity required)
- Identify specific tests ordered (avoid "custom" panels)
- For drug testing, a current medication list and point-of-care test results may be relevant and aid in supporting medical necessity.

BCBSTX follows the Centers for Medicare & Medicaid Services guidelines. Medicare will only pay for tests that are medically reasonable and necessary based on the clinical condition of each individual patient. Confirmation of drug screening is only indicated when the result of the drug screen is different than suggested by the patient's medical history, clinical presentation or the patient's own statement. Medicare makes this statement to reinforce that the ordering provider is cautioned that the justification for the need for testing is required.

Laboratory results documentation must include:

- Complete identification of performing entity (name, address, CLIA#)
- Patient name and DOB
- Ordering provider name and NPI#
- Facility name if applicable
- Date sample collected
- Date sample received in lab
- Date test results reported
- Complete test results, including validity testing if performed

Although BCBSTX does not require a laboratory provider to recover and submit medical records from an ordering provider, the **burden of proof remains with the billing provider to be able to substantiate the medical necessity of the laboratory services billed.** If necessary, BCBSTX will request records from an ordering provider to provide supporting information during a laboratory claim audit/review. Insufficient or a lack of supporting information will result in denial of the laboratory claim. Review an example of BCBSTX 's Urine Drug Testing Policy MED207.154.

Medicare auditors similarly require a billing provider to assume responsibility for obtaining supporting documentation as needed from a referring physician's office.* The ordering provider's medical record must support the medical necessity for each service ordered. The record must be specific to an individual patient and not consist of "standing, routine or orders per protocol." Such one-size-fits-all ordering will not support the necessity for testing and may result in a payment denial for the laboratory service.

**Familiarity with health care plan medical policies regarding laboratory testing may prevent unexpected claim denials.** Orders alone do not ensure reimbursement. Medical policies, benefits, eligibility and medical record documentation are the determining factors for reimbursement.

Laboratories should be mindful of requests for testing received from inpatient and intensive outpatient behavioral health facilities. This is because laboratory services are included in per diem rates paid to the entities and should not be unbundled and submitted for separate claim reimbursement. In those instances, separate reimbursement for laboratory services may be denied or disallowed because payment is included in the ordering provider's per diem payment.

Health plan medical policies, and Medicare local and national coverage documents can be found online by searching BCBSTX's website or Medicare's public website. Individual benefit/coverage information can be found by calling Customer Service at the number listed on the back of a member's BCBSTX ID card.

**Medicare Program Integrity Manual (Pub. 100-08), Chapter 3, Section 3.2.3.*

---

## Reimbursement Percentage Update for Modifier 52 (Reduced Services)

Effective February 1, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes to the reimbursement percentage for Modifier 52 (Reduced Services).

The modifier reimbursement percentages are located under General Reimbursement Information.
Brief description of the change:

Effective February 1, 2018, the reimbursement percentage for Modifier 52 (Reduced Services) will be 50 percent.

BCBSTX provides general reimbursement information policies, fee schedule request forms and fee schedule information under the General Reimbursement Information section of the Standards and Requirements tab on our website. Additionally, reimbursement changes and updates are posted under "Reimbursement Changes/Updates" in the Professional Reimbursement Schedules section. The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted.

Please be advised that this reimbursement information contains confidential information proprietary to BCBSTX. The use and disclosure of this information is restricted under Texas Insurance Code Section 1301.136(b), Texas Insurance Code Section 843.321(b) and the terms of your BCBSTX agreements. If you have any questions or if you need additional information, please contact your BCBSTX Network Management Representative.

---

## Government Programs: 835 Electronic Remittance Advice (835 ERA) Update

This notice applies to government programs providers servicing the following Blue Cross and Blue Shield of Texas (BCBSTX) members:

- Blue Cross Medicare Advantage℠*
- STAR, STAR Kids and CHIP

**Including the product types of HMO, PPO, HMO-POS and HMO-SNP (if applicable).*

This an update to a March 2017 announcement, which advised that missing ERA files could not be reloaded for claims submitted for members enrolled in any of the above-referenced Medicare Advantage and BCBSTX Medicaid plans. Therefore, impacted providers were instructed to refer to the paper Provider Claim Summary (PCS) sent by regular mail for remittance information on government programs claims.

**Effective Nov. 30, 2017, government programs providers enrolled to receive the 835 ERA from BCBSTX may request redelivery of missing ERA files, to their designated receivers, issued since Jan. 1, 2017. Please note that ERA files originally issued prior to Jan. 1, 2017 cannot be reloaded.** To request redelivery of ERAs for government programs claims, you may contact Provider Customer Service at the number on the member's ID card. Paper PCSs will continue to be mailed for providers who are not enrolled for ERA.

**Not enrolled for ERA?** Providers may enroll online for ERA and also make any necessary set-up changes through the Availity™ Web portal at no cost. The online enrollment process can be completed in near real-time. Providers will receive a confirmation letter acknowledging the enrollment effective date and related information. To register for Availity, visit their website at availity.com and complete the online application today.

For more information on 835 ERA enrollment and related topics, visit the Electronic Commerce / EFT & ERA section of our Provider website.

*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. 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.*

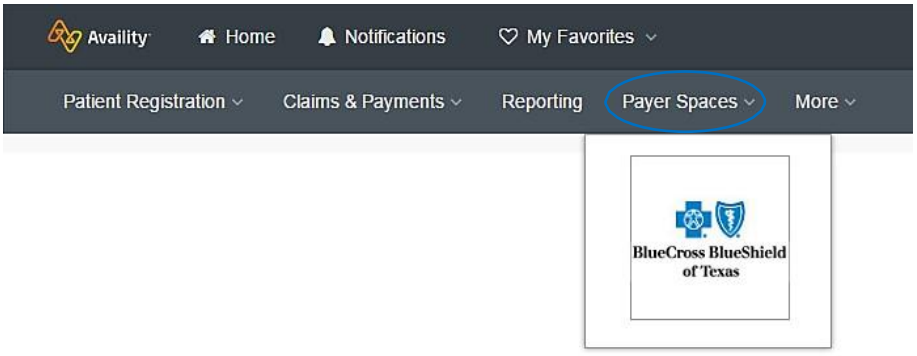
---

## Find BCBSTX Resources in Availity™ Payer Spaces

Have you recently been searching in the Availity Web Portal to locate a specific Blue Cross and Blue Shield of Texas (BCBSTX) tool or enrollment option? Some of our electronic resources offered through Availity have moved to the BCBSTX-branded Payer Spaces section in Availity.

The **BCBSTX Payer Spaces** section contains payer-specific in-house applications, resources and links to the BCBSTX provider website for quick access to pertinent information. You can also view the latest Availity news and announcements for various payer-specific articles, newsletters and reference documents.

Providers may access **BCBSTX Payer Spaces** by selecting the Payer Spaces drop-down option from the Availity navigation menu.




The following online tools and resources are now available via the **Resource tab** within the BCBSTX Payer Spaces section:

- Electronic Fund Transfer online enrollment
- Electronic Remittance Advice online enrollment
- iExchange® online benefit preauthorization registration
- National Drug Code Units Calculator
- Electronic Refund Management (eRM) tool

- And more …

**Note:** The Claim Research Tool (BCBS) remains available in the **Claims & Payments** tab on the Availity navigation menu.

To learn more about BCBSTX's electronic offerings, visit the Provider Tools page in the Education & Reference Center on the BCBSTX provider website. For assistance or customized training, contact a BCBSTX Provider Education Consultant at *PECS@bcbstx.com*.



---

## National Drug Code (NDC) Billing Update for Medicare Advantage Claims

Beginning Dec. 15, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will activate edits to validate NDCs that are submitted on electronic and paper professional and institutional Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM claims. These validation edits are being implemented to align with the Centers for Medicare & Medicaid Services (CMS) encounter data submission requirements. Providers should confirm that the NDCs submitted are appropriate for services rendered and active for the date(s) of service billed.

The table below specifies which NDC-related elements must be entered if NDCs are included on electronic professional and institutional claims for Medicare Advantage members. Claims submitted containing NDCs may be rejected if any of these data elements are missing or incorrect. Rejected claims must be resubmitted with the correct data. If you use a billing service or clearinghouse, please share the above information with your vendor.

| Elements Required when NDC is Present on Electronic Claims | Professional Electronic Claim (837P) Loops and Segments | Institutional Electronic Claim (837I) Loops and Segments |
|---|---|---|
| Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) Code | Loop 2400, SV101-1 = HC<br><br>Loop 2400, SV101-2 = [CPT/HCPCS code] | Loop 2400, SV202-1 = HC<br>Loop 2400, SV202-2 = [CPT/HCPCS code] |
| If the CPT/HCPCS code in SV101-2 (professional claim)/ SV202-2 (institutional claim) is an unlisted procedure code or Not Otherwise Classified (NOC)" code, a description is required | Loop 2400, SV101-7 | Loop 2400, SV202-7 |
| Line Item Charge Amount | Loop 2400, SV102 | Loop 2400, SV203 |
| Unit of Measurement Code | Loop 2400, SV103 = UN | Loop 2400, SV204 = UN |
| Service Unit Count | Loop 2400, SV104 | Loop 2400, SV205 |
| NDC Qualifier | Loop 2410, LIN02 = N4 | Loop 2410, LIN02 = N4 |
| NDC (11-character alpha-numeric value containing no spaces, hyphens or special characters) | Loop 2410, LIN03 = NDC Number | Loop 2410, LIN03 = NDC Number |
| Quantity / Dosage* (Number of NDC units) | Loop 2410, CTP04 | Loop 2410, CTP04 |

| | | |
|---|---|---|
| Unit of Measure (UOM = UN, ML, GR or F2) | Loop 2410, CTP05-1 | Loop 2410, CTP05-1 |
| Prescription Number (when applicable) | Loop 2410, REF01 = XZ<br>REF02 = [prescription number] | Loop 2410, REF01 = XZ<br><br>REF02 = [prescription number] |

If NDCs are submitted on paper professional (CMS-1500) and institutional (UB-04) claims for Medicare Advantage members, the following NDC-related elements must be included:

**Professional (CMS-1500) fields**

- 24A – (shaded area) – NDC Qualifier, NDC 11-digit number, Unit of Measure Qualifier and Unit Quantity
- 24D – CPT/HCPCS code
- 24G – HCPCS unit

**Institutional (UB-04) fields**

- 42 – Revenue code
- 43 – Revenue Code Description, NDC Qualifier, NDC 11-digit number, Unit of Measure Qualifier and Unit Quantity
- 44 – HCPCS code
- 45 – Service/Assessment Date
- 46 – Service Units

*For assistance with calculating the number of NDC units, independently contracted BCBSTX providers may access the NDC Units Calculator Tool at no cost through our secure site – look for the National Drug Codes (NDCs): Billing Resources link on our provider website Home page at bcbstx.com/provider. The NDC Units Calculator Tool is also available via the Availity™ Web Portal.

For additional claim-related information, refer to the appropriate Provider Manual in the Standards and Requirements section of our Provider website. As always, your assigned BCBSTX Provider Network Representative is available to provide personalized assistance to you and your staff.



---

## Notice of changes to Billing and Documentation Information and Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) is implementing changes to clarify existing policies related to billing and documentation requirements for the BlueChoice® PPO, Blue Advantage HMO℠, Blue Essential℠, Blue PremierSM, Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO)℠ plans effective 9/15/17 as reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual in Section E Filing Claims posted on bcbstx.com/provider under Standards and Requirements/ Manuals. Below are the updates to be posted:

**Billing & Documentation Information & Requirements**

### Permissible Billing

BCBSTX does not permit pass-through billing, splitting all-inclusive bills, under-arrangement billing, and any billing practices where a provider or entity submits claims by or for another provider not otherwise provided for in the provider's agreement or in this policy.

## Pass through Billing

Pass-through billing occurs when the ordering physician, professional provider, facility, or ancillary provider requests and bills for a service, but the service is not performed by the ordering physician, professional provider, facility, or ancillary provider.

The performing physician, professional provider, facility, or ancillary provider is required to bill for the services they render unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

- The service of the performing physician, professional provider, facility, or ancillary provider is performed at the place of service of the ordering physician or professional provider and billed by the ordering physician or professional provider;
- The service is provided by an employee of a physician, professional provider, facility, or ancillary provider (i.e., physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider); and
- The service is billed by the ordering physician or professional provider.

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

**AS modifier:** A physician should use the AS modifier when billing on behalf of a PA, APN or CRNFA, including that providers National Provider Identifier (NPI), for services provided when the PA, APN, or CRNFA is acting as an assistant during surgery. Modifier AS is to be used ONLY if the PA, APN, or CRNFA assists at surgery.

**SA modifier:** A supervising physician should use the SA modifier when billing on behalf of a PA, APN, or CRNFA for non-surgical services. Modifier SA is to be used when the PA, APN, or CRNFA is assisting with any other procedure that DOES NOT include surgery.

### Under Arrangement Billing

"Under-arrangement" billing and other similar billing or service arrangements are not permitted by BCBSTX. "Under-arrangement" billing refers to situations where services are performed by a physician, facility, or ancillary provider but the services are billed under the contract of another physician, facility or ancillary provider, rather than under the contract of the physician, facility, or ancillary provider that performed the services.

### All Inclusive Billing

Any testing performed on patients treated by a physician, professional provider, facility, or ancillary provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services. The Physician, professional provider, facility, or ancillary provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to BCBSTX.

For all-inclusive billing, all testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

### Other Requirements and Monitoring

#### CLIA Certification Requirement

Facilities and private providers who perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Therefore, any provider who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

### Review of Codes
BCBSTX may monitor the manner in which test codes are billed, including frequency of testing. Abusive billing, insufficient or lack of documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100% review of medical records for such claims submitted.

### Limitations and Conditions
Reimbursement is subject to:

- Medical record documentation, including appropriately documented orders
- Correct CPT/HCPCS coding
- Member Benefit and Eligibility
- Applicable BCBS Medical Policy(-ies)

### Obligation to notify BCBSTX of Certain Changes
Physicians, facilities, and ancillary providers are required to notify BCBSTX of material changes that impact their contract with BCBSTX including the following:

- Change in ownership
- Acquisitions
- Change of billing address
- Change in billing information
- Divestitures

### Assignment
As a reminder, no part of the contract with BCBSTX may be assigned or delegated by a physician, facility or ancillary provider without the express written consent of both BCBSTX and the contracted provider. If you have any questions or if you need additional information, please contact your BCBSTX Network Management Representative.

---

### New EFT and ERA Information Available Online
Blue Cross and Blue Shield of Texas (BCBSTX) recently updated the Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) page on BCBSTX's provider website. This page focuses on electronic transactions that may increase administrative efficiencies for your office, while also making it easier for you to conduct business with BCBSTX.

Recent enhancements to the EFT/ERA page include resources to help you learn more about EFT and ERA. In addition to new EFT and ERA Online Enrollment Tip Sheets, the page includes links to updated EFT and ERA 835 Companion Guides and other pertinent information.

Electronic options offer health care providers a more efficient alternative to the traditional paper methods. Providers are encouraged to enroll for EFT and ERA through the Availity™ Web Portal, which also allows users to make any necessary set-up changes online. Once an organization is enrolled for ERA, providers and billing services also gain access to the Availity Remittance Viewer. This tool allows users to search, view, save and print remittance information, even if the ERA is delivered to a vendor and/or clearinghouse other than Availity.

Online EFT and ERA enrollment is available to registered Availity users. To register for Availity, simply go to availity.com and sign up today. There is no cost to register to become an Availity user.

For providers who are unable to access Availity to complete the online EFT and ERA enrollment process, paper EFT and ERA enrollment forms are available in the Education and Reference Center/Forms section on BCBSTX's provider website.

We encourage you to visit the EFT/ERA page in the Claims and Eligibility section of our provider website for additional information on electronic options. For assistance with EFT and ERA enrollment through Availity, or to learn more about how to use the remittance viewer tool, contact a BCBSTX Provider Education Consultant at ECommerceHotline@bcbsil.com or 800-746-4614.

*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. 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.*

---

## CLINICAL RESOURCES

### The Magellan Connection: Partnering with PCPs To Manage Patients' Behavioral Healthcare Needs

Magellan Healthcare is contracted to perform behavioral health managed care functions for Blue Cross and Blue Shield of Texas HMO plan members and the Employee Retirement System of Texas (ERS) participants. Magellan offers access to a variety of resources and services that can assist you in enhancing medical and behavioral outcomes for your patients.

**Website resources**

- You can access Magellan's practitioner toolkit of behavioral health resources at www.MagellanPCPtoolkit.com.
    - The Magellan PCP Toolkit is designed to give medical practitioners the information and screening tools needed to assist in making behavioral health referrals.
    - Integrated care is the best practice model that addresses the whole health of an individual. Collaboration of the PCP and the behavioral health professional can improve the safety and efficacy of services to support better outcomes for members.
    - The Magellan PCP Toolkit offers numerous platforms and tools for standardizing and streamlining effective collaborative relationships.
- Blue Essentials, Blue Advantage HMO and Blue Premier members have access to www.MagellanHealth.com/member, Magellan's member website that offers a number of useful behavioral health self-management and educational tools. The member website also provides access to the Magellan Provider Search (provider directory).

**Magellan's Customer Care Line Contact Numbers:**

- Blue EssentialsSM, Blue Advantage HMOSM and Blue PremierSM members: (800)729-2422
- ERS HealthSelectSM of Texas & Consumer Directed HealthSelectSMparticipants:800-442-4093

Keep in mind that you can contact Magellan Healthcare for assistance with screening your patients for co-occurring depression and substance abuse.

- Magellan also offers case management support for members with complex behavioral health needs. Magellan case management programs assess, plan, implement, coordinate, and evaluate options and services to meet a member's clinical and medical needs. Activities vary based on the specifics of the member's needs, and our case managers help create a personalized plan of care for every member.
- We strongly recommend referral to Magellan's case management program for patients whom you suspect may be suffering from severe and persistent mental illness.

---

### Operational Effectiveness: Better and Faster Ways to Do Business Together

How can we help providers so they can effectively drive operational and clinical efficiencies while continuing to deliver quality care? Blue Cross and Blue Shield of Texas (BCBSTX) is committed to making system and process improvements and innovations to better support and collaborate with providers. Now more than ever, collaboration is essential to help control rising health care costs, avoid redundant or unnecessary care, identify opportunities for members to get the right care at the right time and place, and streamline administrative work. Ultimately, we want to make it easier for providers to do business with us and we want to continue to earn their satisfaction.

In the months ahead, we are rolling out new ways to work together, which have been created with efficiency and effectiveness in mind. As we systematically deploy new processes and programs, we are helping providers realize the ability to integrate these new efficiencies into existing workflows with relative ease.

We are introducing more ways to transact provider-payer business electronically with an increased emphasis on online forms, tools and other resources. The increased focus on electronic tools will help improve data accuracy, which in turn helps ensure claims process accurately and provider directories are up-to-date.

**Clinical Data Exchange (CDE) Tool**
Another way we are building efficiencies into the provider-payer relationship is through various **data solutions** that will offer providers greater insight into our members' health status, and the quality and cost of care they deliver. New **CDE tool** capabilities will streamline and speed the online exchange of member clinical data between providers and BCBSTX in a scalable and secure platform.

This technology will enable connected providers to access a member's medical record and the health summary at the site of service. We anticipate this will help providers identify unmet care needs and avoid unnecessary or redundant services. We also anticipate that CDE will help reduce claims processing and payment time as a likely result of fewer pended, denied and appealed claims.

**Provider Performance Analytics and Reporting Tool**
Care quality and cost analytics and reporting augment our clinical data exchange efforts. We are striving to make the health care system work better through the controlled deployment of a single, online platform for a suite of quality and efficiency analytics and reporting. Our new **Provider Performance Analytics and Reporting tool** is accessible in the BCBSTX-branded Payer Spaces section to registered Availity™ Web Portal administrators and assigned users.

This tool offers a robust suite of data dashboards that display valuable information about providers' overall BCBSTX member population and allows users to filter quality data in a variety of ways such as age range, diagnosis type and contract type. Providers can view emergency room and pharmacy risk adjustment and incentive data, among other details. Our reporting tools can help illuminate the services that may help providers maximize reimbursement.

In addition, provider **performance efficiency analytics** offer insight into the cost of care by type of care episode and how it compares to care delivered by peer providers in the same market, specialty or network for similar BCBSTX members. This new platform will allow us to deliver reports faster and with dynamic reporting capability.

As Executive Director of BCBSTX's Quality and Accreditation, Terri Kitchen shares, "With so many different types of performance management metrics available through the dashboards, depending on what the end user needs, there's probably a dashboard for that." We believe that the quality and efficiency data will help providers identify and prioritize practice enhancement opportunities.

To prepare for the use of these new data solutions, we encourage you to become a registered Availity user today at no charge. Becoming a registered Availity user will give you immediate access to many tools and resources that are available now, while also ensuring you will be first in line to begin using new data solutions when they launch.

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

---

## In-home Colorectal Cancer Screening and Hemoglobin A1c Test Kits for Selected Members

**Applies to: Blue Advantage℠, Blue Advantage Plus℠ and Federal Employee Program® Members**

Beginning in October, some Blue Advantage, Blue Advantage Plus and Federal Employee Program (FEP) members received the Fecal Immunochemical Test (FOBT/FIT) and/or Hemoglobin A1c in-home test kits. Members were identified for possible participation if they had no claim history of colorectal cancer screening and/or have a diagnosis of diabetes, and did not have a claim for hemoglobin A1c testing.

Members can expect to receive a communication from Blue Cross and Blue Shield of Texas (BCBSTX) or FEP about the tests. They will have the option to opt out of the program and decline the test kits.

As part of a series, the following two tests will be sent at no additional cost to BCBSTX members:

- FIT test for colorectal cancer screenings
- A1c test for blood sugar control for diabetes

**Home Access Health Corporation** is an independent company that provides laboratory testing. They will process the kits and send results via mail to both the member and their primary care physician (PCP) on file. Our goal is to encourage members to close care gaps by making the process easier to complete the test(s) in the comfort of their own homes.

**How Providers Can Help**

- Encourage your patients to complete these test kits and to return them in the prepaid postage envelope to the address listed.
- Reiterate to your patients that they should include their PCP's name and mailing address with their sample so their PCP can receive the test results.
- Please be on the lookout for these test results so that you can place them into members' records, and be prepared to follow up on any alert values received.

If you have any questions or if you need additional information, please contact your BCBSTX Network Management Representative. Members can call Customer Service at the number listed on the back of their BCBSTX ID card.

---

### Use New Applied Behavior Analysis (ABA) Service Request Forms

There are updated forms on the BCBSTX provider website to use when requesting ABA services. BCBSTX constantly looks for ways to enhance the quality and effectiveness of provider interactions with us. This includes looking for operational and clinical efficiencies that add value while not sacrificing quality. The ABA Service Request forms were updated to capture sufficient data needed by the Clinical Reviewer and reduce additional clinical requests of the provider. Providers should begin using these forms as soon as possible. You can access the ABA forms under the Education and Reference/Forms tab on the BCBSTX provider website.

---

### Requesting Predetermination of Benefits

As a reminder, predetermination of benefits requests may be **submitted electronically** to Blue Cross and Blue Shield of Texas (BCBSTX) through iExchange®, our online benefit preauthorization and predetermination of benefits tool. Providers may also upload attachments, check status and obtain online approval information via iExchange. This online tool is available to physicians, professional providers and facilities contracted with BCBSTX. iExchange may be accessed directly or through the Availity™ Web Portal and is designed to help save you time by reducing the amount of calls and written inquiries submitted to BCBSTX.

If you need to submit a paper predetermination of benefits request to BCBSTX, it is important to send the pertinent medical documentation using our Predetermination Request Form. This form and others are available in the Education & Reference Center/Forms section on the BCBSTX provider website.

**Beginning Dec. 1, 2017, written predetermination requests must be submitted using the Predetermination Request Form. Beginning Jan. 1, 2018, paper requests that are received by BCBSTX without the Predetermination Request Form will be returned to the submitting provider, along with instructions to resend the request using the appropriate form.**

Checking eligibility and benefits is always an important first step, prior to submitting predetermination of benefits and other pre-service requests. Eligibility and benefits requests may be submitted electronically through Availity or your preferred web vendor. **Predetermination of benefits requests are not a substitute for the eligibility and benefits process.**

To learn more about iExchange and other electronic options, visit the Provider Tools section in our online Education & Reference Center. For personalized online training regarding electronic tools, contact our Provider Education Consultants at PECS@bcbstx.com.

**Note:** This information does not apply to Blue Cross Medicare Advantage HMO℠ or Blue Cross Medicare Advantage PPO℠ members.

*Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized 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. If you have any questions, please call the number on the back of the member's ID card.*

*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. iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or Medecision. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.*

---

### Know the Requirements for Preauthorization/Prior Authorization Rules and Retrospective Reviews for Medical Necessity

Certain services require preauthorization/prior authorization and the requirements are specific to each BCBSTX network. BCBSTX posts the Preauthorization/Notifications/Referral Requirements Lists for all of its networks (e.g., Blue Advantage HMOSM, Blue EssentialsSM, Blue PremierSM, etc.) on the BCBSTX provider website. Preauthorization/prior authorization are required to allow for medical necessity review. Claims for services rendered without preauthorization/prior authorization for services requiring it will be denied and providers will be held responsible. Please be aware, retrospective reviews for medical necessity will not be performed for any HMO plans except in limited special circumstances.

---

### UPDATE: Prior Authorizations and Referrals for HealthSelect of Texas Participants

iExchange® is now available for submission of prior authorizations and referrals for HealthSelect of Texas℠ participants. Usage of iExchange for all submissions is highly recommended to reduce call hold times.

iExchange is a web-based application that supports the direct submission and processing of referrals and approval of select outpatient services and inpatient admissions to acute care facilities by network physicians, professional providers, and facilities within Texas. To learn more information about iExchange please visit our Provider Website.

BCBSTX will honor all Prior Authorizations and Referrals previously submitted through United Health Care for HealthSelect participants for service dates post September 1, 2017. Although not required, if you feel verification is needed, providers should call 800-344-2354.

**For phone inquiries and requests, hours of operation are as follows:**
Normal Hours of Operation
(Monday – Friday) 6:00 am – 6:00 pm (Saturday
– Sunday) 9:00 am – 1:00 pm

*iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.*

---

### Preauthorization and Referral Requirements Lists Are Changing Jan. 1, 2018

Beginning Jan. 1, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) will be changing the preauthorization requirements for Blue Choice PPO℠, Blue Essentials℠, Blue Essentials Access℠, Blue Premier℠ and Blue Advantage HMO℠.

The changes include **three new Health Advocacy Solutions (HAS) preauthorization service options**, including Primary, Advanced and Premier. These options allow Blue Choice PPO and Blue Essentials Access self-insured groups to choose one of three preauthorization-specific service options for their group. In addition, Blue Choice PPO fully insured members, Blue Essentials, Blue Essentials Access, Blue Premier and Blue Advantage HMO will have additional care categories that require preauthorization through BCBSTX or eviCore healthcare™ (eviCore).

Preauthorization for certain care categories that are handled through eviCore can be obtained by accessing evicore.com or calling 855-252-1117.

**Check Eligibility First**
As a reminder, it is important to check eligibility through Availity™ or your preferred web vendor prior to rendering services. This step will help you determine if your services require preauthorization through BCBSTX or eviCore.

Please note: Services performed without benefit preauthorization may be denied in whole or in part for payment and you may not seek any reimbursement from the member. For any service not approved for payment, BCBSTX will provide all appropriate appeal rights for review. Please note that a member penalty may also apply based on the benefit plan.

**Preauthorization/Referral Requirements Lists**
You can find the preauthorization/referral requirements lists that are effective Jan. 1, 2018, under Clinical Resources on the BCBSTX provider website. Additional information, such as definitions and links to helpful resources, can be found in the Eligibility and Benefits section.

**iExchange® Automated Preauthorization Tool**
Continue using iExchange to obtain preauthorization for the services that require authorization through BCBSTX on any of the preauthorization lists. The iExchange online tool is accessible to physicians, professional providers and facilities contracted with BCBSTX. For more information or to set up a new account, refer to the BCBSTX iExchange web page.

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

**eviCore Orientation Sessions**
eviCore will be hosting education sessions in December. During these training sessions, BCBSTX will provide a brief overview of the new HAS benefit and Availity's role. Anyone wishing to attend one of the sessions must register in advance. **Sessions are free of charge and will last approximately one hour.**

| Session | Date | Time |
|---|---|---|
| Radiation Therapy | Dec. 5, 2017 | 11 a.m. CT |
| Genomic Lab | Dec. 5, 2017 | 1 p.m. CT |
| Radiology (CT/MR/PET) | Dec. 6, 2017 | 1 p.m. CT |
| Sleep Testing | Dec. 7, 2017 | 10 a.m. CT |
| Sleep DME | Dec. 7, 2017 | 1 p.m. CT |

**How to Register**
- Choose a date and time, and then go to evicore.webex.com.
- Click on the "Training Center" tab at the top of the page.
- Find the date and time of the orientation session you wish to attend by clicking the "Upcoming" tab. All orientation sessions will be named "Blue Cross and Blue Shield of Texas Provider <Program Name> Orientation Session."
- Click "Register."
- Enter the registration information.

**After you have registered for the conference, you will receive an email containing:**

- The toll-free phone number and pass code you will need for the audio portion of the conference
- A link to the online portion of the conference
- The conference password

Please keep the registration e-mail so you will have the link and phone number for the session. If you are unable to participate in a session during any of the times listed, you can find a copy of the presentation on the eviCore BCBSTX implementation site.

*Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits 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. If you have questions, contact the number on the member's ID card.*

*eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of 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. 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.*

*iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.*

---

## 2018 Updates to the Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM Preauthorization Lists

Blue Cross and Blue Shield of Texas (BCBSTX) has updated the list of procedures requiring preauthorization for our Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO) plans. Both updated preauthorization lists will be effective January 1, 2018. If you are not participating in the Blue Cross Medicare Advantage (PPO) network or Blue Cross Medicare Advantage (HMO) network, disregard the information pertaining to that plan.

Blue Cross and Blue Shield of Texas (BCBSTX) has contracted with eviCore healthcare™ (eviCore), an independent specialty medical benefits management company to provide Utilization Management services for new preauthorization requirements. To authorize services requiring preauthorization through eviCore, you can go to eviCore.com or call 855-252-1117.

Preauthorization/Referral Requirements Lists are attached and have been updated to include the services that require preauthorization through BCBSTX and eviCore. The updated preauthorization lists will be located on bcbstx.com/provider under Clinical Resources. For specific codes that apply, the BCBSTX Medicare Advantage CPT Preauthorization Code List can be viewed on the above link from 10/1/2017 through 12/31/2017.

As a reminder, iExchange®, our automated referral and preauthorization tool, is available 24 hours a day, seven days a week (except for every third Sunday of the month when the system will be unavailable from 11 a.m. to 3 p.m. CT) for those services requiring preauthorization through BCBSTX. iExchange is accessible to physicians, professional providers and facilities contracted with BCBSTX. For more information or to set up a new account, complete and submit the iExchange online enrollment form. Failure to timely notify BCBSTX and obtain pre-approval for listed procedures may result in denial of the claim(s) for care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX.

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

*eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.*

*iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by*

*third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.*

---

## STANDARDS & REQUIREMENTS

### BCBSTX Requires Adherence to Vaccine Guidelines

Timely vaccines protect the health of children and adults, saving lives and ensuring the safest, most effective disease prevention possible. To help keep Blue Cross and Blue Shield of Texas (BCBSTX) members safe, doctors treating them should adhere to guidelines recommended by the U.S. Food and Drug Administration (FDA) and Advisory Committee on Immunization Practices (ACIP).

Two categories of vaccines may have been administered in a manner that doesn't align with FDA and ACIP guidelines:

- Human Papillomavirus (HPV) prevention
- Prevention of shingles resulting from the herpes zoster virus

If these vaccines are given to BCBSTX patients, we will:

- Continue reimbursing claims that are medically necessary, and supported by the FDA and ACIP guidelines
- Consider vaccines administered outside of the FDA and ACIP recommendations as experimental, investigational or unproven, and will periodically review such claims for reimbursement
- Recover reimbursements for these vaccines administered outside of the FDA and ACIP recommendations per our contracts

**HPV Vaccination Guidelines**

Gardasil®, Gardasil 9 and Cervarix are vaccines for the prevention of HPV infections and associated diseases, including cancers. Administration of these vaccines is recommended for males and females between 9 and 26 years old. Vaccination at ages 11 or 12 is optimal. Since 2006, these vaccines have been administered in three doses, with the second dose at one or two months after the first, and the third dose six months after the first. In October 2016, for patients between 9 and 14 years old, the ACIP recommendation was updated to two doses, with the second dose at six to 12 months after the first. For patients between 15 and 26 years old, the three-dose regimen is still recommended.

**Shingles Vaccination Guidelines**

Zostavax is a vaccine that prevents shingles and its complications. Zostavax is recommended as a single dose by the FDA at age 50 or older, and by the ACIP at age 60 or older. BCBSTX considers the vaccine medically necessary for anyone age 50 or older in recognition of the FDA guidance.

**Immunization Schedule**

Review the Preventative Services Policy CPCP006 for details on our complete, approved immunization schedule. The schedule can be found on the Clinical Payment and Coding Policies page under the Standards & Requirements tab on the BCBSTX provider website.

*Third-party brand names are the property of their respective owner.*

---

## EDUCATION & REFERENCE

### CMS Notifications

**Applies to: Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM**

The Centers for Medicare and Medicaid Services (CMS) routinely publishes notifications that provide CMS guidance to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare and one of the Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO) Plans.

These CMS notifications are in the Medicare Learning Network (MLN Matters) on CMS.gov and on our BCBSTX provider website, and may include informational regulatory updates and reminders, as well as required actions or changes by the provider rendering services. As such, it is important for providers to review these notifications and ensure your staff is aware of these notifications. We are including the following weblink for your information: CMS notifications regarding the Jimmo Settlement.

Continue reviewing our website and the *Blue Review* for changes.

If you have any questions, please contact your Network Management Representative.

---

## 2017 Annual HEDIS® and QRS Reports

Blue Cross and Blue Shield of Texas (BCBSTX) has a quality improvement program (QIP) to better serve our members. The purpose of the QIP is to monitor and help improve the care and service our members receive from BCBSTX contracted providers. We focus on preventive health, safety and condition management. QIP helps meet the needs of our members in our Blue Essentials℠ HMO, Blue Advantage HMO℠ and Blue Choice℠ PPO Small Business Health Options Program (SHOP) health plans.

There is a standard way to measure important areas of care and service called Health Care Effectiveness Data and Information Set (HEDIS). These measures were developed by the National Committee for Quality Assurance, and are widely used to measure health care performance in the U.S.

The Centers for Medicare & Medicaid Services has a similar set of measures called the Quality Rating System (QRS). These measure similar areas of care and are specifically for members enrolled in Marketplace health care plans.

Through the QIP, BCBSTX measures how we are doing against the goals we've set. The table below summarizes how we are doing on selected measures.

| Care Provided to BCBSTX Members | 2017 Quality Compass National Average | HEDIS Rates: Blue Essentials HMO | QRS Rates: Blue Advantage HMO | QRS Rates: BlueChoice PPO SHOP PPO |
|---|---|---|---|---|
| **Prevention and Screening** | | | | |
| Childhood Immunization<br>• Combination 3 Rate: 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV | 73% | 55% | 73% | 85% |
| Breast Cancer Screening | 71% | 61% | 57% | 67% |
| Cervical Cancer Screening | 74% | 67% | 47% | 66% |
| Colorectal Cancer Screening | 60% | 38% | 38% | 54% |
| **Respiratory Conditions** | | | | |
| Appropriate Testing for Children with Pharyngitis | 84% | 81% | 72% | 83% |
| Medication Management for People with Asthma<br>• Total – Medication Compliance 75% | 49% | 43% | 48% | 60% |

| | | | | |
|---|---|---|---|---|
| **Comprehensive Diabetes Care** | | | | |
| Comprehensive Diabetes Care<br>• Hemoglobin A1c (HbA1c) Testing<br>• HbA1c Control (<8.0%)<br>• Eye Exam (retinal or dilated exam)<br>• Medical Attention for Nephropathy | 90%<br>51%<br>51%<br>89% | 84%<br>28%<br>21%<br>88% | 89%<br>48%<br>34%<br>89% | 89%<br>42%<br>36%<br>87% |
| **Overuse/Appropriateness** | | | | |
| Appropriate Treatment for Children with Upper Respiratory Infection | 88% | 75% | 76% | 82% |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | 28% | 22% | 19% | 7% |
| **Medication Management** | | | | |
| Annual Monitoring for Patients on Persistent Medications – Total | 83% | 84.5% | 86% | 85% |
| **Prenatal/Postpartum Care** | | | | |
| Prenatal and Postpartum Care<br>• Timeliness of Prenatal Care<br>• Postpartum Care | 81%<br>70% | 65%<br>32% | 80%<br>66% | 82%<br>56% |
| | | | | |

*Results are rounded to the nearest percentage. HEDIS is a registered trademark of NCQA*

---

### Working Together to Stop Antibiotic Resistance

According to a PEW Charitable Trusts report regarding antibiotic use in outpatient settings, 30 percent of antibiotics are determined to be unnecessary for treating the prescribed condition (e.g., prescribing antibiotics for viral illnesses, asthma exacerbations, etc.).[1] Additionally, the Centers for Disease Control and Prevention (CDC) reports up to 50 percent of antibiotics are not optimally prescribed in terms of choosing an appropriately focused antibiotic for the condition being treated.[2] These prescribing behaviors contribute to increasing bacterial resistance, which in combination with the relatively lesser availability of new antibiotics to combat these resistant organisms, have been associated with at least 2 million illnesses and 23,000 deaths nationwide.[2]

A new report from the Blue Cross and Blue Shield Association similarly found that 20 percent of nationally prescribed outpatient setting antibiotics are not indicated. While outpatient antibiotic prescriptions for commercially insured people are moving in the right direction nationwide by decreasing 9 percent from 2010 to 2016, individual state performance data is more variable. Antibiotic prescribing in Illinois, for example, has increased 3 percent over this same time frame with some regional areas experiencing increases as high as 36 percent.

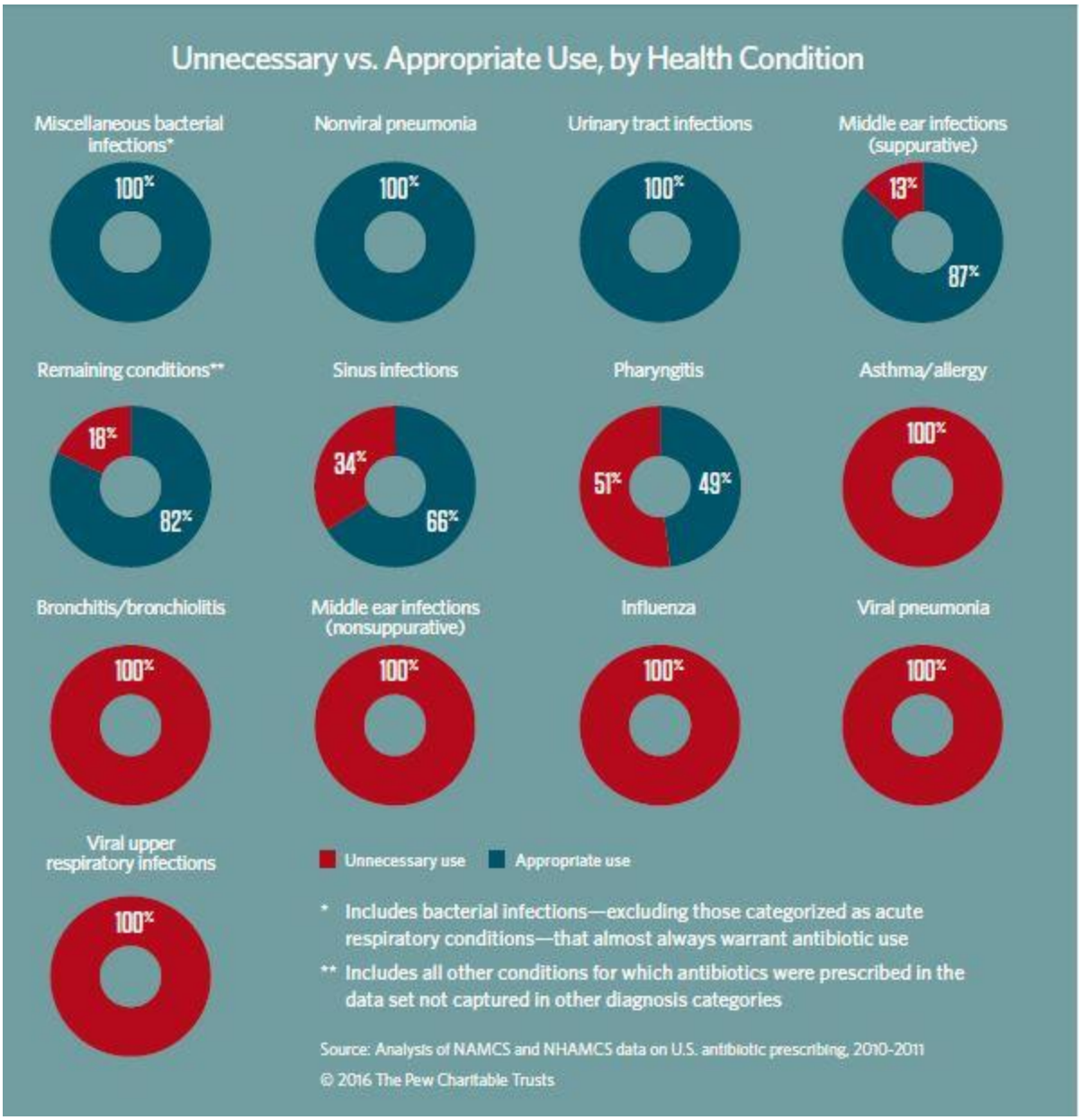
In 2015, the White House released a national action plan for combating antibiotic resistance that includes the goal of reducing inappropriate outpatient antibiotic use by 50 percent by 2020.[3] Blue Cross and Blue Shield of Texas is doing its part by evaluating the antibiotic prescribing patterns of contracted practitioners.

Approximately 120 Texas primary care practitioners were identified for prescribing patterns that significantly deviated from their same-specialty peers. Further analysis found that their antibiotic choice may not be in accordance with recommended practice guidelines. Feedback was provided to these practitioners highlighting potential areas for improvement.

**As a health care provider, there are antibiotic stewardship initiatives you may want to consider, including:**

- Evaluating your prescribing habits.[1]
- Discussing appropriate antibiotic use and potential risks such as adverse side effects with your patients.
- Confirming a diagnosis of bacterial infection before prescribing an antibiotic.
- Re-directing your patient's expectations if antibiotics are not warranted
- Offering your patients advice and specific recommendations for symptom relief. Include ways to help the rest of their family keep from getting sick.
- Offering your patients a contingency plan if symptoms do not improve. Leaving the door open for future treatment may help maintain patient satisfaction.

The following graph shows unnecessary vs. appropriate use of antibiotics by health condition.




For additional information visit the American Academy of Family Practice and the CDC.

Sources:
[1]Antibiotic use in outpatient settings. (2016). Retrieved from http://www.pewtrusts.org/en/research-and-analysis/reports/2016/05/antibiotic-use-in-outpatient-settings
[2]Center for Disease Control (2017*). About Antimicrobial Resistance*. Retrieved from https://www.cdc.gov/drugresistance/about.html
[3]National action plan for combating antibiotic resistant bacteria. (2015). Retrieved from https://obamawhitehouse.archives.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf

---

## Provider Manual Update

Blue Cross and Blue Shield of Texas (BCBSTX) makes periodic updates and clarifications related to operational changes and regulatory mandates to the provider manual, as well as the processes, policies and procedures that you comply with as a network provider. It is important that you stay up-to-date, so we share these changes in our monthly Blue Review newsletter, in the News and Updates and/or the Standards & Requirements/Disclosures sections of the BCBSTX provider website. These changes may also be communicated via mail.

**New Addition**
We added section M to our Blue Essentials℠, Blue Advantage HMO℠ and Blue Premier℠ Provider Manual, which is for the Employee Retirement System of Texas (ERS) Participants Benefit Plan using the Blue Essentials Network. This is an additional resource designated to assist you with ERS HealthSelectSM and Consumer Directed HealthSelect℠ participants who became eligible with BCBSTX on Sept. 1, 2017.

We will continue providing disclosures on our website and in future issues of Blue Review. We encourage you to review both resources as you provide care to your patients. As a provider, it is your responsibility to review and comply with these changes.

If you have any questions, please contact your Network Management office.

---

# In Every Issue – December 2017

The following is information that Blue Cross and Blue Shield of Texas (BCBSTX) is required to provide in all published correspondence with physicians, professional providers, and facility and ancillary providers. For the latest updates, visit the News and Updates area of the BCBSTX provider website.

**Topics:**

- Authorizations and Referrals
- Benefits and Eligibility
- Claims
- Clinical Resources
- Electronic Options
- Pharmacy
- Provider General Information
- Rights and Responsibility

**----------**

## Authorizations and Referrals

### Importance of Obtaining a Preauthorization/Referral

A preauthorization/referral is required for certain types of care and services. Although Blue Cross and Blue Shield of Texas(BCBSTX) participating physicians, professional providers and facility and ancillary providers are required to obtain pre-authorizations/referrals, it is also the responsibility of the member/subscriber to confirm that this action has been taken for services that require a preauthorization/referral.

Pre-authorizations/referrals must be obtained for any services provided by someone other than the member's primary care physician/provider (PCP) (i.e., specialist, ambulatory surgery centers, ancillary, etc.). A preauthorization/referral is also needed for an initial stay in a facility and any additional days or services added on.

If a member/subscriber does not obtain a preauthorization/referral for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

A preauthorization/referral does not guarantee payment. All payments are subject to determination of the member/subscriber's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations and other provisions of the policy at the time services are rendered.

BCBSTX has implemented fax notifications of benefit preauthorization and predeterminations to the requesting provider. This enhancement provides real-time information and eliminates the need for providers to check the status of preauthorization or predetermination requests while waiting on the mailed notification letters. The faxed notification will be in addition to the notification letter sent via mail to the address we have

on file.

Notifications are faxed to the number either on file, or listed on the utilization management or clinical request. You can also check the status of your submitted request via iExchange®. As a reminder, because we are sending confidential protected health information (PHI) to your fax machine, it should be in a secure location that is not accessible to those who do not have the authority to review member/patient PHI.

If a preauthorization/referral request is received from an out-of-network (OON) provider and the member/subscriber does not have an OON benefit, BCBSTX will contact the ordering provider to discuss network options. However, if a member/subscriber has an OON benefit, OON benefits will apply, which could result in a higher cost sharing.

If you need any additional information on the preauthorization process or do not wish to receive faxed notifications, please contact your BCBSTX Network Management Representative.

*Checking eligibility, benefit information and/or if a service has been preauthorized 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. If you have any questions, please call the number on the back of the member's ID card.*

*iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.*

---

### eviCore™ Current and Expanded Preauthorization Requirements

Back in October 2016, Blue Cross and Blue Shield of Texas (BCBSTX) contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to begin providing preauthorization requirements for certain specialized services for Blue Advantage HMO℠. In 2017, additional BCBSTX products and services were added as indicated below.

To determine which specialized clinical services and the effective dates of those services which require preauthorization/prior authorization through eviCore refer to the Preauthorization/Referral/Notification Requirements Lists and the Prior Authorization and Referral List for ERS found on the Clinical Resources page of BCBSTX 's provider web site.

Some of the types of clinical services that may require eviCore authorization are:

- Outpatient Molecular Genetic
- Outpatient Radiation Therapy
- Musculoskeletal
- Chiropractic
- Physical and Occupational Therapy
- Speech Therapy
- Spine Surgery (Outpatient/Inpatient)
- Spine Lumbar Fusion (Outpatient/Inpatient)
- Interventional Pain
- Outpatient Cardiology & Radiology
- Abdomen Imaging
- Cardiac Imaging
- Chest Imaging
- Head Imaging
- Musculoskeletal
- Neck Imaging
- Obstetrical Ultrasound Imaging
- Oncology Imaging
- Pelvis Imaging
- Peripheral Nerve Disorders (Pnd) Imaging

- Peripheral Vascular Disease (Pvd) Imaging
- Spine Imaging
- Outpatient Medical Oncology
- Outpatient Sleep
- Outpatient Specialty Drug

Be sure to review the Preauthorization/Referral/Notification Requirements Lists carefully as the services and effective dates vary by product as well as whether the member's group is self-insured or fully insured (identified by TDI on ID card).

For a detailed list of the services that require authorization through eviCore, refer to the eviCore implementation site Services performed without authorization may be denied for payment and you may not seek reimbursement from members/subscribers.

**eviCore authorizations can be obtained using one of the following methods:**

- Use the eviCore healthcare web portal, which is available 24/7. After a one-time registration, you can initiate a case, check status, review guidelines, view authorizations and eligibility, and more. The web portal is the quickest, most efficient way to obtain information.
- Call eviCore at 855-252-1117 toll-free between 6 a.m. - 6 p.m. CT, Monday through Friday, and 9 a.m. - noon CT, Saturday, Sunday and legal holidays.

For all other services that require a referral and/or authorization as noted on the Preauthorization/Referral Requirements Lists or the Prior Authorization/Referral List for ERS, continue to use iExchange®. iExchange is accessible to physicians, professional providers and facilities contracted with BCBSTX. Learn more about iExchange or set up a new account on BCBSTX's provider website.

Watch for additional information and training opportunities for eviCore in future editions of this newsletter, on the BCBSTX provider website or on the eviCore implementation site.

If you have any questions, please contact your BCBSTX Network Management Representative.

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if a member requires benefit preauthorization or prior authorization. For additional information, such
as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

*Checking eligibility, benefit information and/or if a service has been preauthorized or 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. If you have any questions, please call the number on the back of the member's ID card*
*eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.*

*iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions f or payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendo r(s) directly.*

---

### Reminder: Utilization Management Review

The Medical Management team, which includes physicians and nurses, evaluate hospital admissions (anticipated or unanticipated) and continued stays, as well as outpatient services. The team utilizes a variety of resources, including MCG (formerly Milliman Care Guidelines) criteria and BCBSTX medical policy to inform benefit determinations regarding the level of care, transition of care and the management of home care needs.

Medical management does not make determinations about whether services are medically appropriate, only if the services meet the definition of medically necessary under the terms of the applicable benefit

plan. If a service does not meet the definition of medically necessary, initially the case is referred to a medical director for a review of the medical necessity determination. Board certified physicians are available to review referred cases, make medical necessity determinations and resolve appeals.

See the provider manual for guidance on provider requirements when requesting services. The final determination about what treatment or services should be received is between the patient and their health care provider.

---

### iExchange® Accepts Electronic Medical Record Attachments

Providers can submit electronic medical records attachments when necessary in support of benefit preauthorization requests to iExchange, the Blue Cross and Blue Shield of Texas (BCBSTX) online tool that supports online benefit preauthorization requests for inpatient admissions, medical, behavioral health and clinical pharmacy services.

Electronic medical record documentation may also be submitted via iExchange for predetermination of benefit requests. iExchange offers providers and facilities a secure, online alternative to faxing their patients protected health information. Visit iExchange on BCBSTX's provider website for additional information.

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if benefit preauthorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

*Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits 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. If you have questions, contact the number on the member's ID card.*

---

### HMO Plans – Importance of Obtaining a Referral and/or Preauthorization and Admitting to a Participating Facility as a Network Provider

Blue Essentials℠, Blue Advantage HMO℠ and Blue Premier℠ members require a referral from their Primary Care Physician/Provider (PCP) before receiving services from a specialty care physician or professional provider (except for OBGYNs). The referral must be initiated by the member's PCP, and must be made to a participating physician or professional provider in the same provider network.

If an in-network physician, professional provider, ambulatory surgery center, hospital or other facility is not available in the member's applicable provider network, preauthorization is required for services by an out- of-network physician, professional provider, ambulatory surgery center, hospital or other facility, through iExchange or call the preauthorization number 1-855-462-1785.

**Reminders:**

- The Blue Essentials, Blue Advantage HMO and Blue Premier physician, professional provider, facility or ancillary provider is required to admit the patient to a participating facility, except in emergencies.
- Additional services may also require preauthorization. A complete list of services that require preauthorization for Blue Essentials and Blue Advantage HMO, and for Blue Premier and Blue Premier Access℠, is available on the BCBSTX Provider website under Clinical Resources "Preauthorization/Notification/Referral Requirements Lists."
- Blue Advantage Plus℠ HMO and Blue Essentials Access are benefit plans that allow those members to use out-of-network providers. However, it is essential that those members understand the financial impact of receiving services from an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility. Prior to referring a Blue Advantage Plus enrollee

to an out of network provider for non-emergency services, please refer to Section D Referral Notification Program, of the **Blue Essentials, Blue Advantage HMO and Blue Premier provider manual** for more detail including when to utilize the Out-of-Network Enrollee Notification Forms for Regulated Business and Non-Regulated Business. In addition, see article below titled: **Enrollee Notification Form Required for Out- of-Network Care for Blue Choice PPO℠** and **Blue Advantage HMO℠** (for Blue Advantage Plus).

---

### Enrollee Notification Form Required for Out-of-Network Care for Blue Choice PPO℠ and Blue Advantage HMO℠ (for Blue Advantage Plus)

Prior to referring a Blue Choice PPO or Blue Advantage HMO (for Blue Advantage Plus point-of- service benefit plan) member to an out-of-network provider for non-emergency services – if such services are also available through an in-network provider – the referring participating network provider must complete the appropriate Out-of-Network Care – Enrollee Notification form below.

- Out-of-Network Care - Enrollee Notification Form for Regulated Business (Use this form if "TDI" is on the member's ID card.)
- Out-of-Network Care - Enrollee Notification Form for Non-Regulated Business (Use this form if "TDI" is not on the member's ID card.)

The referring network physician must provide a copy of the completed form to the enrollee and retain a copy in the enrollee's medical record files.

It is essential that Blue Choice PPO and Blue Advantage Plus enrollees fully understand the financial impact of an out-of-network referral to a physician, professional provider, hospital, ambulatory surgery center or other facility that does not participate in their Blue Cross and Blue Shield of Texas provider network. Blue Choice PPO and Blue Advantage Plus enrollees have out-of-network benefits and may choose to use out-of-network providers, however they will be responsible for an increased cost-share under their out-of-network benefits.

For additional information, refer to the Provider Manual's section D Referral Notification Program on the bcbstx.com/provider website.

**----------**

### AIM RQI Reminder

Physicians, professional providers and facility and ancillary providers must contact AIM Specialty Health (AIM) first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPOSM subscribers when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's, professional provider's or facility or ancillary provider's office, a professional provider's office, the outpatient department of a hospital or a freestanding imaging center:

- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study
- PET scan

To obtain a Blue Choice PPO RQI, log into AIM's provider portal at aimspecialtyhealth.com, and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an RQI. If criteria are not met, or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM's ProviderPortal℠ uses the term "Order" rather than "RQI."

*AIM Specialty Health (AIM) is an operating subsidiary of Anthem, Inc.*

Notes:

1. *Facilities cannot obtain a RQI from AIM on behalf of the ordering physician, professional provider, facility or ancillary provider.*
2. *The RQI program does not apply to Medicare enrollees with Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.*

---

### Are Utilization Management Decisions Financially Influenced?

Blue Cross and Blue Shield of Texas (BCBSTX) is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

BCBSTX does not specifically reward practitioners or clinicians for issuing denials of coverage, nor is there compensation based on the number or frequency of telephone calls or other contacts that occur with health care providers, members or subscribers. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

---

## Benefits and Eligibility

### BCBS Medicare Advantage PPO Network Sharing

**Applies to: Blue Cross Medicare Advantage (PPO)**[SM]

**What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO[SM] Network Sharing?**
All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan if the member sees a contracted BCBS MA PPO provider.

**What does the BCBS MA PPO network-sharing mean to me?**
If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX) and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

If you are not a contracted BCBS MA PPO provider with BCBSTX and you provide services for any BCBS MA PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

**How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?**
You can recognize a BCBS MA PPO member when their Blue Cross and Blue Shield Member ID card has the following logo:


The "MA" in the suitcase indicates a member who is covered under the BCBS MA PPO network sharing program. BCBS MA PPO members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID card.

**Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?**
If you are a contracted BCBS MA PPO provider with BCBSTX, you should provide the same access to care for BCBS MA members from other BCBS Plans as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans, but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

**What if my practice is closed to new local BCBS MA PPO members?**
If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

**How do I verify benefits and eligibility?**
Call BlueCard® Eligibility at 800-676-BLUE (800-676-2583) and provide the BCBS MA PPO member's alpha prefix located on the member's ID card. You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:

1. Log in to the Availity Web Portal, the Availity Revenue Cycle Management portal or your preferred vendor
2. Enter required data elements
3. Submit your request

**Where do I submit the claim?**
You should submit the claim to BCBSTX under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.

**What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?**
If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

**What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO network sharing?**
When you provide covered services to other BCBS MA PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the BCBS MA PPO claim, BCBSTX will send you the payment. However, these services will be paid under the BCBS MA member's out- of-network benefits unless for urgent or emergency care.

**What is the BCBS MA PPO member cost sharing level and co-payments?**
A BCBS MA PPO member cost sharing level and co-payment is based on the BCBS MA PPO member's health plan. You may collect the co-payment amounts from the BCBS MA PPO member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800- 676-BLUE (800-676-2583).

**May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?**
No, you may not balance bill the BCBS MA PPO member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or co-pays.

**What if I disagree with the reimbursement amount I received?**
If there is a question concerning the reimbursement amount, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

**Who do I contact if I have a question about BCBS MA PPO network sharing?**
If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

---

# Claims

**Notice of changes to Billing and Documentation Information and Requirements**
Blue Cross and Blue Shield of Texas (BCBSTX) is implementing changes to clarify existing policies related to billing and documentation requirements for the BlueChoice® PPO, Blue Advantage HMOSM, Blue Essential℠, Blue Premier℠, Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO)℠ plans effective Sept. 15, 2017, as reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual in Section E Filing Claims posted on bcbstx.com/provider under Standards and Requirements/ Manuals. Below are the updates to be posted:

**Billing & Documentation Information & Requirements**

### Permissible Billing

BCBSTX does not permit pass-through billing, splitting all-inclusive bills, under-arrangement billing, and any billing practices where a provider or entity submits claims by or for another provider not otherwise provided for in the provider's agreement or in this policy.

### Pass through Billing

Pass-through billing occurs when the ordering physician, professional provider, facility, or ancillary provider requests and bills for a service, but the service is not performed by the ordering physician, professional provider, facility, or ancillary provider.

The performing physician, professional provider, facility, or ancillary provider is required to bill for the services they render unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

- The service of the performing physician, professional provider, facility, or ancillary provider is performed at the place of service of the ordering physician or professional provider and billed by the ordering physician or professional provider;
- The service is provided by an employee of a physician, professional provider, facility, or ancillary provider (i.e., physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider); and
- The service is billed by the ordering physician or professional provider.

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

**AS modifier:** A physician should use the AS modifier when billing on behalf of a PA, APN or CRNFA, including that providers National Provider Identifier (NPI), for services provided when the PA, APN, or CRNFA is acting as an assistant during surgery. Modifier AS is to be used ONLY if the PA, APN, or CRNFA assists at surgery.

**SA modifier:** A supervising physician should use the SA modifier when billing on behalf of a PA, APN, or CRNFA for non-surgical services. Modifier SA is to be used when the PA, APN, or CRNFA is assisting with any other procedure that DOES NOT include surgery.

**Under Arrangement Billing**
"Under-arrangement" billing and other similar billing or service arrangements are not permitted by BCBSTX. "Under-arrangement" billing refers to situations where services are performed by a physician, facility, or ancillary provider but the services are billed under the contract of another physician, facility or ancillary provider, rather than under the contract of the physician, facility, or ancillary provider that performed the services.

**All Inclusive Billing**
Any testing performed on patients treated by a physician, professional provider, facility, or ancillary provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services. The

Physician, professional provider, facility, or ancillary provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to BCBSTX.

For all-inclusive billing, all testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

**Other Requirements and Monitoring CLIA Certification Requirement**
Facilities and private providers who perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Therefore, any provider who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

### Review of Codes
BCBSTX may monitor the manner in which test codes are billed, including frequency of testing. Abusive billing, insufficient or lack of documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100% review of medical records for such claims submitted.

### Limitations and Conditions
Reimbursement is subject to:

- Medical record documentation, including appropriately documented orders
- Correct CPT/HCPCS coding
- Member Benefit and Eligibility
- Applicable BCBS Medical Policy(-ies)

### Obligation to notify BCBSTX of Certain Changes
Physicians, facilities, and ancillary providers are required to notify BCBSTX of material changes that impact their contract with BCBSTX including the following:

- Change in ownership
- Acquisitions
- Change of billing address
- Change in billing information
- Divestitures

### Assignment
As a reminder, no part of the contract with BCBSTX may be assigned or delegated by a physician, facility or ancillary provider without the express written consent of both BCBSTX and the contracted provider.

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

---

### New ClaimsXten™ Rules to be Implemented
Beginning on or after September 18, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will implement 4 new rules to the ClaimsXten software database. These new rules are defined as:

**Add On Without Base Code** – This rule will identify claim lines containing a CPT/HCPCS add-on-code billed without the presence of one or more related primary service/base procedure codes. According to American Medical Association (AMA), "add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code."

**Global Component Billing** – This rule will identify procedure codes which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule will also identify when duplicate submissions occur for the total global procedure or its components across different providers.

**Duplicate Component Billing** – This rule identifies when a professional or technical component of a procedure is submitted and the same global procedure was previously submitted by the same provider ID for the same member for the same date of service.

**New Patient Code for Established Patient** – Identifies claim lines containing new patient procedure codes that are submitted for established patients. According to AMA, "A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last 3 years." As well, similar guidance is provided by Centers for Medicare Medicaid Services (CMS): According to Pub 100-04, Medicare Claims Processing Manual Ch. 12, Physicians/Non-Physicians Practitioners, Section 30.6.7, Subsection A, "Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years."

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the Education & Reference/Provider Tools/ Clear Claim Connection page on our Provider website at bcbstx.com/provider. Information also may be published in upcoming issues of the Blue Review.

*Checks of eligibility and/or benefit information are 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.*

*ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third-party vendor that is solely responsible for its products and services.*



---

## Reminder: Medicare Advantage Plans Overpayment Recovery

**Applies to: Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM**

As a reminder, a new process was implemented for overpayment recovery on claims processed after Jan. 1, 2017, for Blue Cross Medicare Advantage PPO and Blue Cross Medicare Advantage HMO. The process includes:

- The Electronic Refund Management and Claim Inquiry Resolution tools on Availity™ are no longer available for government program claims.
- Request for refund letters will be sent by mail for all providers.

Please review your refund letter closely and remit your refund to the address indicated on the letter. If you identify an overpayment and wish to send a voluntary refund, please use the following grid to determine the appropriate address:

| Original Claim Check Date | Send to Address |
|---|---|
| **Check Date prior to 1/1/17** | Blue Cross and Blue Shield of Texas<br>P.O. Box 731431 Dallas,<br>TX 75373-1431 |
| **Check Date 1/1/17 or after** | Blue Cross and Blue Shield of Illinois Claims Overpayment<br>29068 Network Place<br>Chicago, IL 60673-1290 |

**If you are unsure about the original payment date, please send payments to:**

Blue Cross and Blue Shield of Texas
Box 731431
Dallas, TX 75373-1431

*Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to 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.*

---

## Benefit Categories Contained in IVR Phone System

The list of common benefit categories contained within the Blue Cross and Blue Shield of Texas (BCBSTX) Interactive Voice Response (IVR) phone system has been expanded as of June 19, 2017, to include additional common benefit categories.

The IVR quotes the same level of eligibility and benefit information that a Customer Advocate provides. Our Customer Advocates will continue to be available for more complex benefit quotes.

An updated IVR benefit containment list is below. This list outlines those categories that were effective on Dec. 12, 2016, along with the additional categories implemented June 19, 2017.

As a reminder, this information is continually reviewed and may vary across different BCBSTX networks, products and/or group policies. There were no other benefit categories being added to the Federal Employee Program (FEP) IVR Contained Benefits in June 2017. The current contained Benefit Category lists are shown below.

| Contained Benefit Categories Effective Dec. 12, 2016 | Additional IVR Contained Benefit Categories Effective June 19, 2017 |
|---|---|
| Allergy Colonoscopy<br>Consultations<br>Coordinated Home Care<br>Electrocardiogram (EKG)<br>Extended Care Facility Hospital<br>Inhalation Therapy<br>Laboratory Mammogram<br>Office Services Office Visit<br>Pap Smear Physical<br>Exam Preventive Care<br>Private Duty Nursing<br>Ultrasound<br>X-ray | 23-hour Observation<br>Air Ambulance<br>Anesthesia Assistant<br>Surgeon CAT Scan<br>Dialysis<br>Ground Ambulance<br>Hospice<br>Medical Supplies<br>MRI<br>Pathology<br>PET Scan<br>Prosthetics<br>Prostate-specific Antigen (PSA)<br>Sterilization |

| FEP IVR Contained Benefit Categories | |
|---|---|
| Accidental Injury | Maternity |
| Allergy | Office Visit |
| Chiropractic Services | Outpatient Physical, Occupational and Speech Therapy |
| Diagnostic – Lab, X-ray, Outpatient Diagnostic | Vision |
| Inpatient Benefits – Inpatient Hospital, Inpatient Surgery | |

**Note:** The above listings are not applicable to Blue Cross Medicare Advantage (PPO)SM or Blue Cross Medicare Advantage (HMO)SM government program member policies. For eligibility and benefits for these government programs via phone, refer to the number on the member's BCBSTX identification card.

As a reminder, checking eligibility and benefits electronically through Availity™ or your preferred web vendor is the quickest way to access BCBSTX member information. To learn more about online solutions, see the Provider Tools section of the BCBSTX provider website.

Checking eligibility, benefit information and/or if a service has been preauthorized 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. If you have any questions, please call the number on the back of the member's ID card.

*Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to 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.*

---

### Clinical Payment and Coding Policies Now Online

BCBSTX is now publishing Clinical Payment and Coding Policies on our website. These payment and coding policies describe BCBSTX's application of payment rules and methodologies for CPT®, HCPCS and ICD-10 coding as applied to claims submitted for covered services. This information is offered as a helpful general resource regarding BCBSTX payment polices and is not intended to address all reimbursement related issues. New policies have been posted and existing policies will be added over time. We regularly adjust clinical payment and coding policy positions as part of our ongoing policy review processes. Check this newsletter and the News and Updates section on our website for newly adapted or revised policies.

---

### Update to After-hours and Weekend Care Codes Payment Policy

Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its payment policy regarding after-hours and weekend care codes.

After-hours or weekend care is reimbursable, within limitations, for services provided by an individual physician or other health care professional who is required to provide office-based services outside of regular posted office hours to treat a patient's urgent illness or condition.

Effective Jan. 1, 2017, BCBSTX will no longer reimburse facility-based or non-office based providers for CPT Codes 99053, 99056 and 99060. These codes will be considered inclusive of the primary procedure. Please contact your Network Management Representative if you have any questions or if you need additional information.

---

### ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and HCPCS codes are periodically added to or deleted from the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version.

Blue Cross and Blue Shield of Texas (BCBSTX) will normally load this additional data to the BCBSTX claim processing system within 60 to 90 days after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSTX provider website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) also will be posted on the BCBSTX provider website.

To help determine how coding combinations on a claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to our website at bcbstx.com/provider for additional information on gaining access to C3.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the C3 page. Additional information may also be included in upcoming issues of the *Blue Review*.

*Checks of eligibility and/or benefit information are 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.*



---

## Additional Code-auditing Software

Blue Cross and Blue Shield of Texas (BCBSTX) implemented additional code-auditing software, Verscend ConVergence Point™. BCBSTX implemented this code- auditing software in June 2017*.

This software further enhances the auditing of professional and outpatient facility claims for correct coding according to the Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT®), and Centers for Medicare and Medicaid Services (CMS) guidelines. Providers may use the Claim Inquiry Resolution Tool, available on the Availity™ Web Portal, to research specific claim edits.

**The above notice does not apply to government program claims.*



---

## Technical and Professional Components

**Modifiers 26 and TC:** Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only.

**Note:** When a physician or professional provider and facility or ancillary provider performs both the technical and professional service for a lab or radiological procedure, he/she must submit the total service, not each service individually.

---

## Surgical Procedures Performed in the Physician's Office

When performing surgical procedures in a non-facility setting, the physician and professional provider reimbursement covers the services, equipment and some of the supplies needed to perform the surgical procedure when a member/subscriber receives these services in the physician's or professional provider's office.

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in a physician's or professional provider's office. To help determine how coding combinations on a claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind Blue Cross

and Blue Shield of Texas' (BCBSTX) code-auditing software. Refer to the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3.

*Please note the physician's and professional provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied since the global physician's or professional provider's reimbursement includes staff and equipment.*

---

### Improvements to the Medical Records Process for BlueCard® Claims

Blue Cross and Blue Shield of Texas (BCBSTX) is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.

As always, we request that you submit your medical records to BCBSTX if needed for claims processing. Requests for medical records from other Blues Plans before rendering services, as part of the preauthorization process, should be submitted directly to the requesting Plan.

---

### Contracted Providers Must File Claims

As a reminder, physicians, facilities, professional providers and ancillary providers must file claims for any covered services rendered to a patient enrolled in a Blue Cross and Blue Shield of Texas (BCBSTX) health plan. You may collect the full amounts of any deductible, coinsurance or copayment due and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your provider contract with BCBSTX.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

---

### Billing for Non-Covered Services

As a reminder, contracted physicians, professional providers, facility and ancillary providers may collect payment from members/subscribers for copayments, co-insurance and deductible amounts. The physician, professional provider, facility or ancillary provider may not charge the member/subscriber more than the patient share shown on their provider claim summary (PCS) or electronic remittance advice (ERA).

If Blue Cross and Blue Shield of Texas (BCBSTX) determines that a proposed service is not a covered service, the physician, professional provider, facility or ancillary provider must inform the member/subscriber in writing in advance. This will allow the physician, professional, facility or ancillary provider to bill the member/subscriber for the non-covered service rendered.

In no event, shall a contracted physician, professional provider, facility or ancillary provider collect payment from the subscriber for identified hospital acquired conditions and/or serious reportable events.

---

### Avoidance of Delay in Claims Pending COB Information

Blue Cross and Blue Shield of Texas (BCBSTX) receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our physicians, professional providers, facility and ancillary providers is a possible delay, or even denial of services, pending receipt of the required information from the member/subscriber.

**Here are some tips to help prevent claims processing delays when there is only one insurance carrier:**

- CMS-1500, box 11-d – if there is no secondary insurance carrier, mark the “No” box.
- Do not place anything in box 9, a through d – this area is reserved for member information for a secondary insurance payer.

It is critical that no information appears in box 11-d or in box 9 a-d if there is only one insurance payer.

---

### Hospitals, and Routine Services and Supplies

Routine services and supplies are generally already included by the provider in charges related to other procedures or services. As such, these items are considered non-billable for separate reimbursement. The following guidelines may assist hospital personnel in identifying items, supplies, and services that are not separately billable. This is not an all-inclusive list.

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over-the-counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

---

## Clinical Resources

### BCBSTX Lab Guidelines

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for Blue Essentials℠, Blue Premier and Blue Advantage HMO℠ members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) Blue Choice PPO℠ subscribers. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

**Quest Diagnostics Offers:**

- Online scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto QuestDiagnostics.com/patient or call 888-277- 8772.
- Convenient patient access to more than 195 patient service locations.
- 24/7 access to electronic lab orders, results and other office solutions through Care360® labs and meds.

For more information about Quest Diagnostics lab testing solutions or to establish an account, contact your Quest Diagnostics Physician Representative or call 866-MY-QUEST (866-697-8378).

For physicians, professional providers or facility and ancillary providers located in the HMO Reimbursable Lab counties, only the lab services/tests indicated on the Reimbursable Lab Services list will be reimbursed on a fee-for-service basis if performed in the physician’s, professional provider’s office for Blue Essentials members. All other lab services must be sent to Quest You can access the county listing and the Reimbursable Lab Services list in the General Reimbursement Information section located under the Standards and Requirements tab.

**Note: Physicians, professional providers or facility and ancillary providers who are contracted/affiliated with a capitated IPA/medical group and physicians, professional providers or facility or ancillary providers who are not part of a capitated IPA/medical group but who provide services to a member/subscriber whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.*

---

## Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

Quest Diagnostics, Inc., Clinical Pathology Laboratory (CPL) and LabCorp, Inc. are the preferred outpatient clinical reference laboratory providers for Blue Cross Medicare Advantage (PPO) members.

Note: This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

**For locations or questions contact:**

- Quest Diagnostics at 888-277-8772 or questdiagnostics.com/patient
- Clinical Pathology Laboratory at 800-595-1275 or cpllabs.com
- LabCorp at 800-845-6167 or labcorp.com

As previously indicated, if lab services are performed at the participating physician's or other professional provider's office, the physician or professional provider may bill for the lab services. However, if the physician's or other professional provider's office sends the lab specimens to a contracted lab for completion, only the contracted lab can bill Blue Cross Medicare Advantage (PPO) for the lab services.

**Medical Necessity Review of Observation Services**

As a reminder, it is the policy of Blue Cross and Blue Shield of Texas (BCBSTX) to provide coverage for observation services when it is determined to be medically necessary based on the medical criteria and guidelines as outlined in the Milliman Care Guidelines. Claims for observation services are subject to post-service review, and BCBSTX may request medical records for the determination of medical necessity.

When medical records are requested, documentation should include the following information:

- The attending physician's order for observation care with clock time (or clock time can be noted in the nurse's observation admission note)
- The physician's admission and progress notes confirming the need for observation care
- The supporting diagnostic and/or ancillary testing reports
- The admission progress notes (with the clock time) outlining the patient's condition and treatment
- The discharge notes (with clock time) with discharge order and nurse's notes
- Itemized bill

---

## Coordination of Care Between Medical and Behavioral Health Providers

Blue Cross and Blue Shield of Texas (BCBSTX) continually strives to promote coordination of member care between medical and behavioral health providers. We understand that communication between providers and their patients regarding the treatment and coordination of care can pose challenges. Here are few resources available to you through BCBSTX:

**The Coordination of Care Form Available Online**

To provide assistance when coordinating care, BCBSTX has created a Coordination of Care form that is available online. This new form may help in communicating patient information, such as:

- To provide member treatment information to another treating provider
- To request member treatment information from another treating provider. It is important to note that a written release to share clinical information with members' medical providers must be obtained prior to the use of this form. BCBSTX recommends obtaining a written release prior to the onset of treatment.

If you are requesting member treatment information from another provider, it is recommended that the Patient Information and Referring Provider sections of the form be completed to expedite the care coordination process for the receiving provider.

**If You Need Help Finding Behavioral Health Providers for Your Patients**
Call the number on the back of members' BCBSTX ID cards to receive assistance in finding outpatient providers or behavioral health facilities.

**Behavioral Health or Medical Case Management Services**
If you believe a patient has complex health needs and could benefit from additional support and resources from a clinician, you can make a referral to one of the BCBSTX Case Management programs by calling the number on the back of the member's BCBSTX ID card. Case Management can also provide you and the member with information about additional resources provided by their insurance plan.

---

# Electronic Options

### Multiple Online Enrollment Options Available in Availity™

Blue Cross and Blue Shield of Texas (BCBSTX) offers you multiple enrollment opportunities for electronic options through the Availity Web Portal. This is in addition to other electronic transactions available to you through Availity or your preferred web vendor portal. Instead of faxing or mailing paper enrollment forms, you can complete
the online enrollment options listed below through Availity at no cost. Availity also provides single sign-on access to several online tools that offer greater convenience and security, without the need for another user ID and password.

**Online Enrollment for EFT and ERA**
BCBSTX contracted providers* can enroll online for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA), and make any necessary set-up changes in Availity. The online enrollment process can be completed in near real-time.

Providers will receive a confirmation letter acknowledging the enrollment effective date and related information. Once enrolled for ERA, providers and billing services also gain access to the Availity Remittance Viewer. This online tool permits users to search, view, save and print remittance information, even if the ERA is delivered to a different clearinghouse or vendor.

**Single Sign-on Access**

- **Benefit Preauthorization Via iExchange®**
  Once you are registered as an Availity user, you may enroll through the Availity Web Portal for iExchange. This tool supports online submission and electronic approval of benefits for inpatient admissions, as well as select outpatient and clinical pharmacy services. iExchange also offers you an alternative to calling to request the status of most benefit preauthorization requests. Additionally, iExchange accepts electronic medical record documentation for predetermination of benefits requests. As a reminder, always check eligibility and benefits first to find out if benefit preauthorization is required for a member.

  Please note that for behavioral health services, you should continue to use the current fax and telephone benefit preauthorization methods.

- **Electronic Refund Management (eRM)**
  Registered Availity users can also gain access to eRM, an online tool that helps simplify the overpayment reconciliation process. You will receive electronic notification of overpayments with the option to deduct from a future payment or pay by check. eRM also gives access to the Claim Inquiry Resolution (CIR) tool. CIR offers online assistance that helps save your staff time by reducing the number of calls and specific written inquiries on finalized claims.

  Please note that the eRM and CIR tools are not available for government programs claims.

**Learn More**
To learn more about these and other electronic tools and resources, visit the Provider Tools section of our website. Also, see the Provider Training page for dates, times and registration for online training sessions on a variety of topics.

For assistance or customized training, contact a BCBSTX Provider Education Consultant at PECS@tx.com.

**Register with Availity**
Visit availity.com to complete the online application today. If you need registration assistance, contact Availity Client Services at 800-AVAILITY (800-282-4548).

*Checking eligibility, benefit information and/or the fact that a service has been preauthorized 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. If you have any questions, please call the number on the back of the member's ID card.*

**This excludes atypical providers who have not acquired a National Provider Identifier (NPI).*

*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. iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative healthcare management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity or Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.*

---

## Availity™ Claim Research Tool Offers Enhanced Status Results

Using an electronic route, such as the Availity Claim Research Tool (CRT), is the most convenient, efficient and secure method of requesting detailed claim status. The CRT tool now returns more detailed information than ever before.

The CRT allows registered Availity users to search for claims by member ID, group number and date of service, or by National Provider Identifier (NPI) and specific claim number, also known as a Document Control Number (DCN). With easy-to-read denial descriptions, the tool enables users to check the status of multiple claims in one view to obtain real-time claim status.

The CRT Search Results page now delivers the rendering provider ID and name submitted on the claim. Additionally, the claim status Service Line break-down returns:

- Diagnosis Code
- Copay
- Coinsurance
- Deductible
- Modifier
- Unit or Time or Mile

This necessary information is available within a few clicks, lessening the need to speak with a Customer Advocate. For additional information, refer to the CRT tip sheet, which can also be found on the Provider Tools page in the Education & Reference section of our provider website. As a reminder, you must be registered with Availity to utilize the CRT. For registration information, visit availity.com, or contact Availity Client Services at 800- 282-4548.

**Learn More About Availity**
We host complimentary webinars for providers to learn how to use the CRT and other electronic tools to their fullest potential. You do not need to be an existing Availity user to attend a webinar. Go to our Provider Training website to view available webinars.

---

## Online Portal Applications Help Expedite Administrative Workflows

Does your office or organization ever ask: **"Is this patient eligible for Blue Cross and Blue Shield Texas (BCBSTX) benefits? Does this service require preauthorization? or How did my claim process?"** If so, these questions and so many more can be answered in a matter of seconds with a few key strokes using an online portal application, such as Availity™.

Electronic options deliver real-time resolutions, avoiding disapproved services and optimizing your payment. You can confirm patient coverage, preauthorize services and post payments with a few simple clicks.

**Not only can you conduct HIPAA-compliant transactions online, using Availity you can also:**

- Submit pre- and post-exam transactions
- Conduct pre-service requests
- Complete post-service reconciliations
- Update provider demographics
- Enroll for electronic remittance and fund transfers

If you have not registered and would like to learn more about Availity, and our online referral and preauthorization tool iExchange®, register for a Back to Basics: Availity 101 webinars.

Additionally, for more advanced training of online tools, email a Provider Education Consultant at PECS@bcbstx.com.

---

## Corrected Claim Request Change, Effective as of July 11, 2016

As a reminder, corrected claim requests for previously adjudicated claims must be submitted as electronic replacement claims, or on the appropriate professional (CMS-1500) or institutional (UB-04) paper claim, and Claim Review form.

**Electronic Submission**

Electronic replacement claims should be submitted with the appropriate claim frequency code. Frequency code 7 will result in Blue Cross and Blue Shield of Texas (BCBSTX) adjudicating the original claim number (sometimes referred to as a Document Control Number, or DCN) with the corrections. The replacement claim will be issued a new BCBSTX claim number and subsequently deny based on the re-adjudication of the original claim.

**Note:** Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSTX claim number will not be adjudicated. See below for additional information on claim frequency codes and guidelines to assist you with when and how to use them for making corrections to electronic claims submitted to BCBSTX.

| **Claim Frequency Codes** | | | |
|---|---|---|---|
| **Code** | **Description** | **Filing Guidelines** | **Action** |
| **5** Late Charge(s) | Use to submit additional charges for the same date(s) of service as a previous claim. | File electronically, as usual. Include only the additional late charges that were not included on the original claim. | BCBSTX will add the late charges to the previously processed claim. |
| **7** Replacement of Prior Claim | Use to replace an entire claim (all but identity information). | File electronically, as usual. File the claim in its entirety, including all services for which you are requesting reconsideration. | BCBSTX will replace the original claim with corrections and the replacement claim will be denied. Refer to the original claim for adjudication. |

| | | | |
|---|---|---|---|
| **8** Void/Cancel of Prior Claim | Use to eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period." | File electronically, as usual. Include all charges that were on the original claim. | BCBSTX will void the original claim from records, based on request. |

**Paper Submission**
More than 98 percent of the claims BCBSTX receives from providers are submitted electronically. BCBSTX encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer web vendors available to providers. If you are a registered Availity® web portal user, you have access to submit direct data entry replacement claims electronically, at no additional cost.

As of July 11, 2016, any changes to a claim that are specified only on the Claim Review form (or via a letter) will be returned with a notice advising resubmission on the appropriate CMS-1500 or UB-04 paper claim form. Paper claim submitters are required to indicate “corrected claim” on the paper claim form and the accompanying Claim Review form.

---

# Pharmacy

### Reminder: Pharmacy Program Benefit Changes – Effective Jan. 1, 2017

Blue Cross and Blue Shield of Texas (BCBSTX) implemented pharmacy benefit changes on Jan. 1, 2017, for some members with prescription drug benefits administered through Prime Therapeutics®.

Based on claims data, letters are sent from BCBSTX to alert members who may be affected by one or more of the 2017 pharmacy benefit changes. A summary of the changes, as outlined in the member letters, is included below for your reference.

**Drug List Changes and Medication Coverage Revisions/Exclusions**
Some members’ plans may now be based on a new drug list:

1. **New Performance Drug List and Performance Select Drug Lists** – Some members may have one of these new drug lists, which are closed drug lists listing all covered medications only. As a result, some medications will move to a higher copay/coinsurance payment tier and select drugs/drug classes may be excluded from coverage. Additionally, if your patients had a prior authorization approval for a drug that is now excluded from coverage, you can submit a drug list coverage exception request to BCBSTX. Your patients may also ask you about therapeutic alternatives.
2. **Enhanced Drug List *(formerly known as Generics Plus Drug List)*** – Some members may move to this drug list, and as a result, select medications may move to a higher copay/coinsurance payment tier. Your patients may ask you about generics or lower cost alternatives.
3. Some members may also be affected by **annual or quarterly drug list changes**, such as drugs moving to a higher payment tier or excluded from coverage. Your patients may ask you about therapeutic or lower cost alternatives.
4. The **Standard Drug List** is now known as the **Basic Drug List**.
5. As a reminder, medications that have **not received FDA approval** are **not covered** under the BCBSTX pharmacy benefit.

**Utilization Management Program Changes**
Some members’ plans may now be subject to new prior authorization and step therapy programs and/or dispensing limits. If you have a patient who is taking select medications included in these programs, he/she may need to meet certain criteria, such as an approval of a prior authorization request, for coverage consideration.

Additionally, these programs may correlate to your patient’s drug list.

**Specialty Drug Changes**
Starting Jan. 1, 2017, members with an individual benefit plan offered on/off the Texas Health Insurance Marketplace who are using a drug manufacturer's coupon or copay card will not have the specialty drug payment applied to their plan deductible or out-of-pocket maximum. This is unless the coupon is a permitted third-party cost-sharing payment. Your patients can contact BCBSTX if they have questions about this change.

**Pharmacy Network Changes**
Some members' plans may experience changes to the pharmacy network:

1. **CVS Exclusion** – Effective Jan. 1, 2017, CVS pharmacies™ and CVS pharmacies in a Target® store were removed from most members' pharmacy network.
2. **New Pharmacy Networks** – Some members' plans may move to a preferred network where prescriptions filled at these preferred tiered pharmacies offer the lowest copay/coinsurance amounts. 90- day supplies can also be filled at these preferred tiered pharmacies or through mail order for coverage consideration.

**Members who continue to fill prescriptions at a pharmacy no longer in their network will pay more.** In most cases, no action is required on your part for any of these pharmacy network changes as members can easily transfer prescriptions to a nearby in-network pharmacy. If your office stores pharmacy information on your patients' records, you may want to ask your patients which pharmacy is their new choice.

If your patients have questions about their pharmacy benefits, please advise them to call the Pharmacy Program phone number on their member ID card. Members also may visit bcbstx.com and log in to Blue Access for Members℠ for a variety of online resources.

**Changes to be implemented, as applicable, based on the member's 2017 plan renewal, or new plan effective date, unless otherwise noted. These changes do not apply to members with Medicare Part D or Medicaid coverage.*

*A "preferred" or "participating" pharmacy has a contract with BCBSTX or BCBSTX's pharmacy benefit manager (Prime Therapeutics) to provide pharmacy services at a negotiated rate. The terms "preferred" and "participating" should not be construed as a recommendation, referral or any other statement as to the ability or quality of such pharmacy. Please note that changes to participating pharmacies may be made in the future.*

*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 and pharmacy choice is between the member and their health care provider.*

*Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSTX and contracting pharmacies is that of independent contractors. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.*

---

## Pharmacy Benefit Tips

For Blue Cross and Blue Shield of Texas (BCBSTX) members with prescription drug benefits administered by Prime Therapeutics®, BCBSTX employs several strategies common to the health benefits industry to manage prescription drug benefits. These strategies may include formulary management, benefit design modeling, specialty pharmacy benefits, and clinical programs, among others. These programs allow BCBSTX members to have access to affordable quality health care. You can help support these initiatives by following the tips, guidelines and reminders below:

1. **Prescribe Drugs Listed on the member's drug list (Formulary)**
   The BCBSTX drug lists are provided as a guide to help in the selection of cost-effective drug therapy. Every major drug class is covered, although many of the drug lists cover most generics and fewer brand name drugs. The lists also provide members with criteria for how drugs are selected, coverage considerations and dispensing limits. While these drug lists are a tool to help members maximize their prescription drug benefits, the final decision about what medications should be prescribed is between the health care provider and the patient.

BCBSTX drug lists are regularly updated and can be found under Pharmacy Program on the BCBSTX provider website.

**Note:** For members with Medicare Part D or Medicaid coverage, the drug lists can be found on the plan's website:

- Blue Cross MedicareRx (PDP)SM: bcbstx.com/medicare/part_d_druglist.html
- Blue Cross Medicare Advantage (HMO)SM and (PPO)SM: bcbstx.com/medicare/mapd_drug_coverage.html
- Blue Cross Medicare Advantage Dual Care (HMO SNP)SM: bcbstx.com/medicare/snp_drug_coverage.html
- Texas STAR: bcbstx.com/star/prescription-drugs/drug-coverage
- Texas CHIP: bcbstx.com/chip/prescription-drugs/drug-coverage

**Remind Patients About Covered Preventive Medications**
Many BCBSTX health plans include coverage at no cost to the member for certain prescription drugs and over-the-counter (OTC) medicine products used for preventive care services and women's contraception.*

**ACA $0 Preventive Drug List:** bcbstx.com/pdf/rx/rx-aca-prev-list-tx.pdf
**Women's Contraceptive Coverage List:** bcbstx.com/pdf/rx/contraceptive-list-tx.pdf

**Not available for all plans. Members should call the customer service number on their ID card to help determine what benefits may be available, including any requirements, limitations or exclusions that apply. Please refer to the member's certificate of coverage.*

**Submit Necessary Prior Authorization Requests**
For some medications, the member's plan may require certain criteria to be met before prescription drug coverage may be approved. You will need to complete the necessary prior authorization request and submit it to BCBSTX. More information about these requirements can be found under Pharmacy Program on the BCBSTX provider website.

**Assist Members with Formulary Exceptions**
If the medication you wish to prescribe is not on your patient's drug or the preventive care lists, a formulary exception may be requested. You can call the customer service number on the member's ID card to start the process, or complete the online form at: myprime.com/en/coverage-exception-form.html.

Visit the Pharmacy Program section of our website for more information.

*Prime Therapeutics, LLC, is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.*

*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.*

---

### Dispensing QVT (Quantity Versus Time) Limits

To help minimize health risks and to improve the quality of pharmaceutical care, dispensing QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer's package insert.

For current Drug List Dispensing Limits, visit Pharmacy Program/Dispensing Limits on the BCBSTX provider website.

---

### Prescription Drug Lists

Throughout the year, the Blue Cross and Blue Shield of Texas (BCBSTX) Clinical Pharmacy department frequently reviews the prescription drug lists. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

For current drug updates, visit Pharmacy Program/Prescription Drug List and Prescribing Guidelines on the BCBSTX provider website.

---

## Provider General Information

### BCBSTX New Employer Group Plan – Employees Retirement System of Texas (ERS) Effective Sept. 1, 2017

Blue Cross and Blue Shield of Texas (BCBSTX) was awarded the six- year contract for the Employees Retirement System of Texas (ERS) account, effective Sept. 1, 2017.

ERS participants covered under HealthSelect℠ of Texas and Consumer Directed HealthSelectSM benefit plans will access care through the Blue Essentials℠ provider network in all 254 counties in Texas.

**ERS participants plan options:**

- HealthSelect of Texas In-Area (Texas)
- Participants must select a primary care physician (PCP) participating in the Blue Essentials provider network and referrals are required to see Blue Essential providers for in network benefits.
- Consumer Directed HealthSelect In-Area (Texas)
- Consumer Directed HealthSelect participants have open access to providers in the Blue Essentials provider network for their in-network benefits. This plan does not require PCP selection and does not require referrals.

**ERS participants can be identified through their BCBSTX ID card:**

- The plan names HealthSelect of Texas and Consumer Directed HealthSelect will be printed directly on the ID card.
- ERS Participants will have a unique Blue Essentials network ID labeled HME.

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit quotes include participant verification, 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 to guard against medical identity theft. When services may not be covered, participants should be notified that they may be billed directly.

For a list of services that require prior authorization for ERS participants through BCBSTX or eviCore, refer to the ERS HealthSelect of Texas Prior Authorization/Notification/Referral Requirements List or ERS Consumer Directed Health Select Prior Authorization/Notification/Referral Requirements List on the Clinical Resources page of bcbstx.com/provider.

Continue to watch for additional information regarding ERS in future editions of the Blue Review newsletter and on our website at bcbstx.com/provider.

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

---

## Medicare Outpatient Observation Notice Requirement

**Applies to: Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM**

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and critical access hospitals (CAH) to provide notification to individuals receiving observation services as outpatients for more than 24 hours.

Hospitals and CAHs are required to give the CMS-developed standardized notice – the **Medicare Outpatient Observation Notice (MOON)** – to a Medicare beneficiary or enrollee who has been receiving observation services as an outpatient for more than 24 hours. The notice must be provided no longer than 36 hours after observation services are initiated. To obtain a copy, visit the CMS website and then scroll down for copies of the CMS MOON instructions and forms in both English and Spanish.

The MOON will inform nearly one million beneficiaries annually of the reason the individual is an outpatient receiving observation services and the implications of observation services on cost sharing.

An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice. A signature must be obtained from the individual (or an individual qualified to act on their behalf) to acknowledge the receipt and understanding of the notice (or in cases of refusal of signature by such individual, signature by the staff member of the hospital or CAH providing the notice).

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

---

## Provider Training

BCBSTX is proud to offer complimentary educational webinar sessions. These online training sessions give you the flexibility to attend live sessions. Provider billers, utilization areas and administrative departments will benefit from these webinars. Please visit Education and Reference on the bcbstx.com/provider website to view what is available and sign up for training sessions.

---

## After-hours Access Is Required

Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians/providers, specialty care physicians, professional providers, and facility and ancillary providers provide urgent care, and emergency care or coverage for care 24 hours a day, seven days a week. Providers must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

**Acceptable after-hours access mechanisms may include:**

- An answering service that offers to call or page the physician/provider or on-call physician/provider;
- a recorded message that directs the patient to call the answering service and the phone number is provided; or
- a recorded message that directs the patient to call or page the physician/provider or on-call physician/provider and the phone number is provided.

For more detail, please refer to the provider manuals for Blue Choice PPO℠ Physician, Professional Provider and Facility and Ancillary Provider Manual (Section B) and Blue, Blue Premier Physician, Professional Provider, Facility and Ancillary Provider Manual (Section B) available in the Education & Reference section of our provider website. Click on the "Manual" link (note, a password is required).

---

### Medical Record Requests: Include Our Letter as Your Cover Sheet

When you receive a letter from Blue Cross and Blue Shield of Texas (BCBSTX) requesting additional information, such as medical records or certificates of medical necessity, please utilize the letter as a cover sheet when sending the requested information to us.

This letter contains a barcode in the upper right corner to help ensure that the information you send is matched directly to the appropriate file and/or claim. Do not submit a Claim Review form in addition to the letter, as this could delay the review process. Thank you for your cooperation!

---

### Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the Blue Cross and Blue Shield of Texas (BCBSTX) provider website on the 1st or 15th day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted.

To view active and pending medical policies go to bcbstx.com/provider and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to active and pending medical policies.

---

### Draft Medical Policy Review

To streamline the medical policy review process, you can view draft medical policies on the Blue Cross and Blue Shield of Texas (BCBSTX) provider website and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

To view draft medical policies go to our provider website and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

---

## Rights and Responsibilities

### Blue Choice PPO℠ Subscribers/Blue Advantage HMO℠ Member Rights and Responsibilities

As a provider for Blue Cross and Blue Shield of Texas (BCBSTX), you are obligated to be aware of subscribers'/members' rights and informed of subscribers' responsibilities. Our health plan subscribers/members may refer to their benefit booklet for a listing of their rights and responsibilities, which are also included below; you can also access these documents on our website at bcbstx.com.

| RIGHTS | RESPONSIBILITIES |
|---|---|
| **Subscriber(s)/Member(s)** | **Subscriber(s)/Member(s)** |
| **You have the right to:** | **You have the responsibility to:** |
| Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities.<br>Make recommendations regarding the organization's subscribers' rights and responsibilities policy. | Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, to provide care. |
| Participate with practitioners in making decisions about your health care. | Follow the plans and instructions for care you have agreed to with your practitioner. |
| e treated with respect and recognition of your dignity and your right to privacy.<br>A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. Voice complaints or appeals about the organization or the care it provides. | Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible. |

**Member Rights – You Have the Right to:**

- Receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policy.
- Participate with practitioners in making decisions about your health care.
- Be treated with respect and recognition of your dignity and your right to privacy.
- A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.

**Member Rights – You Have the Responsibility to:**

- Meet all eligibility requirements of your employer and the Health Maintenance Organization (HMO).
- Identify yourself as an HMO member by presenting your ID card and pay the copayment at the time of service for network benefits.
- Establish a physician/patient relationship with your primary care physician/provider (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency or services are performed by your HMO participating OBGyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, to care for you. Including changes in your family status, address and phone numbers within 31 days of the change.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Notify your primary care physician/provider or HMO plan within 48 hours or as soon as reasonably possible after receiving emergency care services.
- Communicate complete and accurate medical information to health care providers.

- Call in advance to schedule appointments with your network provider and notify them prior to canceling or rescheduling appointments.
- Read your coverage documents for information about benefits, limitations, and exclusions.
- Ask questions and follow instructions and guidelines given by your provider to achieve and maintain good health.

Understand your health problems and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

---

## Contact Us

View our quick directory of contacts for BCBSTX.

---

## Update Your Information

Do you need to update your location, phone number, email or other important details on file with BCBSTX? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local Network Management Representative to have up to 10 of your office email addresses added.

---

bcbstx.com/provider