

BLUE REVIEWSM

A newsletter for physician, professional, facility, ancillary and Medicaid providers

Sept. 7, 2016

Pharmacy Benefit Tips

For Blue Cross and Blue Shield of Texas (BCBSTX) members with prescription drug benefits administered by Prime Therapeutics®, BCBSTX employs a number of industry-standard management strategies to ensure appropriate utilization of prescription drugs. These strategies can include formulary management, benefit design modeling, specialty pharmacy benefits, and clinical programs, among others. You can help us achieve these goals by:

1. Prescribing Drugs Listed on the Formulary

The BCBSTX formularies 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 formularies 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 formularies 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](#)
- [Blue Cross Medicare Advantage \(HMO\)SM and \(PPO\)SM](#)
- [Blue Cross Medicare Advantage Dual Care \(HMO SNP\)SM](#)
- [Texas STAR](#)
- [Texas CHIP](#)

2. Reminding Patients of Covered Preventive Medications

Many BCBSTX health plans include coverage at no cost to the member for certain prescription drugs, women's contraceptive products and over-the-counter (OTC) medicines used for preventive care services.*

- [ACA \\$0 Preventive Drug List](#)
- [Women's Contraceptive Coverage List](#)

**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.*

3. Submitting 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.

4. Assisting 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 can be requested. You can call the customer service number on the member's ID card to start the process, or complete the [form online](#).

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 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 is between the member and their health care provider.

iExchange® Now Accepts Electronic Medical Record Attachments

Blue Cross and Blue Shield Texas (BCBSTX) is pleased to announce that enhancements have been made to iExchange, our online tool that supports online benefit preauthorization requests for inpatient admissions, medical, behavioral health and clinical pharmacy services. Effective Sept. 1, 2016, iExchange now accepts electronic medical record attachments when necessary in support of benefit preauthorization requests. Electronic medical record documentation may also be submitted via iExchange for predetermination of benefit requests. With these enhancements, iExchange offers providers and facilities a secure, online alternative to faxing their patients' protected health information.

Join us for an iExchange webinar! Do you have questions? Would you like training on how to use iExchange? We welcome the opportunity to share more information about iExchange with you and your staff. Our webinars spotlight recent enhancements, as well as navigation tips and key features of the online tool. For iExchange webinar dates, times and online registration, visit [iExchange](#) on BCBSTX's provider website.

Not enrolled for iExchange? Sign up now. iExchange is accessible to independently contracted physicians, professional providers, facility and ancillary providers who are participating in the various health benefit products offered by BCBSTX. For details and to sign up online, refer to [iExchange](#) on BCBSTX's provider website.

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.

CDC Guidelines for Prescribing Opioids for Chronic Pain

Part 3 of a 3-part series describing the new CDC guidelines for prescribing opioids. Part 1 and 2 were previously published.

In March of 2016, the Centers for Disease Control and Prevention (CDC) issued new recommendations for prescribing opioid medications for chronic pain, excluding reasons for cancer, palliative and end-of-life care.¹ These recommendations were in response to an increased need for provider education due to a nationwide epidemic of opioid overdose and opioid-use disorder.

The CDC has developed 12 recommendations, grouped into three areas of consideration:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up and discontinuation
- Assessing risk and addressing harms of opioid use

The first (Blue Review June 2016) and second (Blue Review August 2016) areas of consideration were discussed previously. The third area of consideration – assessing risk and addressing harms of opioid use – is described below.

Assessing Risk and Addressing Harms of Opioid Use

1. Before starting opioid therapy and during treatment, providers should assess the risk for opioid-related harms. Providers should evaluate strategies, such as offering naloxone, if there is an increased risk of opioid overdose due to history of overdose, high opioid dosages or concurrent benzodiazepine use.
 - Special populations that may be at higher risk of opioid related harms include: patients with sleep-disordered breathing (including sleep apnea), pregnant women, patients with renal or hepatic insufficiency, patients aged 65 years or older, patients with mental health conditions, patients with substance abuse disorder and patients with prior nonfatal overdose.
 - Naloxone, an opioid antagonist that can reverse severe respiratory depression, can save lives if used properly for opioid overdose. Friends and family who administer naloxone must be properly trained. Experts agree that providers should consider offering naloxone when prescribing opioids to patients at increased risk of opioid overdose, including patients with a history of overdose, substance abuse disorder or taking benzodiazepines with opioids. Resources for prescribing naloxone in a primary care setting can be found through ***Prescribe to Prevent*** at prescribetoprevent.org.
2. Providers should utilize state prescription drug monitoring program (PDMP) data and assess patient opioid history to determine whether or not there are any dangerous drug combinations occurring or if the patient is receiving unsafe quantities of controlled substances.
 - PDMPs are state-based databases that collect information on controlled prescription drugs dispensed by pharmacies and in some cases by dispensing physicians. The Texas Prescription Monitoring Program is located at TexasPATX.com.
 - Before an opioid prescription is written and dispensed, providers and pharmacists should review PDMP data to see if the patient is receiving high total opioid dosages or dangerous combinations that put the patient at risk for overdose.
3. Before starting opioid treatment, providers should use urine drug testing to assess whether or not the patient is already on controlled or illicit substances. The provider may want to consider urine testing at least annually as well.
 - Opioid pain medications in combination with other opioid pain medications, benzodiazepines or illicit substances can put the patient at increased risk of overdose and opioid related harms. Urine drug tests can provide information that the patient does not provide and can help detect drug seeking behaviors.
 - Providers can use urine drug test results to help with patient safety by tapering or discontinuing opioids if the member is at risk of opioid use disorder, offering naloxone or referring for behavioral treatment for substance use disorder.
4. As much as possible, providers should avoid prescribing opioid pain medication and benzodiazepines concurrently.
 - Concurrent benzodiazepine and opioid use can cause central nervous system and respiratory depression.
 - If opioid treatment is needed, providers should taper benzodiazepines gradually to prevent rebound side effects.
5. For patients with opioid use disorder, providers should offer to help with evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone combined with behavioral therapies.
 - Clinical evidence has found that opioid dependence in primary care settings is between three and 26 percent among patients with chronic pain on opioid therapy.

- Contextual evidence has found opioid agonist or partial agonist treatment with methadone maintenance therapy or buprenorphine may be helpful in preventing relapse in patients with opioid use disorder. Behavioral therapy with medication treatment is also recommended by clinical practice guidelines.
- Physicians must be certified to provide buprenorphine in an office-based setting. Physicians can receive training to receive a waiver from the Substance Abuse and Mental Health Services Administration.

¹Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain- United States, 2016. MMWR Recomm Rep 2016; 65:1-49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>.

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Online Claim Status Available: Availity® Claim Research Tool

As a reminder, **as of July 13, 2015**, Blue Cross Blue Shield of Texas (BCBSTX) Customer Service no longer assists with general claim status inquiries. BCBSTX supports electronic options as the most convenient, efficient and secure method of requesting claim status information for providers, health care professionals and billing agencies. Utilizing the Availity Claim Research Tool (CRT) provides expanded detailed status that will help expedite your patient account reconciliation process.

The CRT offers real-time claim status, along with better denial descriptions. This online tool allows you to search for claims by patient ID, group number and date of service, or by a specific claim number, also known as a Document Control Number (DCN). The CRT also enables you to check the status of multiple claims in one view.

BCBSTX hosts complimentary **Back to Basics: Availity 101** webinars for providers to learn how to use the electronic tools to their fullest potential. You are invited to register for an upcoming webinar on the BCBSTX provider website.

For additional information, refer to the [CRT Tip Sheet](#). You must be registered with Availity to utilize the CRT. For registration information visit availity.com, or contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548).

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Medicare Marketing Guidelines for Providers

The 2017 Centers for Medicare & Medicaid Services (CMS) Annual Election Period for beneficiaries is fast approaching. For those providers who have contracted with Blue Cross and Blue Shield of Texas (BCBSTX) to provide services to our Blue Cross Medicare Advantage (HMO)SM or Blue Cross Medicare Advantage (PPO)SM members, it's important to keep in mind the rules established by CMS when marketing to potential new members.

You may not be planning specific marketing activities, but what if a patient asks for information or advice? **Remaining neutral when assisting with enrollment decisions is essential.** See below for a partial listing of additional “Dos” and “Don’ts” for contracted providers, as specified within the CMS Medicare Marketing Guidelines (MMG) for contract year 2017 (excerpted from the section on Provider-based Activities):

<p>DO:</p> <ul style="list-style-type: none"> • Provide the names of Plans/Part D sponsors with which [you] contract and/or participate (see MMG section 70.11.2 for additional 	<p>DON'T:</p> <ul style="list-style-type: none"> • Accept Medicare enrollment applications • Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific
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<p>information on provider affiliation)</p> <ul style="list-style-type: none"> • Provide information and assistance in applying for the LIS* • Make available and/or distribute plan marketing materials in common areas • Refer [your] patients to other sources of information, such as SHIPs** plan marketing representatives, [the] State Medicaid Office, local Social Security Office, CMS' website at medicare.gov or 800-MEDICARE • Share information with patients from CMS' website, including the 'Medicare and You' Handbook or 'Medicare Options Compare' (from medicare.gov), or other documents that were written by or previously approved by CMS 	<p>plan based on financial or any other interests of the provider</p> <ul style="list-style-type: none"> • Mail marketing materials on behalf of Plans/Part D Sponsors • Offer inducements (e.g., free health screenings, cash, etc.) to persuade beneficiaries to enroll in a particular plan or organization • Accept compensation directly or indirectly from the plan for enrollment activities • Distribute materials/applications within an exam room setting
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The above list provides just a sampling of important points for your convenience. For a more in-depth review of the guidelines that are applicable to providers, please refer to the [Provider Medicare Marketing Guidelines](#) excerpt.

If you have questions about these guidelines or are planning marketing activities, please refer to the [Managed Care Marketing](#) page on CMS' website.

*LIS refers to low-income subsidy

**SHIPs are Senior Health Insurance Assistance Programs

This material is provided for informational purposes only and is not the provision of legal advice. If you have any legal questions with respect to CMS rules or regulations, you should seek the advice of legal counsel.

Implantable Device Vs. Medical Supply/Material

The National Uniform Billing Committee's (NUBC) definitions of implants are:

- Revenue Code 274 – Prosthetic/orthotic devices
- Revenue Code 275 – Pacemaker
- Revenue Code 278 – Other Implants

An **implantable device** is that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid plastic materials used to augment tissues, or to fill in areas traumatically or surgically removed. Also included is an object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.

Examples of other implants reported under revenue code 278 include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds (not an all-inclusive list).

Supplies that are not implantable should be submitted as **supply charges**. In conjunction, a device is not a "material or supply furnished incident to a service." Items used as routine supplies should not be submitted as an implant.

Guide wires, catheters and clips that are used during surgery, but do not remain in the body, are used the same way as an instrument and are not "implanted" should not be submitted as an implant.

Additional reference and definition of implantable devices, supplies and materials can be located in the UB04 Editor and the website of the implantable device's manufacturer.

Preventing Falls at Home

As we age, we want to live in the comfort and security of our own homes for as long as possible. Luckily, we can make simple changes at home to help prevent falls.

Staying healthy and strong is important to preventing falls. Stay active! Spending time with friends and family, participating in hobbies and exercising regularly can help keep the mind and body healthy.

Here are some key ways to prevent falls:

- **Bathrooms:** Install grab bars in the shower or tub. They make it easier to get in and out safely. A night light provides additional lighting.
- **Stairs:** Install lights over stairs, steps and landings to make your home brighter. Remove items from the stairs to keep the area clutter free. Provide handrails on both sides of the stairs from top to bottom.
- **Bedrooms and Hallways:** Adding night lights can help brighten the way. Tape down area rugs; better yet, consider not using them.
- **Vision:** Have your vision checked regularly.
- **Convenience:** Keep items you use a lot in cabinets or drawers that are in easy reach.

Resource: [Centers for Disease Control and Prevention](#)

Health Information and Vulnerable Populations: Q&A With Dr. Esteban Lopez

Efforts to make health care accessible and effective face special challenges among those with low-income, people whose first language isn't English and the uninsured. In this interview with the health care consulting firm Oliver Wyman Health, Dr. Esteban Lopez, Blue Cross and Blue Shield of Texas Chief Medical Officer & Market President, Southwest Texas, explains how community engagement, careful attention to language and cultural differences, and tailored approaches to delivery of care can help overcome those challenges.

Reminder: Pass-through Billing

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

The performing physician, professional provider or facility and ancillary provider should bill for these services 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 or facility and ancillary provider is performed at the place of service of the ordering provider and is billed by the ordering physician or professional provider.
- The service is provided by an employee of a physician, professional provider or facility and ancillary provider (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 this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used *ONLY* if they assist at surgery.)

- **SA modifier:** A supervising physician should use this modifier when billing on behalf of a PA, APN or CRNFA for **non-surgical** services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that *DOES NOT* include surgery.)
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Reminder: New Preauthorization Requirements through eviCore

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 (outlined below).

Effective Oct. 3, 2016, eviCore will manage pre-service authorization for the following specialized clinical services:

- Molecular and genomic testing
- Radiation oncology for all outpatient and office services

These new preauthorization requirements apply to the **Blue Advantage HMOSM (and Blue Advantage PlusSM HMO product)** provider networks.

The updated **Blue Advantage HMO and Blue Advantage Plus HMO Preauthorization/Referral Requirements** list has been updated to include the **services listed above that require preauthorization through eviCore, for dates of service beginning Oct. 3, 2016**. The updated preauthorization list will be located on the provider website at bcbstx.com/provider under the Standards & Requirements tab and General Reimbursement Information section. Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.

For all **other** services that require a referral and/or preauthorization, as noted on the Preauthorization/Referral Requirements list, you will continue to use iExchange[®]. iExchange is accessible to physicians, professional providers and facilities contracted with BCBSTX. For more information or to set up a new iExchange account, please go to bcbstx.com/provider/tools/iexchange.html.

BCBSTX and eviCore will be providing additional information in the coming weeks, on the provider website at bcbstx.com/provider and in *Blue Review*, including:

- Training opportunities/webinars
- How to register with eviCore on their website
- eviCore phone and fax number

You may also contact your Network Management consultant for more information.

Reminder: Use the Correct Place of Service Codes When Billing

Blue Cross and Blue Shield of Texas (BCBSTX) would like to remind all providers to bill with the correct, "original place of service" codes when billing for all services. Billing with the valid place of service is very important and allows claims to be adjudicated more efficiently.

Patient [eligibility and benefits](#) should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership validation, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It's strongly recommended that providers **ask to see the member's ID card for current information and photo ID** to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

Reminder: Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2016

Drug List (Formulary) Changes

Based on the availability of new prescription medications and the Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some revisions were made to the Blue Cross and Blue Shield of Texas (BCBSTX) **Standard drug list** and **Generics Plus drug list** that

became effective on July 1, 2016.

Brand Medications Added to the Standard and Generics Plus Drug Lists, Effective July 1, 2016:

Preferred Brand ¹	Drug Class/Condition Used For
Adynovate	Hemophilia
Brilinta	DVT, Stroke and Embolism Prophylaxis
Coagadex	Hemophilia
Depen	Wilson's Disease, Cystinuria
Narcan	Opiate Overdose
Uptravi	Pulmonary Arterial Hypertension

Brand Medications Added to the Generics Plus Drug List, Effective July 1, 2016:

Preferred Brand ¹	Drug Class/Condition Used For
Eliquis	DVT, Stroke and Embolism Prophylaxis

Utilization Management Program Changes

Effective July 1, 2016, several drug categories and/or targeted medications were added to the current Prior Authorization (PA) and Step Therapy (ST) programs for BCBSTX select members on standard pharmacy benefit plans.

Drug Categories Added to the Pharmacy PA Standard Programs, Effective July 1, 2016:

Drug Category	Targeted Medication(s) ^{1, 2}
Ophthalmic Immunomodulators	Restasis

Targeted Drugs Added to Current Pharmacy PA Standard Programs, Effective July 1, 2016:

Drug Category	Targeted Medication(s) ^{1, 2}
Therapeutic Alternatives	Kadian, Northera, Onmel, Sporanox, Spritam, Zegerid, Zylfo/Zyflo CR

Drug Categories Added to Current Pharmacy ST Standard Programs, Effective July 1, 2016³:

Drug Category	Targeted Medication(s) ^{1, 2}
Atypical Antipsychotics	Abilify, Abilify Discmelt, Abilify Maintena, Aripiprazole ODT, Aristada, Clozaril, Fanapt, Fazaclo, Clozapine ODT, Geodon, Invega, Invega Sustenna, Invega Trinza, Latuda, Rexulti, Risperdal, Risperdal M-Tab, Risperdal Consta, Saphris, Seroquel, Seroquel XR, Versacloz, Zyprexa, Zyprexa Zydis, Zyprexa Relprev

For the most up-to-date drug list and list of drug-dispensing limits, visit the Pharmacy Program section of our website at bcbstx.com/provider.

¹Third party brand names are the property of their respective owners.

²These lists are not all inclusive. Other medications may be available in this drug class.

³Members on a current drug regimen will be grandfathered from participation in the ST program.

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 other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

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Notices and Announcements

BCBSTX Announces New PPO Contracted Air Transportation Provider for Members

On Aug. 1, 2016, Alacura will begin providing scheduled, non-emergency medical transportation using fixed-wing (airplane) aircraft services from provider to provider (including connecting ground transportation) for Texas PPO group members. HMO and government program members are excluded from the program.

Non-contracted and/or non-medically necessary air ambulance transports can expose our members to significantly greater out-of-pocket costs and are much costlier for employers. We believe Alacura will greatly benefit our members by assisting them with coordination and servicing of medically appropriate air ambulance transportation.

Facilities should continue to coordinate pre-arranged, non-emergency air ambulance transportation with the assigned BCBSTX nurse (refer to the pre-notify or pre-authorization medical phone number on the back of the member's ID card). BCBSTX will then notify Alacura of the pre-authorized flight for coordination and servicing. Air ambulance coverage is based on current member benefits as well as medical necessity review. Providers may contact Alacura at 844-4ALACURA (844-425-2287) to follow-up on flight coordination.

Member eligibility and benefits should be verified prior to rendering service. Eligibility and benefit quotes include: membership verification, coverage status and other important information, such as an applicable copayment, co-insurance and deductible amounts. We strongly recommend that providers ask to see the member's ID card for current information and photo ID to guard against medical identity theft. When services are not eligible for coverage, members should be notified that they may be billed directly.

Our growing portfolio of product offerings is part of BCBSTX's efforts to meet its goal of increasing access and affordability of health care products to our members and the community that we serve. Making it easier for you and your staff to conduct business with us is equally important. We appreciate your patience, cooperation and support as we work to adapt to this new air ambulance transportation option.

Remittance Viewer Webinars

The remittance viewer offers providers and billing services a convenient way to retrieve, view, save or print claim detail information and help reconcile claim data provided by Blue Cross and Blue Shield of Texas (BCBSTX) in the 835 Electronic Remittance Advice (ERA).

To gain access to the remittance viewer, you must be a registered Availity[®] user, enrolled to receive the Availity ERA. Online enrollment for ERA may be completed via the [Availity web portal](#). For additional details, view the [Remittance Viewer Frequently Asked Questions](#) and the [Remittance Viewer Tip Sheet](#). Online training sessions have been scheduled to provide an introduction to the remittance viewer. Participants will learn how to gain or grant access, conduct a search, view general and payer-specific information, and save or print results. In addition, a Question and Answer time will be available.

Note: Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSTX claim number will not be adjudicated. 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, please refer to [Electronic Replacement/Corrected Claim Submission](#) (PDF).

Refer to [Remittance Viewer Webinars](#) on our website and select a date and time to attend:

- [Sept. 7, 2016 – 11 a.m. to noon CT](#)
- [Sept. 14, 2016 – 11 a.m. to noon CT](#)
- [Sept. 21, 2016 – 11 a.m. to noon CT](#)
- [Sept. 28, 2016 – 11 a.m. to noon CT](#)

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directly.

In Every Issue

The following is information that 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.

Reminder: Corrected Claim Request Change, Effective July 11, 2016

As a reminder, effective July 11, 2016, 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 entirely 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.

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

HMO Blue TexasSM, Blue Advantage HMOSM and Blue PremierSM members require a referral from their 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 **HMO Blue Texas, 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 **HMO Blue Texas** and **Blue Advantage HMO**, and for **Blue Premier** and **Blue Premier AccessSM**, is available on the BCBSTX Provider website. Under the 'Standards and Requirements' tab, click on [General Reimbursements](#) (password is 'manual') and scroll down to the "Preauthorization/Notification/Referral Requirements Lists".

Blue Advantage PlusSM HMO Point of Service (POS) is a benefit plan that allows 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 **HMO Blue Texas, Blue Advantage HMO and Blue Premier Provider Manual** for more detail including when to utilize the [Out-of-Network Enrollee Notification Form](#).

Importance of Obtaining Preauthorization for Initial Stay and Add-on Days

Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or professional provider obtains preauthorization for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

If an insured person does not obtain preauthorization for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

Preauthorization does not guarantee payment. All payments are subject to determination of the insured person'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.

Implantable Device Versus Medical Supply/Material

We have received a number of questions from providers about billing for implants. To help address the topic, we have provided a reminder about the National Uniform Billing Committee definition of an implant.

National Uniform Billing Committee (NUBC) definition of an implant:

- Revenue Code 274 – Prosthetic/orthotic devices
- Revenue Code 275 – Pacemaker
- Revenue Code 278 – Other Implants

An implantable device is that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Also

included is an object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.

Examples of other implants reported under revenue code 278 include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds (not an all-inclusive list).

Supplies that are not implantable should be submitted as supply charges. In conjunction, a device is not a "material or supply furnished incident to a service." Items used as routine supplies should not be submitted as an implant. Guide wires, catheters and clips that are used during surgery but do not remain in the body are used the same way as an instrument and are not "implanted" should not be submitted as an implant.

Additional reference and definition of implantable devices, supplies and material can be located in the UB04 Editor and the website of the implantable device's manufacturer.

Enrollee Notification Form Required for Out-of-network Care for Blue Choice PPOSM and Blue Advantage HMOSM (for Blue Advantage Plus)

Effective Jan. 1, [an out-of-network care form](#) is required to be completed by the referring network physician for enrollees of **Blue Choice PPOSM** and **Blue Advantage HMOSM (for Blue Advantage Plus point-of-service benefit plan only)**, prior to referring or directing an enrollee to an out-of-network physician, professional provider, hospital, ambulatory surgery center or other facility, for non-emergency services, if such services are available through an in-network provider.

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 BCBSTX 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.

Prior to referring or directing a **Blue Choice PPO or Blue Advantage Plus** enrollee to an out-of-network provider for non-emergency services, referring network physicians must complete this form if such services are also available through an in-network provider. The referring network physician must provide a copy of the completed form to the enrollee and retain a copy in his or her medical record files.

Use of this form is subject to periodic audit to determine compliance with this administrative requirement outlined in the provider manuals.

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.

Blue Choice PPOSM Subscribers/Blue Advantage HMOSM Member Rights and Responsibilities

As a provider for 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:

<ul style="list-style-type: none"> • Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities. • Make recommendations regarding the organization's subscribers' rights and responsibilities policy. 	<ul style="list-style-type: none"> • Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.
<ul style="list-style-type: none"> • Participate with practitioners in making decisions about your health care. 	<ul style="list-style-type: none"> • Follow the plans and instructions for care you have agreed to with your practitioner.
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

HMO Blue Texas Member Rights and Responsibilities

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 (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OBGyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, in order 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 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.

Fee Schedule Updates

Reimbursement changes and updates for Blue Choice PPO, HMO Blue Texas (Independent Provider Network only), Blue Advantage HMO and Blue Premier practitioners will be posted under Standards and Requirements / General Reimbursement Information / Reimbursement Schedules and Related Information / Professional Schedules section on the BCBSTX provider website at bcbstx.com/provider.

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. To view this information, visit the [General Reimbursement Information](#) section on the BCBSTX provider website. The CPT/HCPCS Drug/Injectable codes Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule will be updated monthly.

After-hours Access Is Required

BCBSTX requires that primary care physicians, 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 or on-call physician;
- 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 or on-call physician and the phone number is provided.

For more detail, [please refer to the provider manuals](#) for **Blue Choice PPOSM Physician, Professional Provider and Facility and Ancillary Provider Manual** (Section B) and **HMO Blue TexasSM / Blue Advantage HMOSM / 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).

BCBS Medicare Advantage PPO Network Sharing

What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPOSM 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 as long as 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 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:

- Log in to the [Availity Portal](#), the [Availity Revenue Cycle Management Portal](#) or your preferred vendor
- Enter required data elements
- 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.

Medical Record Requests: Include Our Letter as Your Cover Sheet

When you receive a letter from 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!

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 particular 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 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 based on the fact that the global physician's or professional provider's reimbursement includes staff and equipment.

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 a 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 **ProviderPortalSM** 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 BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.*

Quest Diagnostics, Inc., Is the Exclusive HMO and Preferred Statewide PPO Clinical Reference Lab Provider

Quest Diagnostics, Inc., is the **exclusive** outpatient clinical reference laboratory provider for HMO Blue TexasSM members and Blue Advantage HMOSM subscribers,* and the **preferred statewide** outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPOSM 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:

- On-line 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 capitated 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 or facility or ancillary provider's office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician's, professional provider's or facility or ancillary provider's offices will not be reimbursed. 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.*

Improvements to the Medical Records Process for BlueCard[®] Claims

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 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).

In the event that 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.

Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the 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

In an effort to streamline the medical policy review process, you can view draft medical policies on the 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.

No Additional Medical Records Needed

Physicians, professional providers or facility or ancillary provider who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) from AIM Specialty Health need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

Predetermination does not guarantee payment. All payments are subject to determination of the insured person'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.

Importance of Obtaining a Preauthorization/Referral

A preauthorization/referral is required for certain types of care and services. Although BCBSTX participating physicians, professional providers and facility and ancillary providers are required to obtain preauthorizations/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.

Preauthorizations/referrals must be obtained for any services provided by someone other than the member's primary care physician (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.

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.

Avoidance of Delay in Claims Pending COB Information

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.

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.

Access the [Standard Drug List Dispensing Limits](#) and [Generics Plus Drug List Dispensing Limits](#) documents online.

Prescription Drug Lists

Throughout the year, the 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.

Are Utilization Management Decisions Financially Influenced?

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.

Contact Us

View our [quick directory of contacts](#) at BCBSTX.

Update Your Contact Information

Accurate provider directories are an important part of providing BCBSTX members/subscribers with the information they need to manage their health. If any of your information has changed, [please update your contact information](#).

Disclaimer

BCBSTX makes no endorsements, representations, or warranties about any products or services offered by independent third-party vendors mentioned in this newsletter. The vendors are solely responsible for the products or services offered by them. If you have any questions about the products or services mentioned in this newsletter, contact the vendor directly.

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