BlueCross BlueShield of Texas

BLUE REVIEW℠

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

**July 7, 2017**

# Notices & Announcements

## Become a BCBSTX HealthSelect℠ of Texas Provider Today

**Are you currently providing or interested in providing health care services for Employees Retirement System of Texas (ERS) participants?** ERS will utilize the Blue Essentials℠ network to support its custom Point of Service (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 Sept. 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 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 runs 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.

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## 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.

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

We are excited to announce that 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 HealthSelect℠ benefit plans will access care through the **Blue Essentials℠** provider network in all 254 counties in Texas.

**ERS participant plan options:**

1. **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.
2. **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, refer to the **ERS HealthSelect 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's provider website.

In addition, BCBSTX has contracted with **eviCore™ healthcare (eviCore**), an independent specialty medical benefits management company, to provide utilization management services for the prior authorization requirements outlined below. The requirements are also indicated on the HealthSelect or Consumer Directed HealthSelect Prior Authorization/Notification/Referral Requirements lists for ERS participants.

- Molecular and genomic testing
- Radiation oncology for all outpatient and office services
- Advanced radiology imaging
- Sleep studies and sleep durable medical equipment

**To obtain prior authorization through eviCore you may use 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 (not listed above) that require a referral and/or prior authorization, providers should refer to the telephone numbers on participants' ID cards, or physicians, professional providers and facilities contracted with BCBSTX can access iExchange®. Go to iExchange to learn more or set up a new account.

Watch for additional information regarding ERS in future editions of this newsletter and on BCBSTX's provider website.

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



# Network Participation

### 2017 Blue Essentials℠ Benefit Option Highlights

Earlier this year, Blue Cross and Blue Shield of Texas (BCBSTX) announced the name change of their HMO Blue Texas℠ network to **Blue Essentials**. BCBSTX appreciates your participation in the new network and is excited to share additional information about a few health plans with access to the network.

The **Blue Essentials** network will be coupled with plan designs that help manage costs, and allow flexibility and customization like predefined deductibles, coinsurance and copayments for certain health care services. Below are highlights of three health benefit plan options that access the Blue Essentials network.

**Blue Essentials**

- Helps members manage costs because they are required to select a primary care physician and get referrals for services with network providers.
- Covers out-of-network coverage, except for emergency services.
- Provides emergency and urgent care when members are traveling out of state.
- Offers customer support and reference tools to guide members with making informed decisions about their benefits.

**Blue Essentials Access℠**

- Allows "open access" within the **Blue Essentials** provider network where primary care physician selection and referrals are **NOT** required (as of Jan. 1, 2017). This access gives opportunities to contracted physicians and hospitals throughout the state of Texas.
- Provides an alternative solution for members who are looking for cost savings while still having the freedom to choose in-network providers without selecting a primary care physician or obtaining a referral to see a specialist.
- Offers emergency and urgent care when members go out of network or are traveling out of state.

**HealthSelect℠ of Texas and Consumer Directed HealthSelect℠ Plan Design**

- Beginning Sept. 1, 2017, BCBSTX will administer HealthSelect of Texas and Consumer Directed HealthSelect for the Employees Retirement System of Texas (ERS). Eligible participants will access care through the Blue Essentials provider network in all 254 counties in Texas.

**Health Plans with Access to the Blue Essentials Network**

| Benefit Plan/Product Name | Network Code | Network | Mid- & Large Market Availability | Retail & Small Group Availability | Network Coverage | PCP Required | Referral Required | OON Benefits | Plan Design |
|---|---|---|---|---|---|---|---|---|---|
| Blue Essentials | HMO | Blue Essentials | 51-151 Fully Insured; 151+ Fully Insured & Self-funded/ ASO | N/A | State wide | Yes | Yes | No | HMO |
| Blue Essentials Access | HMO | Blue Essentials | 51-151 Fully Insured; 151+ Fully Insured & Self-funded/ ASO | N/A | State wide | No | No | No | HMO Open Access |
| HealthSelect of Texas | HME | Blue Essentials | ERS – Effective 9/1/2017 | N/A | State wide | Yes (for in-network benefit level) | Yes (for in-network benefit level) | Yes | POS |
| Consumer Directed HealthSelect | HME | Blue Essentials | ERS – Effective 9/1/2017 | N/A | State wide | No | No | Yes | Open Access HDHP/ HSA |

**Please note**: If you are currently a participating provider in the **Blue Essentials** (formerly HMO Blue Texas) provider network, no action is required on your part. **However, if you would like to be contracted for the Blue Essentials provider network, please go to the Blue Essentials Network Participation page on BCBSTX's provider website or contact your Network Management Representative.**

Watch for additional information regarding Blue Essentials in future editions of this newsletter and on BCBSTX's provider website.

# Claims & Eligibility

### Careful Documentation Paves the Way for Accurate Coding Capture

It all begins with you and your patients – this fact did not change with the transition to ICD-10. However, with ICD-10, a higher level of specificity in your documentation is necessary in many instances, including documenting laterality to support proper assignment of ICD-10-CM/PCS codes. To help ensure claims are properly billed and appropriate benefits are applied, your documentation must paint a clear and complete picture of each patient's condition with details to support subsequent diagnoses and treatment.

**Quality of Care, Provider Profiles and Reimbursement**

Careful documentation cannot be understated. It is important for auditing purposes because a patient's health record helps demonstrate adherence to quality of care measures. Also, medical record data is used to help develop provider report cards and to demonstrate meaningful use of electronic health records. Provider profiles can be made public through online transparency or comparison tools, and potential patients may use this information when they choose where to go for care. Additionally, accurately capturing the severity of illness may ultimately affect case management index weighting and different forms of reimbursement.

**Documentation Tools and Services**

Clinical documentation improvement (CDI) tools and services are widely available. As part of the transition to ICD-10 coding, many providers implemented CDI programs. Regardless of whether your organization or office has implemented a specific program, there are some basic CDI principles you can use to support accurate ICD-10 coding:

1. **Lay the groundwork** by outlining a complete history
2. **Go below the surface** by highlighting potential red flags and risk factors
3. **Include progress notes** to illustrate how the patient was monitored and evaluated
4. **Put the pieces together** with details on why decisions were made
5. **Focus on teamwork** between medical, coding and billing staff

**ICD-10 Coding – We're Here to Help Video**
For a quick overview of the importance of documentation and coding capture, we invite you to watch our a short video, which also includes a link to helpful information on BCBSTX's provider website.

*This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims. Health care providers are instructed to submit claims using the most appropriate codes based upon the medical record documentation and coding guidelines and reference materials.*

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## Reminder: Medicare Advantage Plans Overpayment Recovery

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

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<br>Dallas, 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
P.O. 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.*

# Education & Reference

### The Keys to Unlocking a Great Discharge Summary

Physicians and other practitioners need to know details about care a patient receives during an inpatient hospital stay. The hospital discharge summary is the key source for this information.

Studies have shown that providing timely, structured discharge summaries to practitioners favorably impacts readmission rates, patient satisfaction and continuity of care. One study found that at discharge, approximately 40 percent of patients have test results pending and that 10 percent of those require some action.

Primary Care Physicians (PCP) and patients may be unaware of these results[1]. A prospective cohort study found that one in five patients discharged from the hospital to their homes experienced an adverse event, defined as an injury resulting from medical management rather than from the underlying disease, within three weeks of discharge[2]. This study found 66 percent of these were drug-related adverse events[3].

**Key information often missing from discharge summaries includes:**

- diagnostic test results
- treatment or hospital course
- discharge medications with reasons for changes
- test results pending at discharge
- follow-up plans

**Provider Satisfaction Surveys**

The Blue Cross and Blue Shield of Texas (BCBSTX) Provider Satisfaction Surveys include questions about practitioner satisfaction with hospital discharge summaries. Below are the 2015 and 2016 survey results. While solid improvement is seen across the measures, improvements in timelines and content can still be made.

| Survey Question | Goal | BCBSTX 2015 Results | BCBSTX 2016 Results |
|---|---|---|---|
| 34. When your patients are admitted to a hospital, are you sent summary information after the discharge? | 85% | 72% | 80% |
| 35. When you receive hospital discharge information, does it reach your office within five business days? | | 80% | 84% |
| 36. When you receive hospital discharge information, does it contain adequate information about medications at discharge? | | 88% | 89% |
| 40. Overall Satisfaction with Continuity of Care | | 76% | 80% |

Communications between the hospital and PCPs is critical to ensure a smooth and durable transition of the patient to the next level of care.

BCBSTX applauds practitioners who have adopted a structured approach to discharge summaries and strongly encourages those who have not to consider adopting this practice.

**Sources**

[1] Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143(2):121–8.

[2] Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161–7.

[3] Snow, V., MD. (2009). Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. Journal of Hospital Medicine, 4(6), 364-370. doi:10.1002

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# Clinical Resources

### 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.

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### FEP® Self-measured Blood Pressure Monitoring

The Blue Cross and Blue Shield Federal Employee Program® (FEP) and the American Medical Association (AMA) are working together to provide physicians with resources designed to improve health outcomes for patients with hypertension or suspected hypertension. This effort supports the goals of the Million Hearts® initiative.

Information covering self-measured blood pressure monitoring, a component of the Improving Health Outcomes: Blood Pressure Program developed by the AMA, is designed to help you and your office staff engage your patients in the self-measurement of their own blood pressure. According to a 15-member task force appointed by the Centers for Disease Control and Prevention (CDC), when physicians and their office staff engage their patients in the self-measurement of their own blood pressure combined with additional support (i.e., patient counseling, education or web-based support), self-measured blood pressure monitoring becomes very effective and cost efficient.

**Free Blood Pressure Monitors**

In support of this effort, FEP initiated a program to provide free blood pressure monitors* to FEP enrollees over age 18 who have a diagnosis of hypertension or have high blood pressure without a diagnosis of hypertension. If you have a patient who completes the Blue Health Assessment (BHA) and reports they have high blood pressure, and then you and your patient discuss home monitoring, your patient is then eligible to receive a free blood pressure monitor.

**Wellness Incentive Program**

The BHA is a health-risk assessment and the first step in the FEP Wellness Incentive program. In addition to the free blood pressure monitor, members can earn financial incentives for completing the BHA and for achieving goals related to a healthy lifestyle. FEP members can go to www.fepblue.org for more information.

Please do not hesitate to contact FEP Customer Service at 800-442-4607 for more details regarding this program.

*The blood pressure monitors were selected by Blue Cross and Blue Shield. The AMA does not endorse any particular brand or model of blood pressure monitor.

*The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.*

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## 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℠**. Over the coming months, additional BCBSTX products and services are being added as indicated below.

The following is a summary of the pre-service authorizations for specialized clinical services that eviCore will manage. Be sure to closely review the effective dates and services included for each individual product as they do vary.

### Blue Cross Medicare Advantage (HMO)℠ and Blue Cross Medicare Advantage (PPO)℠

**Effective June 1, 2017:**

- **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**

### Blue Choice PPO℠ and Blue Premier℠ Fully Insured Members* (identified by TDI listed on their membership card)

**Effective Aug. 1, 2017:**

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

*Currently, the eviCore preauthorization requirement does not include Administrative Services Only (ASO) Blue Choice PPO or Blue Premier members.

### Blue Essentials℠ and Blue Essentials Access℠ Fully Insured Members* (identified by TDI listed on their membership card)

**Effective Sept. 1, 2017:**

- **Molecular and genomic testing**
- **Radiation oncology for all outpatient and office services**
- **Advanced radiology imaging**
- **Sleep studies and sleep durable medical equipment**

*Currently, the eviCore preauthorization requirement does not include Administrative Services Only (ASO) Blue Essentials or Blue Essentials Access members.

### Employee Retirement System of Texas (ERS): HealthSelect of Texas and Consumer Directed HealthSelect
**Effective Sept. 1, 2017:**

- **Molecular and genomic testing**
- **Radiation oncology for all outpatient and office services**
- **Advanced radiology imaging**
- **Sleep studies and sleep durable medical equipment**

### Blue Advantage HMO and Blue Advantage Plus℠ HMO
**Effective Oct. 3, 2016:**

- **Outpatient Molecular Genetics**
- **Outpatient Radiation Therapy**

The updated **Preauthorization/Referral/Notification Requirements Lists** and the **Prior Authorization and Referral List for ERS** can be found on the Clinical Resources page of BCBSTX's provider website. These lists include the services that require preauthorization or prior authorization through **eviCore** for the effective dates listed above.

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.

Preauthorization or ERS prior authorization through **eviCore** 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 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.

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# In Every Issue – July 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

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## Authorizations and Referrals

### Real-time Preauthorization and Predetermination Notifications

Beginning April 1, 2017, we 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 you 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.*

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### 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.

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### 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.*

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

**Blue Essentials℠** (formerly known as HMO Blue Texas℠), **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 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 Blue Essentials (formerly known as **HMO Blue Texas), 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)**.

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### 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.

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### 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 PPO℠ 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 **Provider**Portal℠ 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.*

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### 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.

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.

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### 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.

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# Benefits and Eligibility

### BCBS Medicare Advantage PPO Network Sharing

**What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO℠ 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:

- Log in to the Availity Web 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.

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# Claims

### 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.

| IVR Contained Benefit Categories Effective Dec. 12, 2016 | Additional IVR Contained Benefit Categories Effective June 19, 2017 |
|---|---|
| Allergy<br>Colonoscopy<br>Consultations<br>Coordinated Home Care<br>Electrocardiogram (EKG)<br>Extended Care Facility<br>Hospital<br>Inhalation Therapy<br>Laboratory<br>Mammogram<br>Office Services<br>Office Visit<br>Pap Smear<br>Physical Exam<br>Preventive Care<br>Private Duty Nursing<br>Ultrasound<br>X-ray | 23-hour Observation<br>Air Ambulance<br>Anesthesia<br>Assistant Surgeon<br>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)℠ or Blue Cross Medicare Advantage (HMO)℠ 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.*

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### 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.

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### Flublok Quadrivalent Billing

Effective Jan. 1, 2017, the American Medical Association approved the use of Current Procedural Terminology (CPT®) code 90682 (influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use), which best describes Flublok Quadrivalent. Flublok Quadrivalent is for persons 18 years of age and older. Please be aware that Flublok Quadrivalent is not yet accessible for administration. Once available for the 2017-2018 flu season, BCBSTX will cover CPT 90682 when used appropriately.

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### 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.

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### 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.*

*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.*

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### Rescheduled Implementation Date of Additional Code-auditing Software

In February 2017, Blue Cross and Blue Shield of Texas (BCBSTX) published an article about the implementation of the 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 & 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.

*ConVergence Point is a trademark of Verscend Technologies, Inc., an independent third party vendor that is solely responsible for its products and services.*



*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.*

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### 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.

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### 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.

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### Reminder: Pass-through Billing

Blue Cross and Blue Shield of Texas (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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### 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.

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### 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.

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## 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.

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## 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.

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## Implantable Device Versus Medical Supply/Material

We have received several 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 definitions of implantable devices, supplies and material are in the UB04 Editor and the website of the implantable device's manufacturer.

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### 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.

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## Clinical Resources

### 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

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### 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:**

1. **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.

2. **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.

3. **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.

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**2015 Continuity and Coordination of Care Report Results, and Recommended Interventions** Continuity and coordination of care is important to the care of members. Therefore, it is important that the Primary Care Physician/Provider (PCP) be kept informed of a member's condition and any treatment provided by specialist providers (SCP), ancillaries or other health care providers.

Blue Cross and Blue Shield Texas (BCBSTX) monitors the continuity and coordination of care between PCP and specialist providers across the health care network, at least annually. From 2014 Physician Office Review evaluations, opportunities were identified to improve communication between PCP and specialist consultations. The BCBSTX 2015 Provider Satisfaction Survey was modified to include questions related to continuity and coordination of care to better analyze strengths and opportunities.

**Specific questions were added to the following areas:**

- Referral to an ophthalmologist or optometrist for patients requiring a diabetic eye exam and receiving results
- Timely discharge summary data for patients who have been hospitalized is provided to practitioners and includes medication administration instructions

The audits from the Physician Office Review Program had high scores related to continuity and coordination of care. One consideration from the evaluation is that offices were randomly selected without knowledge of patients that required continuity and coordination services from other providers. This resulted in very small denominator of records to assess for continuity and coordination of care.

Recommendation for future studies is that the methodology should be evaluated to generate a sample of members in need of continuity and coordination of care.

**In the 2015 Provider Satisfaction Survey the following items scored less than the target of 85 percent:**

- Receiving eye exam results from eye care professionals
- Receiving summary information after inpatient discharge
- Overall satisfaction with continuity of care

| Survey Question | Goal | BCBSTX 2015 Score |
|---|---|---|
| 33. Do ophthalmologists and optometrists inform you of their findings after seeing patients you referred for diabetes eye exams? | 85% | 77% |
| 34. When your patients are admitted to a hospital, are you sent summary information after the discharge? | | 72% |
| 35. When you receive hospital discharge information, does it reach your office within five business days? | | 80% |
| 36. When you receive hospital discharge information, does it contain adequate information about medications at discharge? | | 88% |
| 40. Overall Satisfaction with Continuity of Care | | 76% |

The findings of this survey recognize the barriers to care that impact continuity-of-care coordination and BCBSTX's HEDIS rates. The possibilities for improvements were identified to remove barriers impacting continuity and coordination of care.

**To support continuity and coordination of care, BCBSTX is recommending the following interventions:**

1. Specialists should provide a report to the Primary Care Physician/Provider summarizing the member's visit, the services provided and recommended follow-up treatment or needs.
2. Hospitals provide timely discharge summary reports to primary care physicians/providers that include a synopsis of the stay, treatment or procedures done, follow-up needs and a list of discharge medications.

Please contact Quality Improvement Programs at 800-863-9798 with questions or comments.

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# 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.*

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### 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.

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## 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.

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## Corrected Claim Request Change, Effective as of 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 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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# 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.

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## 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

### 2. 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.*

### 3. 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.

### 4. 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.*

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### 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.

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### 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.

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## Provider General Information

### Medicare Outpatient Observation Notice Requirement

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

As of March 1, 2017, the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) required 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.

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### 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.

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### 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 Essential ( formerly known as HMO Blue Texas℠),Blue Advantage HMO℠, 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).

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### 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!

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### 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 Blue Essentials℠ (formerly known as HMO Blue Texas℠) members and Blue Advantage HMOSM subscribers* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (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 Blue Essentials (formerly known as HMO Blue Texas) members. Please note all other lab services/tests performed in the physician's or professional 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.*

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### 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.

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### 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.

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## 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. |
| Be 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.<br>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.

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**Contact Us**
View our quick directory of contacts for BCBSTX.

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**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.

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**bcbstx.com/provider**
Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association