November 2018

NOTICES & ANNOUNCEMENTS

Medicare Advantage: Interpreting the 'PLB' Segment on the 835 Electronic Remittance Advice (ERA)

Please share this document with your practice management/hospital information system software vendors for assistance on submitting reversal or corrected claims for Medicare Advantage members.

New Application Process for Joining BCBSTX Networks

Blue Cross and Blue Shield of Texas (BCBSTX) welcomes providers to apply to join its networks. To make the process of applying fast and easy, soon prospective providers will be able to fill out a new electronic Provider Onboarding form. This electronic form streamlines the application process and lessens the amount of time it takes to get a response.

The Provider Onboarding form will help set up a provider record number and will allow providers to indicate in which networks they would like to participate. The new electronic form will be posted under the Network Participation/How to Join section on the BCBSTX provider website.

The form should be filled out by:

- Individual providers new to BCBSTX's networks
- Groups and clinics new to BCBSTX's networks
- Existing contracted groups or clinics that are adding a new provider

If you have any questions or if you need additional information, please visit the BCBSTX provider website or contact your local BCBSTX Network Management Representative.

Prostate Cancer Screening Benefit Level Change

Currently, Blue Cross and Blue Shield of Texas (BCBSTX) covers prostate cancer screening at no member cost-share when billed with a preventive diagnosis.

Beginning Jan. 1, 2019, this screening will no longer be covered at the no member cost-share level. Instead, it will be treated as a standard medical benefit and any applicable cost sharing (copay, coinsurance and deductible) may apply based on the member's health plan.

This initiative applies to all non-grandfathered retail and group members. It does not apply to members who have Medicaid or Medicare plans.

What does this mean for you? You may now need to seek payment from both BCBSTX and the member.

Note: Some groups may elect to continue coverage at the no member cost-share level. Members may confirm their coverage by calling the number on the back of their customer ID card.

You should check eligibility and benefits electronically through Availity®, or your preferred Web vendor. Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

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New Lactation Consultation Designation added to Demographic Change Form

Effective Aug. 24, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) implemented a new designation on Provider Finder® called Lactation Consultation. The Lactation Consultation designation can be used for network providers who offer lactation support services to members (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal and postpartum periods. This type of service is often provided by OB-GYNs, pediatricians, certified nurse midwives, certified nurse practitioners, certified nurse specialists and other providers acting within the scope of their license.

If you provide this type of service, please use the online Demographic Change form to initiate the process of identifying that you or your practice offer lactation consultation services. Adding this designation to your profile in Provider Finder will help existing and prospective members get access to these services easier.

You may also use the Demographic Change form located on the Information Change Request page to update your location, phone number, email or other important details on file with BCBSTX.

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

Prepping for the 2018-2019 Flu Season

Flu season is upon us and Blue Cross and Blue Shield of Texas (BCBSTX) wants to provide you with immunization updates to give your patients and our members the best possible care.

The Centers for Disease Control and Prevention (CDC) recommends yearly flu shots for all patients ages six months and older without contraindications during the 2018-2019 influenza season. Clinicians may administer any licensed, age-appropriate flu shot. The prefilled intranasal sprayer flu vaccine, which was not recommended the past two flu seasons, is now recommended for this season. Please remember, it's vital to review the "Table of Approved Vaccines" on the CDC website for the most recent updates on newly available products and the approved age ranges.

For 2018-2019, there is a new preservative-free flu vaccine, Fluad Quadrivalent Pediatric® with adjuvant MF59, for children 6 to 23 months of age. The Current Procedural Terminology (CPT®) code is 90689 for claims processed with dates of service on or after Jan. 1, 2019. Before Jan. 1, 2019, claims may be submitted with 90749-Unlisted vaccine/toxoid or Q2039-Influenza virus vaccine, not otherwise specified.

Also, please file your claims with the accurate coding. The coding chart from the American Academy of Pediatrics (AAP) indicates which billing code to use based on the vaccine administered (this chart is not a comprehensive list). When billing flu vaccines, please note code descriptions may contain specifics to vaccine products such as dosage, formulations (such as trivalent vs. quadrivalent), preservative vs.

preservative-free, or other distinctive features (i.e. split virus, recombinant DNA, cell cultures, or adjuvanted).

Details on our complete approved immunization schedule can be found on the BCBSTX provider website under Standards & Requirements, Clinical Payment and Coding Policies, "Preventive Services Policy CPCP006".

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New Preventive Service for Medicare Members at Risk for Type 2 Diabetes

The Medicare Diabetes Prevention Program (MDPP) has been proven by a National Institutes of Health (NIH) trial to greatly reduce the progression of prediabetes to type 2 diabetes[1]. Effective immediately, your at-risk senior patients who have a Blue Cross and Blue Shield of Texas (BCBSTX) Medicare health plan and meet the eligibility criteria can participate in this program at no cost to them.

MDPP Eligibility Criteria:

- Blood value:
  - Fasting plasma glucose of 110 to 125 mg/dL, or
  - A1C value between 5.7 to 6.4, or
  - Oral glucose tolerance test between 140 to 199 mg/dL
- BMI greater than 25 (or if Asian, greater than 23)
- No diagnosis of end-stage renal disease, type 1 or type 2 diabetes; previous gestational diabetes is not an exclusion to participation

BCBSTX has partnered with Solera Health Inc. (Solera) to facilitate MDPP services for our members. Solera will work closely with members to enroll them in programs in their area.

This program is meant to help participants change their lifestyle, establish healthy habits and lose five to nine percent of their body weight. This modest weight loss dramatically decreases the risk of developing type 2 diabetes.

This two-year program is focused on encouraging healthier food choices and increased activity. The first year includes weekly lessons in a small group setting for six months, followed by monthly lessons for six months. The second year provides ongoing support for participants who, during the first year, meet the five percent weight-loss goal and attend a minimum of two sessions every three months. Throughout the two years, participants have access to a one-on-one lifestyle health coach to help set goals and stay on track.

Your patients who may be eligible have already received letters from BCBSTX informing them of Solera's services. If you or your patients need additional information, please refer to the FAQs below. Patients can verify their eligibility and enroll in the program by going to solera4me.com/bcbstx or by calling 866-671-8597 (TTY 771), Monday through Friday from 8 a.m. to 8 p.m. CT.

Solera Health Medicare Diabetes Prevention Program – Provider FAQ

Q: What is the MDPP (also known as the National Diabetes Prevention Program [NDPP])?
A: The MDPP is an evidence-based lifestyle program that prevents or delays the progression of prediabetes to type 2 diabetes by helping participants lose weight and adopt healthy habits.

Q: How effective is the MDPP in reducing the risk of type 2 diabetes?
A: The NIH demonstrated in a 2002 randomized controlled trial of over 3,000 adults that the NDPP reduced the risk of developing type 2 diabetes by 58 percent, a significant improvement over Metformin. Numerous translation studies have shown similar results in all age groups; however, the MDPP was most effective in those over age 65.[1]

Q: What is the MDPP?
A: The MDPP is the NDPP available to those Medicare beneficiaries who meet the program eligibility requirements. The MDPP uses the same curriculum as the NDPP, but the eligibility requirements for

Medicare coverage are more targeted in that they require qualifying blood values before enrollment. While the NDPP can be provided either in-person or virtually, the MDPP must be delivered in-person. The MDPP program is a once in a lifetime service delivered for a period of two years for members who meet sustained engagement and weight loss targets.

Q: What's included in the program?
A:

- **Core Services:** 16 weekly lessons over the first six months, followed by monthly sessions over the last six months
- **Ongoing Maintenance:** Second year of maintenance sessions for those who meet the 5 percent weight-loss goal and attend a minimum of two sessions per three-month period
- **Lifestyle health coach** helps set goals and keeps participants on track
- **Small, in-person group** for support and encouragement

Q: Who is eligible for the program?
A: MDPP is a covered preventive service for eligible Blue Cross Medicare Advantage℠ Medicare members.

Members must complete a blood screening test within 12 months prior to enrollment and meet the requirements below to qualify for the program. If your patient needs a blood screening test, please refer them to an in-network lab.

MDPP criteria for eligibility are:

- Enrollment in Medicare Part B
- Blood value:
    - Fasting plasma glucose of 110-125 mg/dL, or
    - A1C value between 5.7-6.4, or
    - Oral glucose tolerance test between 140
    - 199 mg/dL
- BMI greater than 25 (or if Asian, greater than 23)
- No diagnosis of end-stage renal disease, type 1 or type 2 diabetes (previous gestational diabetes is not an exclusion to participate)

Q: If eligible, how do members enroll?
A: Eligible members enroll in the MDPP through our program administrator, Solera Health, by visiting solera4me.com/bcbstx or by calling 866-671-8597 (TTY 771), Monday through Friday from 8 a.m. to 8 p.m. CT.

As a health care provider, you may refer eligible patients to this program. Patients can also self-refer by visiting solera4me.com/bcbstx or by calling Solera directly.

Q: Is there a cost to members for participating?
A: MDPP is a covered preventive service with no cost-sharing. There is no cost to members – no copay, no coinsurance and no deductible. The member may receive an Explanation of Benefits (EOB) from Blue Cross Medicare Advantage for this service. No action is necessary if a member receives an EOB, since there is no cost to the member.

Q: Whom should I contact if I have questions about the program?
A: For questions about the MDPP, please call Solera Health at 866-671-8597 (TTY 771), Monday through Friday from 8 a.m. to 8 p.m. CT.

[1]Centers for Disease Control and Prevention

Solera4me is provided by Solera Health, an independent company. Solera is wholly responsible for its own products and services. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Solera.

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. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

PREAUTHORIZATION INFORMATION

BCBSTX Pre-authorization and Notification Changes Beginning Jan. 1, 2019

Effective Jan. 1, 2019, benefit plans managed by Blue Cross and Blue Shield of Texas (BCBSTX) will be updating preauthorization and prenotification requirements.

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit information includes membership verification, coverage status and, preauthorization requirements. To obtain fast, efficient and detailed information for BCBSTX members, please access the Availity® Eligibility and Benefits tool located on Availity.com. Please note that you must be registered with Availity to gain access to this **free online tool**. Additional tip sheets are available on the BCBSTX provider website under Claims and Eligibility.

Watch for future updates to the Pre-authorizations/Notifications/Referral Requirements lists reflecting the 2019 changes. These will be posted on the BCBSTX provider website under the Clinical Resources page.

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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. Benefit determination will occur when 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 when rendered.

Blue Cross Medicare Advantage℠ Preauthorization List Update

BCBSTX has determined there were several codes missing from the Jan. 1, 2019, preauthorization list that published on Sept. 17, 2018. A revised list has been posted on Preauthorizations/Notifications/Referral Requirements section of BCBSTX's website under the "Blue Cross Medicare Advantage PPO℠ and Blue Cross Medicare Advantage HMO℠ effective Feb. 1, 2019" section. If you have any questions, please contact your BCBSTX Network Management Representative.

Inpatient Services Require Preauthorization

Reminder: Inpatient services for Blue Cross and Blue Shield of Texas (BCBSTX) members require preauthorization approval prior to services being rendered. Obtaining preauthorization approval is the responsibility of participating providers.

To obtain preauthorization for inpatient services through BCBSTX:

- Use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSTX.
- For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

Services performed without benefit preauthorization may be denied in whole or in part for payment and you may not seek any reimbursement from the member. For any service not approved for payment, BCBSTX will provide all appropriate appeal rights for review.

Providers should refer to the Preauthorizations/Notifications/Referral Requirements Lists posted on the provider website for current lists of services that require preauthorization.

NOTE: The Preauthorization requirement also applies to Out of Area Members and obtaining preauthorization approval is the responsibility of participating providers.

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

Correction to the HealthSelect℠ Sleep DME Preauthorization Procedure Codes List

Blue Cross and Blue Shield of Texas (BCBSTX) has determined there were two codes related to sleep durable medical equipment (DME), E0562 and 94660, that were incorrectly reported as no longer requiring prior authorization through eviCore™ for HealthSelect of Texas and Consumer Directed HealthSelect℠ participants. While prior authorization is required through eviCore for these codes, their prior authorization is covered under the initial authorization for the participant's continuous positive airway pressure (CPAP) ventilator.

Providers can refer to the "BCBSTX: Sleep Services Code List" on eviCore.com for the full list of sleep DME codes which continue to require authorization.

We apologize for this error and any inconvenience it may have caused. If you have any questions, please contact your Network Management Representative.

Update to the HealthSelect Prior Authorization List for Cologuard Screening through eviCore

Effective Sept. 1, 2018, the Employee Retirement System of Texas no longer requires prior authorization through eviCore for **Cologuard (procedure code 81528)**. The code has been removed from the "Outpatient Molecular and Genomic Laboratory Management Program Prior Authorization CPT® Code List" on the eviCore website for HealthSelect of Texas and Consumer Directed HealthSelect participants. If you have any questions, please contact your Network Management Representative.

CLAIMS & ELIGIBILITY

Proper Coding is Crucial with 'Annual Visit' Campaign

Blue Cross and Blue Shield of Texas (BCBSTX) continues a preventive care campaign to remind our members to schedule their annual exams. This month, we are encouraging members with asthma to see their health care provider.

We know you see a lot of patients. Since this campaign may add to your patient volume, we wanted to remind you about carefully documenting patients medical records.

Careful documentation is needed for proper assignment of ICD-10-CM/PCS codes. To help make sure claims are properly billed and the right benefits are applied, your documentation must paint a complete picture of each patient's condition. That includes details to support later diagnoses and treatment.
As you know, medical record data is also used to help create provider report cards and show meaningful use in electronic health records. Potential patients may use provider profiles, with online comparison tools, to choose where to go for care.

Clinical documentation improvement tools and services are widely available. Regardless of whether you established a clinical documentation improvement (CDI) program, there are some basic CDI tips you can use to help support accurate ICD-10 coding on your claims:

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

Thank you for your efforts to support our members' health and wellness at their annual visits and all other visits.

Careful medical record documentation will help ensure your claims accurately reflect the care and services you give to our members.

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.

New Updates to Clinical Payment and Coding Policies

Blue Cross and Blue Shield of Texas (BCBSTX) has implemented clinical payment and coding policies based on criteria developed by specialized professional societies, national guidelines (e.g., MCG™) and the Centers for Medicare & Medicaid Services (CMS) Provider Reimbursement Manual. Additional sources are used and can be provided upon request. The clinical payment and coding guidelines are not intended to provide billing or coding advice, but to serve as a reference for facilities and providers.

The following policy was revised and is effective **Aug. 1, 2018:**

- Psychological and Neuropsychological Testing

Effective **Nov. 1, 2018**, the following policies were updated or will be newly implemented:

- Preventive Services - (Updated)
- Revenue Codes Requiring CPT or HCPCS Codes - (New)

Refer to Clinical Payment and Coding Policies under Standards and Requirements on the provider website for details on the policy being implemented.

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

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CLINICAL RESOURCES

Changes to Prior Approval Requirements for Home-based Sleep Study for FEP Members

In January 2017, benefit prior approval requirements for sleep studies performed outside the home were implemented for some Federal Employee Program® (FEP) members. Claims and appeals revealed that when outpatient facilities submitted claims for the equipment used for home-based sleep studies, our claims system presumed the services took place outside the home. For home-based sleep studies, this issue resulted in higher copayments and claim denials for FEP Basic Option members.

FEP made changes to correct this issue. Effective Sept. 4, 2018, the following unattended sleep study and portable test monitor procedure codes, when billed by outpatient facilities, are considered eligible home-based sleep studies that no longer require benefit prior approval:

- 95800
- 95801
- 95806
- G0398
- G0399
- G0400

Benefit prior approval continues to be required for all sleep studies performed outside the home.
As a reminder, it is important to check eligibility and benefits for all members. This step will help you verify membership and other important details, such as copayment, coinsurance, deductible amounts and whether benefit prior approval may be required for a member/service. We encourage you to check eligibility and benefits online using the Availity® Provider Portal, or your preferred web vendor. If you do not have web access, you may call 800-972-8382 to check eligibility and benefits for FEP members.

This material if for educational purposes only and is not intended to be a definitive source for coding claims. Health care providers are instructed to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized or obtained benefit prior approval 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 member's ID card.

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The Importance of Diabetic Eye Exams

Many practitioners refer their diabetic patients to eye care specialists for an annual eye examination. It is important for referring providers to know details about the care a patient gets and to receive communication from you concerning that care. It is important to follow the American Diabetes Association (ADA) position statement on diabetic retinopathy and screening recommendations, which was updated in 2017:

- **Initial Exams:**
    - Within five years of diagnosis for adults who have Type 1 diabetes
    - At the time of diagnosis for adults with Type 2 diabetes

- **Exam Frequency:**
    - Every two years in the absence of retinopathy
    - Annually in the presence of retinopathy
    - At more frequent intervals in the presence of progressive retinopathy and/or deterioration of vision due to disease progression

- **Pregnancy:**
    - Educate women who are planning to be or are pregnant and who also have diabetes about the risk of diabetic retinopathy developing or progressing
    - Perform an eye exam prior to or at the time of diagnosis of pregnancy, during every trimester, and one year after delivery in the presence of pre-existing Type 1 or Type 2 diabetes

- **Exams:**
  - Should not be substituted by retinal photography
  - Should be conducted as mentioned above[1]

To help improve outcomes, consider the following:

- **Incorporate** ADA recommendations into practice. Following the above recommendations will ensure best practice for patients.
- **Gather** patient information. Ask the patient about their diabetes history, medications they are taking, symptoms they are experiencing and if they have any questions.
- **Educate** your patients. Help them understand why a retinal exam for patients with diabetes is different than an eye exam for glasses and why it is essential to help prevent future problems.
- **Reassure** your patients with diabetes that a yearly retinal exam might be covered by medical insurance.
- **Submit** claims accurately. When submitting a claim for a diabetic patient eye exam, be sure to include "diabetes" as a diagnosis to ensure proper payment. A list of diabetes codes for diabetic eye exams and procedures is included in this communication for your reference.
- **Communicate** eye care exam results with the patient's primary care physician.

We thank you for collaborating with us in the care of our Blue Cross and Blue Shield Service of Texas Federal Employee Plan members. Please remember to share eye care exam results with the patient's PCP. Refer to the news and updates article on the provider website for a sample template for notifying the PCP. Working together, we can improve the care of people with diabetes. Please contact FEPQIPrograms@BCBSTX.com if you would like further information. Learn more about diabetic retinopathy.

Codes to Identify Eye Exams and Procedures for Diabetic Retinal Disease**

67028	**67030**	**67031**	**67036**	**67039**	**67040**	**67041**	**67042**	**67043**	**67101**
67105	**67107**	**67108**	**67110**	**67112**	**67113**	**67121**	**67141**	**67145**	**67208**
67210	**67218**	**67220**	**67221**	**67227**	**67228**	**92002**	**92004**	**92012**	**92014**
92018	**92019**	**92134**	**92225**	**92226**	**92227**	**92228**	**92230**	**92235**	**92240**
92250	**92260**	**99203**	**99204**	**99205**	**99213**	**99214**	**99215**	**99242**	**99243**
99245	**2022F**	**2024F**	**2026F**	**3072F**	**S0620**	**S0621**	**S3000**		

<EXAMPLE OF A NOTE TO SEND TO REFERRING PROVIDER>

(Insert Practice Logo in this Space)

Diabetic Eye Examination Report **(Insert Practice Name)**

____

TO: _______________ **RE:** _____________________________

FAX: ______________________ **Current Eye Medications:**

____

____

Date of Examination: ____________

Dilated fundus examination: ☐**Y** ☐**N**
Result of Examination:
☐No diabetic retinopathy at this time
☐Proliferative diabetic retinopathy
☐Non-proliferative diabetic retinopathy

Glaucoma examination: ☐**Y** ☐**N**
Result of examination: ☐**Present** ☐**Suspected** ☐**Absent**

Other ocular conditions:

Recommendations:
☐ No treatment is necessary at this time, just yearly monitoring for any changes
☐ Close monitoring of ocular health status with a review in 3 months
☐ Close monitoring of ocular health status with a review in 6 months
☐ Referral to________________________________
☐ An appointment has been made with________________________________

I have discussed these findings with the above patient and stressed the importance of regular monitoring of eye health. Please let me know if I can provide you with more information. It's a pleasure to participate in the continued care of our mutual patient.

[1]Diabetic Retinopathy: A Position Statement by the American Diabetes Association, Sharon D. Solomon, Emily Chew, Elia J. Duh, Lucia Sobrin, Jennifer K. Sun, Brian L.VanderBeek, Charles C. Wykoff, Thomas W. Gardner, Diabetes Care, Mar 2017, 40 (3) 412-418; DOI: 10.2337/dc16-2641

***Based on NCQA 2019 HEDIS® specifications.*

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Proper Documentation of Obstetrical Care

Communication between health care professionals during a patient's pre-pregnancy, pregnancy and postpartum medical journey is important. It is recommended that when caring for a patient, the following be documented in their chart to ensure effective coordination and continuity of care:

Prenatal Visit in First Trimester:

- Prenatal risk assessment with counseling to include education, complete medical and obstetrical history, physical exam (e.g., American College of Obstetricians and Gynecologists (ACOG) form)
- Prenatal lab reports (OB panel/TORCH antibody panel/Rubella antibody test/ABO/ Rh)
- Ultrasound, Estimated Date of Delivery (EDD)

Duration of Prenatal Visits:

- Prenatal flow sheet (ACOG, electronic medical record (EMR) or other)
- All progress/visit notes for duration of pregnancy
- Ultrasound reports and all consult reports

Delivery:

- Documents, such as hospital delivery records, verifying member had a live birth
- If the patient had a non-live birth, records that document the non-live birth

Postpartum:

- Documentation of a postpartum visit on or between 21-56 days after delivery
- Postpartum office visit progress notation that documents an evaluation of weight, blood pressure, breast exam, abdominal exam and pelvic exam

Thank you for your partnership with us in the care of Blue Cross and Blue Shield of Texas Federal Employee Plan members.

The Cost of Treating Individuals with Antibiotic Resistance

Antibiotic resistance is on the rise and leading to increasing costs of inpatient care. A recent national study reported on the additional health care costs for treating adult patients with antibiotic-resistant bacterial infections.[1] This study compared acutely hospitalized (excluding prison, nursing home, long-term care, and some similar facilities) patients with antibiotic-resistant infections to patients without antibiotic-resistant infections from 2002 to 2014. Researchers found that treating patients with antibiotic-resistant infections added $1,383 per episode and $2.2 billion total in increased annual hospital costs.

Implementing an antimicrobial stewardship program in hospitals and other health care facilities have shown an annual cost-savings of $200,000 to $400,000 compared to health care facilities that do not implement a program.[2]

However, the scope of antibiotic resistance and benefits of antibiotic stewardship applies beyond acute hospitalization. To combat antibiotic resistance, antibiotic stewardship programs also need to include collaborative outpatient setting efforts between providers and insurance companies. For example, in outpatient clinics, a CDC report estimates 30 percent of antibiotics prescribed are unnecessary.[2] Moreover, when antibiotics are indicated, this same report notes prescribers do not always use guideline-recommended, first-line antibiotics.[2]

New research by The Pew Charitable Trusts and the Centers for Disease Control and Prevention (CDC) similarly showed patients seen at urgent care centers for common respiratory conditions such as asthma, flu and the common cold were more likely to receive unnecessary antibiotics, compared with patients treated for the same illnesses at other immediate-care types of facilities.[4] This research looked at antibiotic use in emergency departments, retail health clinics (located within businesses such as pharmacies and grocery stores) and urgent care centers (typically stand-alone facilities where patients seek immediate and unscheduled care). All played a large role in providing unscheduled outpatient care in the U.S. Data showed about 46 percent of patients in urgent care centers who were diagnosed with one of the above respiratory conditions, for which antibiotics are neither recommended nor effective, received an antibiotic prescription compared with 25 percent and 14 percent in emergency departments and retail health clinics respectively.

To help support antibiotic stewardship quality improvement, Blue Cross and Blue Shield of Texas (BCBSTX) started an antimicrobial stewardship program in the third quarter of 2017 and continues to monitor and reach out to providers who prescribe antibiotics more than their peers and not according to CDC recommendations.

Using an approach similar to the collaborative Pew Charitable Trust and CDC study, BCBSTX uses the Healthcare Effectiveness and Data Information Set (HEDIS)® Quality Indicators described in the below table to identify providers who may not have followed the recommended treatment course when prescribing an antibiotic. Identified top-prescribing providers, adjusted by specialty and state, receive an outreach letter from BCBSTX notifying them of these patterns and encouraging them to consider better antibiotic stewardship based on CDC resources.

The program resulted in a 28 percent improvement in these prescribing behaviors among providers who received initial notifications and follow-ups. These program results help support broader antibiotic-related quality performance measures, which are audited annually (see table), and compared to Quality Compass (QC) national average, benchmarking results.

The 2018 BCBSTX HEDIS/ Quality Rating System (QRS) Results Compared to 2017 QC National Average:

Quality measure	TX MKP HMO	TX Medicaid STAR	TX Com HMO Houston	TX Com HMO Dallas	TX Com HMO ESW	QC National average-50th	QC National average-75th	QC National average-90th
Appropriate Treatment for Children with Upper Respiratory Infection (URI)*	77.38%	94.43%	79.21%	78.30%	85.86%	**89.33%**	**92%**	**95%**
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) **	22.00%	35.00%	19.55%	25.24%	22.56%	**26.77%**	**31%**	**39%**

**The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).*
***The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).*
MKP= Marketplace
Com= Commercial

[1]*Thorpe, K. E., Joski, P., & Johnston, K. J. (2018). Antibiotic-resistant infection treatment costs have doubled since 2002, now exceeding $2 billion annually. Health Affairs 37 (2). doi: 10.1377/hlthaff.2017.1153*
[2]*Center for Disease Control Prevention. (2017). Antibiotic Use in the United States, 2017: Progress and Opportunities. Retrieved from https://www.cdc.gov/antibiotic-use/stewardship-report/pdf/stewardship-report.pdf*
[3]*National Committee for Quality Assurance (NCQA). HEDIS & Performance Measurement. Available at http://www.ncqa.org/hedis-quality-measurement*
[4]*Palms DL, Hicks LA, Bartoces M, Hersh AL, Zetts R, Hyun DY, Fleming-Dutra KE. Comparison of antibiotic prescribing in retail clinics, urgent care centers, emergency departments, and traditional ambulatory care settings, JAMA Int Med. 2018 Jul 16. doi: 10.1001/jamainternmed.2018.1632.*

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

2018 Annual HEDIS®/QRS Reports

Blue Cross and Blue Shield of Texas (BCBSTX) has a Quality Improvement Program (QIP) to better serve you. The purpose of the QIP is to monitor and improve the care and service our members receive. We focus on encouraging preventive health and safety, and provide education related to chronic conditions.

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

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

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

Care Provided to BCBSTX Members	2018 Quality Compass National Average	Blue Essentials℠ HMO HEDIS Rate		Blue Advantage HMO℠ QRS Rates	
		2017	2018	2017	2018
Childhood Immunization • Combination 3 Rate: 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV	73%	55%	58%↑	73%	72%↓
Breast Cancer Screening	71%	61%	62%↑	57%	58%↑
Cervical Cancer Screening	74%	67%	67%	47%	47%
Colorectal Cancer Screening	61%	38%	43%↑	38%	45%↑
Appropriate Testing for Children with Pharyngitis	86%	81%	88%↑	72%	76%↑
Medication Management for People with Asthma • Total – Medication Compliance 75%	52%	43%	40%↓	48%	55%↑
Comprehensive Diabetes Care • Hemoglobin A1c (HbA1c) Testing • HbA1c Control (<8.0%) • Eye Exam (retinal or dilated exam) • Medical Attention for Nephropathy	90% 53% 52% 89%	84% 28% 21% 88%	88%↑ 22%↓ 25%↑ 88%	89% 48% 34% 89%	89% 47%↓ 29%↓ 89%
Appropriate Treatment for Children with Upper Respiratory Infection	88%	75%	81%↑	76%	77%↑
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	31%	22%	23%↑	19%	22%↑
Medication Management					
Annual Monitoring for Patients on Persistent Medications – Total	83%	85%	84%↓	86%	87%↑
Prenatal/Postpartum Care					
Prenatal and Postpartum Care • Timeliness of Prenatal Care • Postpartum Care	81% 71%	65% 32%	66%↑ 37%↑	80% 66%	89%↑ 69%↑

Key improvements in 2018 are seen in both the commercial (Blue Essentials) and retail (Blue Advantage HMO) memberships for:

- Colorectal cancer screening
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infections
- Timeliness of prenatal care and postpartum care

The most significant decline from last year fell under Comprehensive Diabetes Care. More specifically, in HbA1c control in our commercial membership and eye exams in our retail membership.

How You Can Help

While BCBSTX provides education and resources to our members, your support in these efforts can positively impact your patient's compliance with necessary preventive care screenings and routine monitoring of chronic health conditions. An established process to identify gaps in care and dedicated outreach staff are just a couple ways you can improve your patient's health outcomes.

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

Important Reminder: Effective Aug. 1, 2018, Medical Policy and Coverage for Amniotic Membrane and Amniotic Fluid SUR704.011

Blue Cross and Blue Shield of Texas (BCBSTX) Medical Policy SUR704.011, Amniotic Membrane, and Amniotic Fluid became effective Aug. 1, 2018. Per the medical policy, the injection of micronized or particulated human amniotic membrane is considered experimental, investigational and/or unproven for all indications, including but not limited to treatment of osteoarthritis and plantar fasciitis.

Treatment of nonhealing diabetic lower-extremity ulcers using the following human amniotic membrane products (AmnioBand® Membrane, Biovance®, Epifix®, Grafix™) may be considered medically necessary when there is medical record documentation of less than a 20 percent decrease in wound area with standard wound care for at least two weeks.

Sutured human amniotic membrane grafts may be considered medically necessary for the treatment of the following ophthalmic indications: Neurotrophic keratitis, Corneal ulcers and melts, Pterygium repair, Stevens-Johnson syndrome, and Persistent epithelial defects.

Please consult the medical policy for coverage criteria. If medical record documentation does not meet the requirement, claims will be denied. Review additional information on the medical necessity requirements.

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

Appropriate Use of Opioids Program Launched Aug. 1, 2018

On Aug. 1, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) implemented the new Appropriate Use of Opioids Program. This program was developed to encourage the appropriate use of prescription opioids and advocate patient safety for our members. Elements in the new program follow safety guidelines as recommended by the Centers for Disease Control and Prevention (CDC) and other nationally recognized guidelines.

The Appropriate Use of Opioids Program elements include:

- **Opioid Immediate Release (IR) Duration Limit**
  Limits an initial IR prescription opioid fill for up to a seven-day supply for an opioid naïve patient. A member is considered "opioid naïve" if he or she has not had an opioid prescription filled within the past 60 days. Once the initial seven-day supply has been filled, subsequent fills will not be subject to the seven-day duration requirement as long as the member is not opioid naïve.

- **Morphine Equivalent Dose Concurrent Drug Utilization Review (MED cDUR) Hard Edit**
  Promotes the lowest effective dosage of opioids by monitoring and limiting the cumulative daily Morphine Equivalent Dose (MED) to no more than 200 mg per day. The MED is calculated across the submitted claim and selected historical claims. This point of sale edit denies claims when total MED is greater than or equal to 200 mg per day for seven consecutive days.

- **Opioid Quantity Limits**
  Continues to apply existing opioid dispensing limits/quantity limits to single-entity, extended-release and some IR opioids consistent with FDA-recommended dosage guidelines. Dispensing limits are published on the bcbstx.com website and updated quarterly.

Please note: The Appropriate Use of Opioids Program was implemented based on the member's benefit. Most members with BCBSTX prescription drug coverage may be subject to the criteria threshold limits established within this program regardless of their plan renewal date. This program will not apply to members with Medicare Part D or Medicaid coverage. Please call the number on the member's identification card to verify coverage, or for further assistance or clarification on your patient's benefits.

If you have a patient who requires a prescription order for an opioid that exceeds the established limits of this program, you may submit an authorization request to BCBSTX for coverage consideration. Prior Authorization and Step Therapy Programs fax forms can be found in the Pharmacy section of the BCBSTX website.

There may be future drug list changes in the opioid drug category. These updates can be found in the this newsletter, as well as the News and Updates and Pharmacy Program sections on the BCBSTX provider website.

This information is for informational purposes only and is not intended to replace your clinical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage. Only you, in direct consultation with your patient, can determine your patient's drug therapy, regardless of the member's benefits.

Preventive Services Reminder: Zero Copay for Blue Cross Medicare Advantage℠

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

For a detailed list of the services with zero copay, access: Are You Up-To-Date on Your Preventive Services.

Additionally, you should check eligibility and benefits electronically through Availity®, or your preferred web vendor.

Annual Health Assessment Coding*

Code**	Service	Description
G0402	**Initial Preventive Physical Examination**	Code is limited to new beneficiary during the first 12 months of Medicare enrollment.
G0438	**Initial Annual Wellness Visit (AWV)**	The initial AWV, G0438, is performed on patients who have been enrolled with Medicare for more than one year, including new or established patients.
G0439	**Subsequent AWV**	The subsequent AWV occurs one year after a patient's initial visit.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

**Codes for Annual Health Assessments are subject to change by Medicare Advantage Organization (MAO), without prior notice to Medical Group, for codes to be consistent with Medicare coding requirements for Annual Health Assessments.*

***Any updates, deletions and/or additions to coding shall be updated according to nationally recognized coding guidelines.*

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

EDUCATION & REFERENCE

Do you have new staff? Or just need some refreshers? Blue Cross and Blue Shield of Texas (BCBSTX) has posted complimentary educational webinar sessions on the BCBSTX provider website. These online training sessions give you the flexibility to attend live sessions. Provider billers, utilization areas, and administrative

departments will benefit from these webinars. New sessions have been added to the Educational Webinar/Workshop sessions for the following topics:

- Back to Basics: Availity® 101
- iExchange®
- Remittance Viewer

Please visit the Provider Training page on the BCBSTX provider website to view what topics are available and sign up for training sessions.

HEALTH AND WELLNESS

Video: Blue Promise℠ – Emergency Care (Part 1)
Our data shows emergency room costs have gone up by 182 percent in the last four years in Texas. In this edition of Blue Promise, learn what's going on in the market and what can we do to slow runaway health care costs.

Did You Know?

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. It includes a collection of articles to assist provider offices in servicing BCBSTX patients. 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
- CMS Guidance Notifications
- Education & Reference
- Electronic Options
- eviCore™
- Pharmacy
- Provider General Information
- Rights and Responsibility

Authorizations and Referrals

Importance of Obtaining a Preauthorization/Referral

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

To determine if a service requires a referral or preauthorization, refer to the Preauthorizations/Notifications/Referral Requirements Lists under Clinical Resources on bcbstx.com.

Preauthorizations/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.

Preauthorizations are required to allow for medical necessity review. 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. Retrospective reviews for medical necessity will not be performed for any HMO plans except in limited special circumstances.

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

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

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

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

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

Checking eligibility, benefit information and/or if a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

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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 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.

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 section D Referral Notification Program on the bcbstx.com/provider website.

AIM RQI Reminder

Note: Be sure to review the Preauthorizations/Notifications/Referral Requirements Lists under Clinical Resources on the BCBSTX website for changes effective Jan. 1, 2018, to some self-insured Blue Choice PPO℠ plan requirements for Advanced Radiology Imaging.

Physicians, professional providers, and facility and ancillary providers must contact AIM Specialty Health (AIM) first to obtain a Radiology Quality Initiative (RQI) for most Blue Choice PPO℠ members. Refer to the Preauthorizations/Notifications/Referral Requirements Lists for applicable members 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."

Notes:

- Facilities cannot obtain a RQI from AIM on behalf of the ordering physician, professional provider, facility or ancillary provider.
- 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.

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

Are Utilization Management Decisions Financially Influenced?

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

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

Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)SM

What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO 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 Provider 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.

Claims

HMO Plans – PCP Selection and Referral Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) HMO plans are:

- Blue Advantage HMO℠
- Blue Advantage Plus℠
- Blue Essentials℠
- Blue Essentials Access℠
- Blue Premier℠
- Blue Premier Access℠

Blue Essentials Access and Blue Premier Access are considered “open access” HMO plans where no Primary Care Provider (PCP) selection or referrals are required when the member uses participating providers in their network.

For Blue Advantage HMO, Blue Essentials and Blue Premier where referrals are required, it must be initiated by the member's designated PCP and must be made to a participating physician or professional provider in the same provider network.

The table below defines when a PCP selection and referrals to specialists (except OB-GYN) are required and when they are not required. (Note: Members can self-refer to in-network OB/GYNs – no referrals are required.) 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 either iExchange® or by calling the preauthorization number on the back of the member ID card.

Additional services for all HMO plans may require preauthorization. A complete list of services that require preauthorization or a referral for in and out of network benefits is available on the BCBSTX provider website under Preauthorization/Notification/Referral Requirements.

Chart below.

HMO Plan	Designated PCP Required	Referrals Required for In-Network Providers	Out-Of-Network Benefits Available with Higher Member Cost Share
Blue Advantage HMO	Yes	Yes	No
Blue Advantage Plus HMO	Yes	Yes	Yes
Blue Essentials	Yes	Yes	No
Blue Essentials Access	No	No	No
Blue Premier	Yes	Yes	No
Blue Premier Access	No	No	No

*Prior to referring a Blue Advantage Plus member to an out-of-network provider for non-emergency services, please refer to Section D Referral Notification Program, of the Blue Essentials, Blue Advantage HMO and Blue Premier provider manual for more detail including when to utilize the Out-of-Network Enrollee Notification forms for Regulated Business and Non-Regulated Business.

Sample HMO ID cards and other benefit plan ID cards are available on the BCBSTX provider website.

Reminders:

- The Blue Essentials, Blue Advantage HMO and Blue Premier physician, professional provider, facility or ancillary providers are required to admit a patient to a participating facility, except in emergencies.
- Blue Advantage Plus is a benefit plan that allows members to use out-of-network providers. However, members must understand the financial impact of receiving services from an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility.

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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EFT and ERA Information Available Online

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

The EFT/ERA page includes resources to help you learn more about EFT and ERA such as EFT and ERA Online Enrollment Tip Sheets, EFT and ERA 835 Companion Guides and other pertinent information.

Providers are encouraged to enroll for EFT and ERA through the Availity® Provider Portal, which also allows users to make any necessary set-up changes online. Once you are enrolled for ERA, providers and billing

services have access to the Availity Remittance Viewer. This tool allows users to search, view, save and print remittance information, even if the ERA is delivered to a vendor and/or clearinghouse other than Availity. To register for Availity, simply go to availity.com and sign up today. There is no cost to register to become an Availity user.

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

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Billing and Documentation Information and Requirements

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

Billing & Documentation Information & Requirements Permissible Billing

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

Pass-through Billing

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

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

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

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

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

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

Under Arrangement Billing

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

All Inclusive Billing

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

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

Other Requirements and Monitoring CLIA Certification Requirement

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

Review of Codes

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

Limitations and Conditions

Reimbursement is subject to:

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

Obligation to notify BCBSTX of Certain Changes

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

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

Assignment

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

Benefit Categories Contained in IVR Phone System

Below is a list of common benefit categories contained within the Blue Cross and Blue Shield of Texas (BCBSTX) Interactive Voice Response (IVR) phone system.

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

As a reminder, this information is continually reviewed and may vary across different BCBSTX networks, products and/or group policies. The current contained benefit category lists are shown below.

Contained Benefit Categories
• Allergy Colonoscopy Consultations Coordinated Home Care • Electrocardiogram (EKG) Extended Care Facility Hospital • Inhalation Therapy Laboratory Mammogram Office Services Office Visit Pap Smear Physical Exam Preventive Care • Private Duty Nursing Ultrasound • X-ray • 23-hour Observation Air Ambulance Anesthesia Assistant Surgeon CAT Scan Dialysis • Ground Ambulance Hospice • Medical Supplies MRI • Pathology PET Scan Prosthetics • Prostate-specific Antigen (PSA) Sterilization

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

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

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

Checking eligibility, benefit information and/or if a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Clinical Payment and Coding Policies Now Online

BCBSTX is now publishing Clinical Payment and Coding Policies on our website. These payment and coding policies describe BCBSTX's application of payment rules and methodologies for Current Procedural Terminology (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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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 BCBSTX Network Management Representative if you have any questions or if you need additional information.f you have any questions or if you need additional information.

ClaimsXten™ Quarterly Updates

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

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

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

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the C3 page or Claims Filing Tips under Claims and Eligibility on the BCBSTX website. Additional information may also be included in upcoming issues of *Blue Review*.

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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.

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Additional Code-Auditing Software

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

This software further enhances the auditing of professional and outpatient facility claims for correct coding according to the Healthcare Common Procedure Coding System (HCPSC), Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services guidelines. Providers may use the Claim Inquiry Resolution Tool, which is available on the Availity Provider 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.

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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.

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

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

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

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

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA (Health Insurance Portability and Accountability Act of 1996) to add a requirement that if a patient self pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

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

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

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

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

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

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

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

Hospitals, and Routine Services and Supplies

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

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

Clinical Resources

BCBSTX Lab Guidelines

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

Quest Diagnostics offers:

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

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

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

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

Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

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

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

For locations or questions contact:

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

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

Medical Necessity Review of Observation Services

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

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

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

Coordination of Care Between Medical and Behavioral Health Providers

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

The Coordination of Care Form Available Online

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

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

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

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

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

CMS Guidance Notifications

CMS Notifications for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM

The Centers for Medicare and Medicaid Services (CMS) routinely publishes notifications that provide CMS guidance to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare and one of the Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO) plans. These CMS notifications are located in the Medicare Learning Network (MLN Matters) on CMS.gov and in the BCBSTX News and Updates section of the provider website under CMS Notifications Medicare Advantage Plans and may include informational regulatory updates and reminders, as well as required actions or changes by the provider rendering services. As such, it is important for providers to review these notifications and ensure your staff are aware of them.

Education & Reference

Provider Manual Update

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

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 Provider 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 Provider 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).*

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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 Health Insurance Portability and Accountability Act-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.

Electronic Replacement/Corrected Claim Submissions

The Blue Cross and Blue Shield of Texas (BCBSTX) claims system recognizes electronic claim submission types by the frequency code submitted. The **ANSI X12 837** claim format allows you to submit changes to claims that were not included on the original adjudication.

Claim Frequency Codes

The **837 Implementation Guides** refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, they are called “Claim Frequency Codes.” Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim.

Use the frequency codes below for claims that were previously **adjudicated**.

Claim Frequency Codes			
Code	**Description**	**Filing Guidelines**	**Action**
5 Late Charges (Institutional Providers Only)	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 when replacing the 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 adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.

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 this request.

Submitting Electronic Replacement Claims

When submitting claims noted with claim frequency code 7 or 8, the original BCBSTX claim number, also referred to as the Document Control Number (DCN), **must** be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The DCN can be obtained from the 835 Electronic Remittance Advice (ERA) or Electronic Payment Summary (EPS)*. Without the original BCBSTX DCN, adjustment requests will generate a compliance error and the claim will reject. BCBSTX only accepts claim frequency code 7 to replace a prior claim or 8 to void a prior claim.

Specific information and examples for **professional** and **institutional** providers are included below.

Professional Providers

Claim corrections submitted without the appropriate frequency code will deny and the original BCBSTX claim number will not be adjusted. For additional information on submitting electronic replacement claims please refer to the table and example below.

Code	Action
7 Replacement of Prior Claim	BCBSTX will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 Void/Cancel of Prior Claim	BCBSTX will void the original claim from records based on this request.

An example is provided below of the ANSI 837 CLM segment containing the claim frequency code 7, along with the required REF segment and Qualifier in Loop ID 2300 - Claim Information.

Claim Frequency Code

```
CLM*12345678*500***11:B:7*Y*A*Y*I*P~
REF*F8*(Enter the Claim Original Document Control Number)
```

Institutional Providers

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSTX claim number will not be adjusted. For additional information on submitting electronic replacement claims, please refer to the table and example below.

Code	Action
5 Late Charges	BCBSTX will add the late charges to the original processed claim.
7 Replacement of Prior Claim	BCBSTX will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim. *This code is not intended to be used in lieu of late charges.*
8 Void/Cancel of Prior Claim	BCBSTX will void the original claim from records based on this request.

When submitting corrected **institutional** claims, take note of CLM05-2, the Facility Code Qualifier. In this instance, the CLM05-2 field would require a value of **"A"** indicating an institutional claim – along with the appropriate frequency code 7 as illustrated in the example below.

Claim Frequency Code
CLM*12345678*500***11:**A**:7*Y*A*Y*I*P~
REF*F8*(Enter the Claim Original Document Control Number)

Note: If a charge was left off the original claim, submit the additional charge with all the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.

Frequency code 5, Late Charge(s) applies strictly to institutional claims.

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® Provider 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.

**EPS files are not available for Medicaid STAR, STAR Kids, CHIP, Blue Cross Medicare Advantage HMO℠ or Blue Cross Medicare Advantage PPO℠ claims.*

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eviCore™

eviCore Preauthorization Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) contracts with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to administer preauthorization requirements for certain specialized services and products for BCBSTX members.

To determine which specialized clinical services and the effective dates of those services which require preauthorization/prior authorization through eviCore, refer to the Preauthorization/Referral/Notification Requirements found on the BCBSTX provider web site.

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

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

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

- Use the eviCore healthcare web portal, which is available 24/7. After a one-time registration, you can initiate a case, check status, review guidelines, view authorizations and eligibility, and more.

The web portal is the quickest, most efficient way to obtain information.
- Call eviCore at 855-252-1117 toll-free between 6 a.m. - 6 p.m. CT, Monday through Friday, and 9 a.m. - noon CT, Saturday, Sunday and legal holidays.

For all other services that require a referral and/or authorization as noted on the Preauthorization/Referral Requirements Lists or the Prior Authorization/Referral List for ERS, continue to use iExchange®. iExchange is accessible to all physicians, professional providers and facilities. 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.

Pharmacy

Pharmacy Benefit Tips

For Blue Cross and Blue Shield of Texas (BCBSTX) members with prescription drug benefits administered by Prime Therapeutics®, BCBSTX employs many industry-standard management strategies to ensure appropriate utilization of prescription drugs. These strategies can include drug list management, benefit design modeling, specialty pharmacy benefits, clinical programs, among others. BCBSTX providers can assist in this effort by:

1. **Prescribing drugs listed on the drug list**
   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 on the Pharmacy Program page 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]: getbluetx.com/pdp/druglist
- Blue Cross Medicare Advantage[SM]: getbluetx.com/mapd/druglist
- Blue Cross Medicare Advantage Dual Care (HMO SNP)[SM]: getbluetx.com/dsnp/druglist
- Texas STAR: bcbstx.com/star/prescription-drugs/drug-coverage
- Texas CHIP: bcbstx.com/chip/prescription-drugs/drug-coverage
- Texas STAR KIDS: bcbstx.com/starkids/plan-details/drug-coverage.html

2. **Reminding patients of covered preventive medications**
   Many BCBSTX health plans include coverage at no cost to the member for certain prescription drugs, women's contraceptive products and over-the-counter medicines used for preventive care services.*

   - ACA $0 Preventive Drug List
   - Women's Contraceptive Coverage List

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

4. **Assisting members with drug list exceptions**
   If the medication you wish to prescribe is not on your patient's drug list or the preventive care lists, a drug list exception can be requested. You can call the customer service number on the member's ID card to start the process or complete the online form.

Visit the Pharmacy Program page for more information.

**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 and prescription drug list as there may be coverage for additional products beyond these lists.*

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

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Dispensing QVT (Quantity Versus Time) Limits

To help minimize health risks and to improve the quality of pharmaceutical care, dispensing QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer's package insert. For current Drug List Dispensing Limits, visit Pharmacy Program/Dispensing Limits on the BCBSTX provider website.

Prescription Drug Lists

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

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

Provider General Information

Fee Schedule Updates

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

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. The CPT/HCPCS Drug/Injectable codes Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC fee schedule will be updated monthly.

Employees Retirement System of Texas (ERS)

BCBSTX was awarded the six- year contract for the 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 EssentialsSM provider network in all 254 counties in Texas.

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.

Providers can refer to ERS Tools on the provider website under the Education and Reference section for additional information.

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 Educational Webinar/Workshop Sessions on the bcbstx.com/provider website to view what is available and sign up for training sessions.

After-hours Access Is Required

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

Acceptable after-hours access mechanisms may include:

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

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

Medical Record Requests: Include Our Letter as Your Cover Sheet

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

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

Medical Policy Disclosure

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

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

Draft Medical Policy Review

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

View draft medical policies. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

Annual Rights and Responsibilities Notification

Thank you for choosing to be a participating practitioner with Blue Cross and Blue Shield of Texas (BCBSTX). Please review the information below for the latest information that could affect your practice.

Your Rights

As a participating practitioner of our network, you have the right to review information submitted to support your credentialing application and receive the status of your credentialing (or recredentialing) application,

upon request.

Providers have the responsibility to work directly with the reporting entity(ies) to correct erroneous information and/or conflicting information within 30 calendar days. All corrections must be submitted in writing to our Enterprise Credentialing Department, your assigned Network Management Consultant or a Medical Director to avoid future delays in processing your information for consideration in BCBSTX networks.

Mail: 1001 E. Lookout Drive
Richardson, Texas 75082
Fax: 972-766-2137
Email: CredentialingCommittee@bcbstx.com

Please Note: Credentialing decisions will not be made until the applicant has responded or if the response has exceeded the 30 calendar days allocated.

Applicants who only see patients in an office setting and do not have hospital admitting privileges at a network hospital may attest to having coverage for hospital admissions by submitting a signed Hospital Coverage letter. You can find a copy of this letter by visiting the Forms section under Education and Reference on the BCBSTX provider website.

Care Management Programs: Case Management and Disease Management

BCBSTX Case Management (CM) and Disease Management (DM) staff work with enrolled members to increase their knowledge about their condition and help them better manage crisis events when they occur. CM and DM staff support the member and practitioner relationship, and aid communication between them. Members are encouraged to discuss issues and questions with their practitioner, develop a "shared decision making" partnership with their practitioner and take an active role in managing their own health.

Member compliance with physician treatment plans is monitored, including keeping appointments, compliance with medications and completing ordered tests. Program interventions are designed to coordinate with the activities of a member's treating practitioners, specifically their primary care physician and/or appropriate specialist.

As a practitioner, you may refer a member for these care management programs at any time by calling the number on the back of the member's identification (ID) card. A clinician will collaborate with you to provide our members with available resources and additional support.

Member Rights and Responsibilities

As a BCBSTX practitioner, it is important that you are aware of our members' Rights and Responsibilities. Our health plan members can find their Rights and Responsibilities in their benefit booklet or on our website.

Member Rights and Responsibilities include:

- A right to receive information about BCBSTX, our services, our providers and facilities, and member rights and responsibilities.
- A right to be treated with respect and recognition of the member's dignity and right to privacy.
- A right to participate with providers in making decisions about the member's health care.
- A right to have a candid discussion of appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about BCBSTX or the care we provide.
- A right to make recommendations regarding our members' Rights and Responsibilities policy.

- A responsibility to provide, to the extent possible, information that BCBSTX and the provider and facility need to provide care.
- A responsibility to follow the plans and instructions for care that the member has agreed to with their provider.
- A responsibility to understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

Utilization Management Decisions
BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. Utilization Management (UM) determinations are made by licensed clinical personnel based on the:

- benefits policy (coverage) of a member's health plan,
- evidence-based medical policies and medical necessity criteria, and the
- medical necessity of care and service.

All UM decisions are based on appropriateness of care and service, and existence of coverage. BCBSTX prohibits decisions based on financial incentives, nor does BCBSTX specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The criteria used for UM determinations are available upon request. Please call the Customer Service or Health Advocate number on the back of the member's ID card.

Pharmacy Benefits
As a participating practitioner, you are given a list of drugs that are reviewed and updated throughout the year.

For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for the drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines.

For more information regarding our Pharmacy programs, visit the Pharmacy Program section on the BCBSTX provider website. For Federal Employee Program (FEP) members, information can be found at fepblue.org/pharmacy. We encourage you to check the website regularly and watch for updates in this newsletter.

You can find the following information on our website:

- Formulary lists, including restrictions and preferences
- How to use our pharmacy procedures
- An explanation of limits or quotas
- How you can provide information to support an exception request
- The process for generic drug substitutions, therapeutic interchange and step-therapy protocols

BCBSTX distributes the Roles and Responsibilities Notification to our practitioners annually to keep you informed about important topics that impact you and your practice.

Contact Us
View our quick directory of contacts for BCBSTX.

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

bcbstx.com/provider
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