BLUE REVIEW℠

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

OCTOBER 2018

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, beginning Oct. 22, 2018, prospective providers will be able to fill out a new electronic Provider Onboarding form. This change will streamline the application process and lessen the amount of time it takes to get a response.

The Provider Onboarding form will help set up a provider record number and allow providers to indicate which networks they would like to participate. On Oct. 22, 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".

Medicare Marketing Guidelines

Be sure to review the new 2019 Medicare Communications and Marketing Guidelines available on the CMS website. They reflect CMS' interpretation of the marketing requirements and related provisions of the Medicare Advantage (MA), Medicare Prescription Drug (MA-PD), Prescription Drug (PDP) and 1876 Cost Plans benefit rules. The guidelines allow organizations offering both MAs and PDPs the ability to reference one document when developing marketing materials.

Important Reminder: Claims Will Deny if Rendering NPIs are not on File with BCBSTX
The following information does not apply to Medicare Advantage or Medicaid claims.

It is important that your provider record on file with Blue Cross and Blue Shield of Texas (BCBSTX) is accurate and up-to-date. In addition to the National Provider Identifier (NPI) and other demographic information for your group, your provider record must be updated to include the rendering NPIs of all individual providers associated with your group. If claims are submitted for services rendered by providers who are not associated with your provider group according to our records, those claims will be denied.

Beginning Sept. 1, 2018, when a claim is denied due to not having an NPI on file or if the rendering NPI on file is not associated with the billing provider's NPI on file, a denial message will appear on the Electronic Payment Summary (EPS) or paper Provider Claim Summary (PCS). The denial message will include a reminder that updates to the billing provider's record on file must be completed prior to resubmitting the claim.

For providers who receive Electronic Remittance Advice (ERA), they will see the following Claim Adjustment Group Code (CAGC), Claim Adjustment Reason Code (CARC) and the Remittance Advice Remark Code (RARC):

- CO – Claim Adjustment Group Code
- A1 – Claim/Service Denied
- N290 – Missing/Incomplete/Invalid Rendering Provider Primary Identifier

How to Update Your NPI Information on File with BCBSTX
To update your provider record or to add a provider to your current group with BCBSTX, visit the Network Participation section of the BCBSTX provider website.

If you have questions, contact your BCBSTX Network Management Representative for assistance.

Government Programs: Electronic Claim-related Process Improvements and Reminders
This notice applies to providers submitting claims for Blue Cross and Blue Shield of Texas (BCBSTX) government programs, including: Blue Cross Medicare Advantage HMO^{SM}, Blue Cross Medicare Advantage PPO^{SM}, Medicaid STAR, STAR Kids and CHIP.

Providers submitting electronic government program claims for Medicare Advantage and Texas Medicaid members may have experienced membership validation claim rejections and duplicate claim rejections. The duplicate claim rejections occurred when Professional and Institutional electronic claims (837P and 837I transactions) were resubmitted within 90 days of a previously submitted claim that included the exact data for the same patient and date(s) of service.

Effective Sept. 15, 2018, BCBSTX will implement claim processing changes that will eliminate the above referenced claim submission rejections. With this implementation, some providers may encounter new claim

submission edits for Professional and Institutional claims (837P and 837I transactions), which will improve accuracy and timeliness in processing. Claims with insufficient or invalid data will reject upon claim submission; allowing providers to correct the error(s) and resubmit the claim immediately, thereby avoiding claim processing delays. Additionally, submitters should receive the payer acknowledgement response files on the same day if electronic claims were submitted by 5 p.m. CT.

As a reminder, electronic claims that are submitted via the Availity® Provider Portal or Experian™ Health must be submitted using **Payer ID 66001 for Texas Medicaid** (STAR, STAR Kids, CHIP) and **66006 for Medicare Advantage** claims. For claims that are submitted using direct data entry on the Availity Portal, providers should select the drop-down payer option of "BCBSTX Medicaid STAR Kids" or "BCBSTX Medicaid STAR/CHIP" for Texas Medicaid claims and "Blue Cross Medicare Advantage" for Medicare Advantage claims.

Providers who are not registered with Availity or Experian Health should contact their clearinghouses to confirm the appropriate Payer IDs to be used when submitting government program claims, as other clearinghouses may assign their own unique numbers.

These changes will not impact electronic fund transfer (EFT) or electronic remittance advice (ERA).

Please share this notice with your practice management/hospital information system software vendor, billing service or clearinghouse, if applicable. If you have questions regarding an electronic claim rejection message, contact your practice management system software vendor, billing service or clearinghouse for assistance. For additional information on electronic options, refer to the [Electronic Commerce page](#) on the [BCBSTX provider website](#).

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Experian Health is an independent third-party vendor and is solely responsible for its products and services.

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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[SM] 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.

Insurers Required by CMS to Conduct ACA Risk Adjustment Program Audit
In 2018, the Centers for Medicare and Medicaid Services (CMS) will conduct another Initial Validation Audit (IVA) to validate the data used when assessing the payment transfers for the Affordable Care Act's (ACA) Risk Adjustment (RA) program. The provider's role is essential to the success of the IVA.

Therefore, if any of your patients are selected to be included in the IVA, Blue Cross and Blue Shield of Texas (BCBSTX) is asking for your cooperation and commitment to fulfilling the requirements of the IVA. The IVA is expected to begin in June of 2018 and BCBSTX will be working to retrieve the requested medical records that we must submit to our IVA auditor. Our IVA auditor requires medical records to validate the sampled member's risk score calculation which is based on the diagnosis codes submitted on a member's claims, as well as through supplemental diagnosis submissions based on medical record review. As BCBSTX providers, you may be asked to provide medical records to validate all of the diagnosis codes used in the ACA RA risk score calculation. It is of utmost importance that you respond to these requests in a timely manner.

The IVA will be performed on a sample of members enrolled in ACA-compliant individual and small group plans, both on and off-exchange. Our IVA auditor will validate medical claims of the sampled members from the previous calendar year. For example, this IVA will be conducted in 2018 but will review claims with dates of service in 2017. Please be aware some of these claims may have been paid in 2018 and are likely to be included in the IVA sample.

We understand that this is a very busy time; however, to comply with CMS' requirements, we appreciate your full support and cooperation as you receive requests from BCBSTX and deliver the requested medical record(s) in a timely manner.

If you have any questions, please contact your Network Management Representative or email the IVA team

at BCBSTX directly at IVA_Records_Texas@bcbstx.com.

Provider Webinars Scheduled for 2018

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 for 2018 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](#) throughout the year
 to view what topics are available and sign up for training sessions.

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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.

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^{SM} 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^{SM} 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.

Sept. 1 Update to the Blue Cross Medicare Advantage^{SM} Preauthorization List

On Sept. 1, 2018, BCBSTX determined there were numerous codes listed on the Blue Cross Medicare Advantage preauthorization list that are no longer on in use. A revised list is available and has been posted under Preauthorizations/Notifications/Referral Requirements on the BCBSTX provider website. If you have any questions, please contact your Network Management Representative.

Update to the Blue Cross Medicare Advantage Preauthorization List

On May 31, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) determined there are three Preauthorization codes that will no longer require Preauthorization. A revised list has been posted to the BCBSTX provider website under Clinical Resources then select Preauthorizations/Notifications/Referral Requirements and select Blue Cross Medicare Advantage PPO^{SM} and Blue Cross Medicare Advantage HMO^{SM} effective 05/31/2018.

The Blue Cross Medicare Advantage Preauthorization Procedure Code List effective May 31, 2018, has been revised to remove the following three codes, as they no longer require preauthorization.

- Code A0431 Ambulance Services, Conventional Air Services, Transport, One Way (Rotary Wings)
- Code A0433 Advanced life support, level 2 (als 2)
- Code A0436 Rotary wing air mileage, per statute mile

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

ERS Sleep Authorization Requirements

Applies to: HealthSelect^{SM} of Texas and Consumer Directed HealthSelect^{SM}

Effective Aug. 1, 2018, the Employee Retirement System of Texas no longer requires prior authorizations for sleep Durable Medical Equipment (DME) resupply codes. Information about this change and the full list of sleep DME codes that still require prior authorization are available on eviCore.com. If you have any questions, please contact your Network Management Representative.

EDUCATION & REFERENCE

4th Quarter Provider Training Webinars

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.

CLAIMS & ELIGIBILITY

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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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)

11

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.

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

BCBSTX Implementing Two ClaimsXten™ Updates to Add-on Without Base Rule

Blue Cross and Blue Shield of Texas (BCBSTX) is updating one code and removing two others within the "Add-on without Base Rule" implemented Sept. 18, 2017. This is regarding add-on codes 01968, 01969 and 99292 denying when not billed with the parent code. This update will better address special circumstances that often happen when services are rendered. Currently, the rule doesn't allow the base and add-on code(s) to be billed separately or by a different physician per Current Procedural Terminology (CPT®) and Centers for Medicare &Medicaid Services (CMS) guidelines.

BCBSTX recognizes that although CPT defines an add-on code as a code that is not considered "stand-alone", certain unique circumstances may require special consideration.

Obstetric Anesthesia Services
Obstetric anesthesia often involves extensive hours and/or the transfer of anesthesia management to a second physician if/when a patient labors past midnight. As such, special consideration will be given by BCBSTX when:

- A cesarean delivery or an emergency cesarean hysterectomy is performed after a lengthy vaginal labor. The vaginal neuraxial analgesia/anesthesia (01967) and the cesarean anesthesia (01968, 01969) may be performed and billed by two separate anesthesia providers.
- The neuraxial labor analgesia/anesthesia is initiated prior to midnight, and the cesarean delivery or cesarean hysterectomy is performed after midnight. The total anesthesia service is provided as a continuous service, but the two services occur on different, sequential dates.

Critical Care Evaluation and Management Services
Research of industry resources conclude that CPT guidelines and CMS guidelines conflict with each other, and BCBSTX has found it is not unusual for partners within the same practice to assist and/or cover each other for the same patient. Therefore, special consideration will be given when:

- Critical care Evaluation and Management (E/M) add-on code 99292 is submitted as a standalone code on a claim.
- Submitted by a different rendering National Provider Identifier.

These changes will be implemented within an upcoming release. However, interim processes have already been established, effective immediately, to accommodate and remediate previously impacted claims that meet the above criteria. BCBSTX is reviewing previously processed claims back to Sept. 18, 2017, and they will be adjusted as appropriate for payment.

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

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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.

In-home Colorectal Cancer Screening Test

Beginning in August 2018, Blue Cross and Blue Shield of Texas (BCBSTX) began sending some **Blue Advantage HMO**SM and **Blue Advantage Plus**SM **HMO** members a Fecal Immunochemical Test (FIT) in-home test kit. Members identified for participation do not indicate any Blue Cross and Blue Shield of Texas (BCBSTX) claim history for colorectal cancer screenings.

Identified members will receive a communication from BCBSTX about the test and will have the option to opt-out of the program and decline participation.

BCBSTX is working with Home Access Health Corporation, an independent company that provides laboratory testing. Home Access Health Corporation will process the FIT sample and mail results to both the member and the Primary Care Provider (PCP) identified by the member. Our goal is to increase colorectal cancer screening by providing access to a test that may be completed in the comfort of the member's home.

How You Can Help:

- Discuss the importance of colorectal cancer screening and healthy lifestyle choices that will promote wellness.
- Should your patients call your office with questions, please encourage them to participate and complete the FIT kit as soon as possible.
- If you receive a FIT result from Home Access Health, please place it in the patient's medical record and discuss the results with your patient.

If you have any questions or if you need additional information, please contact your [BCBSTX Network Management Representative](#). Members can contact the BCBSTX Customer Service number listed on the back of their BCBSTX identification card.

Preventive Services Reminder: Zero Copay for Blue Cross Medicare AdvantageSM

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)SM or Blue Cross Medicare Advantage (HMO)SM. 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.

<mark>PHARMACY</mark>

Pharmacy Program Updates: Quarterly Pharmacy Changes
Review the pharmacy drug list updates and program changes that went into effect July 1, 2018.

BlueCross BlueShield of Texas

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2018

Drug List Updates (Coverage Additions) – As of July 1, 2018

Preferred Drug[1]	Drug Class/Condition Used For
Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced Drug Lists	
BELSOMRA (suvorexant tab 5 mg, 10 mg, 15 mg, 20 mg)	Insomnia
EXJADE (deferasirox tab for oral susp 125 mg, 250 mg, 500 mg)	Iron Overload
GLYXAMBI (empagliflozin-linagliptin tab 10-5 mg, 25-5 mg)	Diabetes
HEMLIBRA (emicizumab-kxwh subcutaneous soln 30 mg/mL, 60 mg/0.4 mL (150 mg/mL), 105 mg/0.7 mL (150 mg/mL), 150 mg/mL)	Hemophilia
JADENU (deferasirox tab 90 mg, 180 mg, 360 mg)	Iron Overload
OZEMPIC (semaglutide soln pen-inj 0.25 or 0.5 mg/dose (2 mg/1.5 mL), 1 mg/dose (2 mg/1.5 mL))	Diabetes

Drug	Condition
REBINYN (coagulation factor ix recomb glycopegylated for inj 500 unit, 1000 unit, 2000 unit)	Hemophilia
TRELEGY ELLIPTA (fluticasone-umeclidinium-vilanterol aepb 100-62.5-25 mcg/inh)	COPD
ZENPEP (pancrelipase (lip-prot-amyl) dr cap 5000-17000-24000 unit, 25000-79000-105000 unit)	Enzyme Deficiency

Enhanced and Multi-Tier Enhanced Drug Lists	
JANUVIA (sitagliptin phosphate tab 25 mg (base equiv), 50 mg (base equiv), 100 mg (base equiv))	Diabetes
KOMBIGLYZE XR (saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg, 5-500 mg, 5-1000 mg)	Diabetes
ONGLYZA (saxagliptin hcl tab 2.5 mg (base equiv), 5 mg (base equiv))	Diabetes

Performance and Performance Select Drug Lists	
CIPRO (ciprofloxacin for oral susp 250 mg/5 mL (5%) (5 gm/100 mL))	Anti-Infective
efavirenz tab 600 mg	HIV
GLYXAMBI (empagliflozin-linagliptin tab 10-5 mg, 25-5 mg)	Diabetes
HEMLIBRA (emicizumab-kxwh subcutaneous soln 30 mg/mL, 60 mg/0.4 mL (150 mg/mL), 105 mg/0.7 mL (150 mg/mL), 150 mg/mL)	Hemophilia
HEPLISAV-B (hepatitis b vaccine recombinant adjuvanted 20 mcg/0.5 mL)	Hepatitis B Vaccine
IMBRUVICA (ibrutinib cap 70 mg)	Cancer
IMBRUVICA (ibrutinib tab 140 mg, 280 mg, 420 mg, 560 mg)	Cancer
ODACTRA (House Dust Mite Allergen Extract)	Allergies
OPTIONS GYNOL II VAGINAL (nonoxynol-9 gel 3%)	Contraceptives

Drug	Condition
OZEMPIC (semaglutide soln pen-inj 0.25 or 0.5 mg/dose (2 mg/1.5 mL), 1 mg/dose (2 mg/1.5 mL))	Diabetes
QTERN (dapagliflozin-saxagliptin tab 10-5 mg)	Diabetes
REBINYN (coagulation factor ix recomb glycopegylated for inj 500 unit, 1000 unit, 2000 unit)	Hemophilia
SEGLUROMET (ertugliflozin-metformin hcl tab 2.5-500 mg, 2.5-1000 mg, 7.5-500 mg, 7.5-1000 mg)	Diabetes
SHINGRIX (zoster vaccine recombinant adjuvanted for im inj 50 mcg)	Shingles Vaccine
STEGLATRO (ertugliflozin l-pyroglutamic acid tab 5 mg (base equiv), 15 mg (base equiv))	Diabetes
TRELEGY ELLIPTA (fluticasone-umeclidinium-vilanterol aepb 100-62.5-25 mcg/inh)	COPD
trientine hcl cap 250 mg	Wilson's Disease
ZENPEP (pancrelipase (lip-prot-amyl) dr cap 5000-17000-24000 unit, 25000-79000-105000 unit)	Enzyme Deficiency

Performance Select Drug List	
BESIVANCE (besifloxacin hcl ophth susp 0.6% (base equiv))	Ophthalmic Anti-Infective
LIVALO (pitavastatin calcium tab 1 mg (base equiv), 2 mg (base equiv), 4 mg (base equiv))	High Cholesterol
minocycline hcl tab er 24hr 65 mg, 115 mg	Acne

SOLOSEC (secnidazole granules packet 2 gm)	Vaginal Anti-Infective
sumatriptan-naproxen sodium tab 85-500 mg	Migraines
VYZULTA (latanoprostene bunod ophth soln 0.024%)	Glaucoma

UTILIZATION MANAGEMENT PROGRAM CHANGES

- **Effective March 1, 2018,** the Sickle Cell Disease Prior Authorization (PA) program was added for standard pharmacy benefit plans. This program includes the target drug Endari.
- **Effective April 15, 2018,** the Iron Chelator Step Therapy (ST) program was discontinued.
- **Effective May 1, 2018,** the Hemlibra PA program was added for standard pharmacy benefit plans. This program includes the target drug Hemlibra.
- **Effective June 24, 2018,** the Calcitonin Gene-Related Peptide (CGRP) PA program was added for standard pharmacy benefit plans. This program includes the target drug Aimovig.

- **Effective July 1, 2018,** the following changes were applied:

  o The Huntington's Disease PA program and the Tardive Dyskinesia PA program combined to form one new standard PA program: Huntington's Disease/Tardive Dyskinesia. The new combined PA program criteria was updated and will include the current target drugs: Austedo, Ingrezza and Xenazine.
  o Several drug categories and/or targeted medications will be added to current Prior Authorization (PA) and Step Therapy (ST) programs for standard pharmacy benefit plans, upon renewal for select members' plans. *As a reminder,* please review your patient's drug list for the indicator listed in the Prior Authorization or Step Therapy column, as not all programs may apply. Additionally, please be sure to submit the specific prior authorization form the medication being prescribed to your patient.

Drug categories added to current pharmacy PA standard programs, effective July 1, 2018:

Drug Category	Targeted Medication(s)[1]
Basic, Performance and Performance Select Drug Lists	
Neuropathy	Lyrica CR
Parkinson's Disease	Gocovri, Osmolex ER

Targeted drugs added to current pharmacy PA standard programs, effective July 1, 2018:

Drug Category	Targeted Medication(s)[1]
Basic, Performance and Performance Select Drug Lists	
Hereditary Angioedema (HAE)	Berinert, Firazyr, Ruconest
Oral Immunotherapy	Odactra

Drug Category	Targeted Medication(s)[1]
Basic and Performance Drug Lists	
Therapeutic Alternatives	Wellbutrin XL□

☐*Target drug moved from the Antidepressants ST standard program to the Therapeutic Alternatives PA standard program. Grandfathering was also removed from the program criteria. Members on a current drug regimen are included in program participation.*

Drug categories added to current pharmacy ST standard programs, effective July 1, 2018:

Drug Category	Targeted Medication(s)[1]
Basic, Performance and Performance Select Drug Lists	
Insomnia*	Ambien, Ambien CR, Belsomra, Edluar, Intermezzo, Lunesta, Rozerem, Silenor, Sonata, Zolpimist

* Members on a current drug regimen may be grandfathered from participation in the ST program, depending on the member's benefit plan.

Per our usual process of member notification prior to implementation, targeted mailings were sent to members affected by prior authorization program changes. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our Provider website.

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

[1]*Third party brand names are the property of their respective owners*
[2]*These lists are not all inclusive. Other medications may be available in this drug class.*

Prime Therapeutics LLC is a pharmacy benefit management company. Blue Cross and Blue Shield of Texas (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. MyPrime.com is an online resource offered by Prime Therapeutics.

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.

HEALTH AND WELLNESS

Video: Blue Promise℠ – Combating the Opioid Epidemic (Part III)
If current policies and procedures aren't turning the tide against the opioid epidemic, what more could be done? In this edition of Blue Promise, Dr. McCoy speaks with other health care professionals about what individuals and the public can do to help put an end to this crisis.

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.

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.

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^{SM} and Blue Advantage HMO^{SM} (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^{SM} 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^{SM} 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^{SM} 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^{SM}
- Blue Advantage Plus^{SM}
- Blue Essentials^{SM}
- Blue Essentials Access^{SM}
- Blue Premier^{SM}
- Blue Premier Access^{SM}

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.

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.

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.

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^{SM}, Blue Essentials^{SM}, Blue Premier^{SM}, Blue Cross Medicare Advantage (PPO)^{SM} and Blue Cross Medicare Advantage (HMO)^{SM} 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.

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Clinical Payment and Coding Policies Now Online
BCBSTX is now publishing Clinical Payment and Coding Policies on our website. These payment and coding policies describe BCBSTX's application of payment rules and methodologies for 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^{SM}, Blue Premier and Blue Advantage HMO^{SM} members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) Blue Choice PPO^{SM} 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).*

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative healthcare management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity or Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

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.

Corrected Claim Request Change

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

Electronic Submission

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

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

Claim Frequency Codes			
Code	Description	Filing Guidelines	Action
5 Late Charge(s)	Use to submit additional charges for the same date(s) of service as a previous claim.	File electronically, as usual. Include only the additional late charges that were not included on the original claim.	BCBSTX will add the late charges to the previously processed claim.
7 Replacement of Prior Claim	Use to replace an entire claim (all but identity information).	File electronically, as usual. File the claim in its entirety, including all services for which you are requesting reconsideration.	BCBSTX will replace the original claim with corrections and the replacement claim will be denied. Refer to the original claim for adjudication.
8 Void/Cancel of Prior Claim	Use to eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."	File electronically, as usual. Include all charges that were on the original claim.	BCBSTX will void the original claim from records, based on request.

Paper Submission
More than 98 percent of the claims BCBSTX receives from providers are submitted electronically. BCBSTX encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer web vendors available to providers. If you are a registered Availity® 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.

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eviCore^{TM}

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.

<mark>**Provider General Information**</mark>

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^{SM} of Texas and Consumer Directed HealthSelect^{SM} benefit plans will access care through the Blue Essentials^{SM} 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