



April 2019

NOTICES & ANNOUNCEMENTS

Three-character Prefix on Member ID Cards

Blue Cross and Blue Shield member identification numbers (ID) usually begin with a three-character prefix. Previously, the prefixes included only letters. As of April 2018, to ensure we have enough prefixes to support our current and future business needs, the Blue Cross and Blue Shield Association has determined that the prefixes can now be alphanumeric.

Quick Reminders:

- Three-character member ID prefixes may now have both letters and numbers.
- Cards that have prefixes with letters-only are still valid.
- The three-character prefix is always followed by the rest of the member's ID number.
- Include the entire member ID number, with the prefix, on all correspondence and claims.
- Do not omit, randomly select or substitute a different three-character prefix.
- If a member's ID number does not have a three-character prefix, make sure you request their most current identification card.
- Some Blue Cross and Blue Shield member ID prefixes may have less than three characters. Federal Employee Program[®] members, for example, have a single-letter prefix.

Be sure to obtain eligibility and benefits to confirm membership (including the correct ID number), verify the member's coverage and determine if you are in-network or out-of-network for the member's plan before rendering services.

Transferring Hospital DRG Rate Calculation and Discharge Status Code Addition

Blue Cross and Blue Shield of Texas (BCBSTX) will implement system logic **effective July 15, 2019**, to include discharge status code 05 (discharge/transferred to a designated cancer center or children's hospital) to appropriately apply the Diagnosis Related Group (DRG) Per Diem calculation.

The DRG Per Diem rate calculation will continue to apply to the following discharge status codes:

- 02 (discharged/transferred to short term general hospital for inpatient care)
- 82 (discharged/transferred to short term general hospital with a planned acute care hospital inpatient readmission)

If you have any questions or if you need additional information, please contact your BCBSTX [Network Management Representative](#).

Living365® Diabetes Classes for Members

Blue Cross and Blue Shield of Texas (BCBSTX) is working with **Albertsons® Market, Randalls® and Tom Thumb®** pharmacies to offer **Living365®** diabetes education classes starting this month at NO CHARGE to our members. These classes will give members a chance to:

- Go on a “Healthy Eating” grocery store tour led by a registered dietitian. During the tour members will learn about counting carbohydrates, types of fat, reading food labels and much more.
- Engage with a pharmacist to learn more about diabetes and related treatments, monitoring blood glucose, and incorporating physical activity into their lifestyle.
- Participate in a question and answer session.
- Receive educational materials and items such as a tote bag and water bottle.

The classes are scheduled from 6 – 7:30 p.m. as follows:

DATE	PHARMACY	LOCATION
April 4	Randalls	2051 Gattis School Rd, Round Rock, TX
April 25	Albertsons	320 Casa Linda Plaza, Dallas, TX
May 22	Tom Thumb	612 Grapevine Highway, Hurst, TX
June 20	Randalls	5161 San Felipe, Houston, TX

Members can call 877-728-6655, Monday through Friday from 9 a.m. to 6:30 p.m. or [visit this registration page](#) to reserve a space.

At BCBSTX, we believe that healthy actions add up. Please encourage your patients to attend these educational classes.

If you have other questions or concerns, please call the number on the back of the member’s ID card.

Albertsons Market, Tom Thumb and Randalls are independently contracted pharmacies solely responsible for their products and services.

Quality Improvement Program Information Available to Providers

Blue Cross and Blue Shield of Texas (BCBSTX) has a Quality Improvement Program (QIP) to better serve our members. The program focuses on preventive health, behavioral health, patient safety and condition management. By collaborating with physicians, providers and health care professionals, the program promotes safe and appropriate care. It also encourages the efficient use of resources, which ultimately helps reduce health care costs and improves member satisfaction with their health care plan.

The QIP includes many activities to develop, review and monitor services provided, including (but not limited to):

- Member complaints and appeals,
- Member and provider satisfaction,
- Utilization management statistics and systematic measurement of clinical care (e.g., such as cancer screenings), immunizations and chronic conditions (e.g., asthma and diabetes)

Member care and service are evaluated on a regular basis to determine whether members are receiving appropriate care and service, and that they are satisfied with the health plan. Information regarding the QIP is available in the BCBSTX provider manuals. These manuals are available online under [Standards and Requirements section](#) on the [BCBSTX provider website](#). To receive a written summary of the QIP, which includes outcomes, please call the **Quality Improvement Programs Department at 800-863-9798**.

NETWORK PARTICIPATION

BCBSTX Plans and Referral Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) has the following PPO and HMO plans:

Blue Choice PPOSM

Covered members have direct access to all in-network Blue Choice PPO providers. A covered person does not need to obtain a referral from their primary care physician (PCP) to seek services/care from an in-network specialty care physician or provider. Covered persons can choose to use out-of-network providers under their out-of-network benefit. If an out-of-network provider, including facilities, are necessary due to network inadequacy or continuity of care, then authorization is required by BCBSTX.

HMO Plans

- Blue Advantage HMOSM
- Blue Advantage Plus^{SM*}
- Blue EssentialsSM
- Blue Essentials Access^{SM*}
- Blue PremierSM
- Blue Premier Access^{SM*}

Blue Advantage HMO, Blue Essentials and **Blue Premier** require referrals initiated by the covered person's designated PCP and must be made to an in-network physician or professional provider in the covered person's applicable HMO provider network. **Blue Essentials, Blue Advantage HMO** and **Blue Premier** physician and professional providers are required to admit a patient to an in-network facility in the covered person's HMO provider network, except in an emergency.

*Note:

- **Blue Essentials Access** and **Blue Premier Access** are considered "open access" HMO plans where no PCP selection or referrals are required when the covered person uses in-network providers in their applicable HMO network.
- **Blue Advantage Plus** allows covered persons to use out-of-network providers. Covered persons can choose to self-direct their care under their out-of-network benefits at a higher out of pocket. Please be sure the covered person understands the financial impact of receiving services from an out-of-network provider, including facilities.

The table below defines when PCP selection and referrals to specialists are required and if out-of-network benefits are available for the HMO plans.

- Exception: No referrals are required for in network OB/GYNs in the covered person's applicable HMO network.
- When in-network providers and/or facilities are not available in the covered person's applicable HMO network, preauthorization would be required to utilize an out-of-network provider and/or facility.

HMO Plan	Designated PCP Required	Referrals Required for In-Network Providers	Out-Of-Network Benefits Available with Higher Covered Person's Cost Share
Blue Advantage HMO	Yes	Yes	No
Blue Advantage Plus**	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

Before referring Blue Advantage Plus covered persons to an out-of-network provider for non-emergency services, please refer to the **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](#)).

Reminders:

- Some services in both HMO and PPO plans may require preauthorization or prenotification.
- It is imperative that providers use Availity® or their preferred vendor to obtain eligibility and benefits, determine if you are in- or out-of-network for their plan, and whether preauthorization/prenotification is required. Availity allows preauthorization determination by procedure code. Refer to the BCBSTX [Eligibility and Benefits](#) web page for more information on Availity.
- Utilize iExchange® or call the preauthorization number on the back of the covered person's identification (ID) card to obtain authorization.
- Sample [ID cards](#) are available on the BCBSTX provider website.

Provider Onboarding Form User Guide Now Available

Blue Cross and Blue Shield of TX (BCBSTX) welcomes providers to apply to join our networks. We want to make the process of applying for a BCBSTX provider record number ID and joining our networks faster and easier than ever before. Prospective providers will be able to fill out our electronic Provider Onboarding form.

The Provider Onboarding form will be used by BCBSTX to set up a provider record number and if indicated by the provider, request contracts for the networks they would like to participate in. Providers can locate the electronic Provider Onboarding form and the Provider Onboarding Form User Guide on the [BCBSTX provider website](#) under the How to Join BCBSTX Provider Networks section. The [Provider Onboarding Form User Guide](#) can help make the application process easier and faster.

The Provider Onboarding form should be filled out by the following interested providers:

- Individual providers who would be new to our networks
- Groups and clinics that would be new to our networks
- Existing contracted groups or clinics that are adding a new provider

- Providers needing to submit claims electronically as an out-of-network provider

If you have any questions or if you need additional information, please visit our [provider website](#) or contact your local [BCBSTX Network Management Representative](#).

Navigating Provider Finder®

The Provider Finder tool is available on the Blue Cross and Blue Shield of Texas (BCBSTX) website and is used to locate participating BCBSTX providers. Provider Finder improves search results so that our members and providers can easily find in-network physicians, specialists and other health care providers.

It's important for providers to review your own information and use Provider Finder to help direct BCBSTX members to other in-network providers. Below is a step-by-step guide to help you navigate Provider Finder.

1. Access the [link](#) from the BCBSTX.com website.
2. Select the "Search All Providers" link in the "Are You Shopping? Find a Provider by Name or Location" section. (Please encourage members to choose "Search In-Network Providers." This will lead them through a series of prompts to help focus results.)

To check your own information for accuracy, enter your name and your location and select "Find a Doctor or Hospital" at the bottom of the page. Then in the search results, select your name to view your record, which will include the BCBSTX group and retail networks with which you are contracted.

To search for other providers who are in-network for a one of your patients, go back to the "Find a Doctor or Hospital" screen, then:

- Enter a provider's name and location in the "Search All Providers" link in the "Are You Shopping? Find a Provider by Name or Location" section. Then select "Find a Doctor or Hospital" at the bottom of the page.
- Or**
- Enter the location information then choose "More Search Options" to reveal other search options. Choose a provider type or a specialty from the dropdown box. Then select "Find a Doctor or Hospital" at the bottom of the page.

Note: If you are looking for an in-network provider for BCBSTX Medicare/Medicaid members, go back to the "Find a Doctor or Hospital" screen and choose the member's Medicare or Medicaid network in the "Helpful Links" section at the bottom of the page.

Help us continue to help our members find you. If you find discrepancies when checking your own information on the Provider Finder, please submit a [Demographic Change Form](#) to make the necessary changes. Visit the [Update Your Information page](#) for help.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes

[Review pharmacy drug list changes and updates](#), dispensing limit changes, and Utilization Management program changes that went into effect **April 1**.

CLINICAL RESOURCES

Are You Using Shared Decision-Making Aids?

Blue Cross and Blue Shield of Texas (BCBSTX) wants to support you as you work to improve the health outcomes of our members. Below is a list of evidence-based shared decision-making (SDM) aids that provide information about treatment options, lifestyle changes and outcomes. These aids are not intended to replace your guidance, but to complement the conversations you have with your patients. Engaging your patients in decision making can lead to better outcomes and quality of life. For your convenience, this SDM list can also be found under [Clinical Resources/Related Resources](#) on the BCBSTX provider website.

[Mayo Clinic Shared Decision Making National Resource Center](#)

- [Cardiovascular primary prevention choice](#)
- [Depression medication choice](#)
- [Diabetes medication choice](#)
- [Osteoporosis decision aid](#)
- [PCI choice](#) (Percutaneous Coronary Intervention)
- [Smoking cessation around the time of surgery](#)
- [Rheumatoid arthritis \(RA\) choice](#)
- [Statin choice electronic decision aid](#)

[Cincinnati Children's James M Anderson Center for Health Systems Excellence](#)

- ADHD (Attention Deficit Hyperactivity Deficit) treatment for school age child
- Diarrhea treatment with lactobacillus GG
- Human Papilloma Virus (HPV) vaccination
- Hydroxyurea for sickle cell anemia
- Treatment for children with autism
- Behavior concerns in young children
- Juvenile idiopathic arthritis treatment
- Fertility preservation for children newly diagnosed with cancer
- Treatment of obstructive sleep apnea
- Weight loss for adolescents

[Dartmouth-Hitchcock Center for Shared Decision Making](#)

- **Decision Support Toolkit for Primary Care**

The following seven steps offer a framework for implementing patient decision support in primary care:

- [Step 1: Leadership](#)
- [Step 2: Goals and Scope of Project](#)
- [Step 3: Assessment](#)
- [Step 4: Decision Support Tools](#)
- [Step 5: Education and Training](#)
- [Step 6: Implementation](#)
- [Step 7: Quality Monitoring Tools](#)

Decision Support Toolkit for Specialty Care

- **Breast Cancer**

- [Early Stage Breast Cancer Toolkit](#) – Guidelines and tools for integrating decision support into clinical care for women newly diagnosed with early stage invasive breast cancer.
- [Ductal Carcinoma in Situ \(DCIS\) Toolkit](#) – Guidelines and tools for integrating decision support into clinical care for women newly diagnosed with ductal carcinoma in situ.

- [Breast Reconstruction Toolkit](#) – Guidelines and tools for integrating decision support into clinical care for women considering immediate or delayed breast reconstruction after breast cancer surgery.
- **Hip and Knee Osteoarthritis**
 - [Hip and Knee Osteoarthritis Toolkit](#) – Guidelines and tools for integrating decision support into clinical care for patients with knee and/or hip osteoarthritis.

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.

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.

For a detailed list of the services that require authorization through eviCore, refer to the [eviCore implementation site](#).

To determine which specialized clinical services and the effective dates of those services which require preauthorization/prior authorization through eviCore, providers should check eligibility, benefits and preauthorization requirements through Availity® or your preferred vendor. Also reference the [Preauthorization/Referral/Notification](#) page on BCBSTX's provider website. Services performed without authorization may be denied for payment and you may not seek reimbursement from members/subscribers

Note: Some plans may require inpatient Musculoskeletal Surgery Medical Necessity authorization through eviCore. The provider will be required to supply the eviCore preauthorization number to BCBSTX to obtain a BCBSTX preauthorization number for the inpatient stay.

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 requiring a referral and/or authorization through BCBSTX, 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 the BCBSTX [provider website](#).

Annual Medical Record Data Collection for Quality Reporting Begins Feb. 1, 2019

Blue Cross and Blue Shield of Texas (BCBSTX) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS) and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS). HEDIS is the most widely used and nationally accepted effectiveness of care measurement available. Additionally, HHS requires reporting of QRS measures for accredited Qualified Health Plans. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule and patient authorization for release

of information is not required. Texas state law (Chapter 108 of the Texas Health and Safety Code) requires Health Maintenance Organizations in Texas to report HEDIS data, by service area to the Department of State Health Services (DSHS) on an annual basis.

To meet these requirements, BCBSTX will be collecting medical records using internal resources and leveraging an independent contracted third-party vendor, CIOX. If you receive a request for medical records, we encourage you to reply within 3 to 5 business days. Cooperation with the collection of HEDIS and QRS data or any quality improvement activities are required under the providers' contractual obligation at no cost to BCBSTX or as stated within the provider's individual contract.

A BCBSTX representative or a representative from CIOX, our contracted vendor, may be contacting your office or facility anytime between February 2018 through May 2018 to set up appointments for onsite visits or to set up an expected delivery date via fax, provider portal and if necessary U.S. Mail. As a part of the request, you will receive a letter introducing the background and authorizing agencies for the HEDIS and QRS data request, a medical record request list with members' names and other identifying demographics, and the medical record information needed for identified measures. If you have any questions about medical record requests, please contact a representative that will be listed on the provider letter requesting the medical record information.

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.

**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.*

CLAIMS & ELIGIBILITY

Check Eligibility and Benefits: Don't Skip This Important First Step!

Is your patient's membership with Blue Cross and Blue Shield of Texas (BCBSTX) still active? Are you or your practice/medical group in- or out-of-network for a specific patient? Is benefit preauthorization required for a particular member/service?

Get Answers Up Front

Benefits will vary based on the service being rendered and individual and group policy elections. It is imperative to check eligibility and benefits for each patient before every scheduled appointment. Eligibility and benefit quotes include important information about the patients' benefits, such as membership verification, coverage status and applicable copayment, coinsurance and deductible amounts. Also, the benefit quote may include information on applicable benefit preauthorization/prenotification requirements. When it is determined that services may not be covered, you should notify members in writing that they may be billed directly.

Don't Take Chances

Ask to see the member's BCBSTX ID card for current information. Also, ask for a driver's license or other photo ID to help guard against medical identity theft.

Use Online Options

We encourage you to check eligibility and benefits via an electronic 270 transaction through the [Availity® Provider Portal](#) or your preferred vendor portal. You may conduct electronic eligibility and benefits inquiries for local BCBSTX, out-of-area Blue Plans and Federal Employee Program® (FEP®) members.

Learn More

For more information, such as a library of online transaction tip sheets organized by specialty, refer to the [Eligibility and Benefits section](#) of the BCBSTX provider website. BCBSTX also offers educational webinars with an emphasis on electronic transactions, including eligibility and benefits inquiries. Refer to the [Educational Webinar page](#) for upcoming webinar dates, times and registration links to sign up now.

New Clinical Payment and Coding Policy Updates

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.

- Effective **Feb. 18, 2019**, the following policy was updated:
 - [Increased Procedural Services \(Modifier 22\)](#)
- Effective **March 18, 2019**, the following policies were updated:
 - [Applied Behavior Analysis for Autism Spectrum Disorders](#)
 - [Global Surgical Package](#)
 - [Hernia Repair](#)
- Effective **June 22, 2019**, the following policy will be added
 - [Multiple Surgery Procedures](#)

Refer to [Clinical Payment and Coding Policies](#) on the [BCBSTX provider website](#) for the available Clinical Payment and Coding Policies.

If you have any questions or if you need additional information, please contact your BCBSTX [Network Management Representative](#).

Billing BCBSTX Members Additional Fees

There are limits on the additional fees you can charge Blue Cross and Blue Shield of Texas (BCBSTX) members when you are a participating network provider.

When you provide concierge services, these additional fees may be permissible. However, please consider the following when collecting extra amounts from BCBSTX members:

- For **covered** services, the only fees you can collect are copayments, coinsurance and/or deductibles. This means you can't collect "concierge" or any other access fees as a condition of care.
- For services **non-covered** under our benefit plans, you must inform our members in writing of any additional fees, including concierge fees. They must agree to those fees in writing before the services occur.
- Services denied for payment based on bundling or other claim edits cannot be billed to the member even if the member has agreed in writing to be responsible for non-covered services.

As a participating provider, you may not treat our members differently based on whether they pay concierge fees. Members who do not pay extra fees should receive the same access to appointments, after-hours coverage and quality care as those who do pay the fees.

Note: Some health benefit plans (e.g., Health Savings Accounts) may be subject to Internal Revenue Service regulations for covered expenses.

Before rendering care, please check eligibility and benefits using Availity® or your preferred vendor to determine coverage and preauthorization requirements. Refer to the [Eligibility and Benefits page on the BCBSTX provider website](#) for more information on Availity.

Also, refer to Section B of the [Provider Manuals](#) or the [Provider website for information regarding additional fees](#).

If you have any questions or if you need additional information, please contact your BCBSTX [Network Management Representative](#).

Government Programs: New Tool for Verifying Claim Status in Availity®

This notice applies to providers rendering services for the following Blue Cross and Blue Shield of Texas (BCBSTX) government program members:

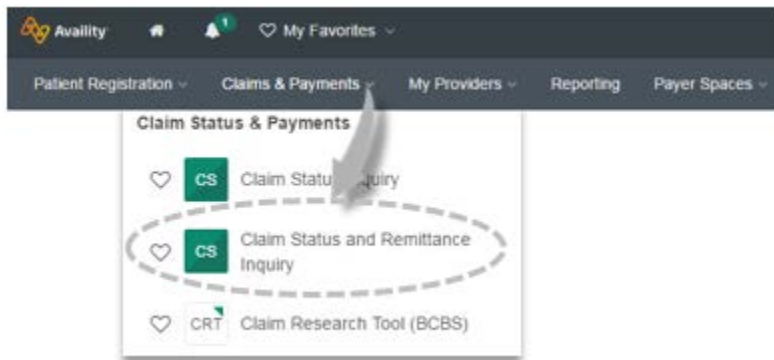
- Texas Medicaid STAR, STAR Kids and CHIP
- Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM

A new claim status tool within the Availity Provider Portal has been added to help with getting claim details online. Instead of using the Claim Status Inquiry tool, government program providers can now obtain claim processing details by using the new Claim Status and Remittance Inquiry tool.

Important claim status information is now available within a few clicks, lessening the need to speak with a Customer Advocate. As a reminder, you must be registered with Availity to use the Claim Status and Remittance Inquiry tool. For registration information, visit availity.com or contact Availity Client Services at 800-282-4548.

How to access and use the new claim status tool via Availity:

- Log in to [availity.com](https://www.availity.com)
- Select the “Claims & Payment” tab from the main menu and then select “Claim Status and Remittance Inquiry”
- Next select “Claim Status”
- Choose the applicable government program payer from the drop-down list
- Enter the essential provider, patient and claim data



Additional Support

Learn how to use this new Availity tool by attending an [Availity 101 training webinar](#) hosted weekly by BCBSTX. If you need assistance or customized training, email our Provider Education Consultant team at PECS@bcbstx.com.

BCBSTX’s Payer Spaces Updates in Availity® Provider Portal

The Blue Cross and Blue Shield of Texas (BCBSTX)-branded Payer Spaces section in the Availity Portal delivers quick access to payer-specific applications, resources and announcements. You must be a registered Availity user to access Payer Spaces. If you are not yet registered, visit [availity.com](https://www.availity.com) and select register, then complete the guided registration process – at no cost.

Updates were recently made to the BCBSTX’s Payer Spaces to help providers do business with us more efficiently. Certain tools such as Refund Management (eRM), NDC Units Calculator Tool and Research Procedure Code Edits have moved from the Resources tab to the Applications tab in our Payer Spaces. Additionally, a new “Filter by Category” option is available in the Resources tab to assist you with locating specific information related to communications, registrations and other available resources. Stay up to date with BCBSTX by visiting the News & Announcement section to view important announcements.

Accessing BCBSTX Payer Spaces via the Availity Portal:

1. In the top navigation bar in Availity select Payer Spaces
2. Choose the BCBSTX Payer Spaces option
3. In Payer Space, use the tabs to navigate and locate the tool or link you need

Some of the applications in Payer Spaces are included in the Availity base role, so it is automatically available to users after BCBSTX adds applications in Payer Spaces. If an application does not display in Payer Spaces, and you need access to it to perform your job, contact your Availity administrator to assign the specific role or permission that gives you access to use these applications.

To learn more about the various electronic tools available to you, visit the [Provider Tools page](#) on our website. If you need additional assistance or personalized training, contact our Provider Education Consultant team at PECS@bcbstx.com.

Leverage the Availity® Provider Portal for Efficiencies and Cost Savings

Back to Basics: 'Availity 101'

This general webinar is offered on an ongoing basis. Join us to learn how to use the Availity Portal to help verify patient information and check claim status. You'll also get an overview of advanced tools, such as the Medical Attachments application for quality and risk adjustment, Claim Encounter Reconciliation Application (CERA) and the Clinical Quality Validation (CQV) tool. To register to attend an upcoming Availity 101 session, refer to the [Educational Webinar/Workshop Sessions](#) page on the provider website.

In-depth Training for New Data-Sharing Tools on the Availity Portal

To help you navigate more advanced tools, such as the new data-sharing tools listed below, helpful tip sheets and other information are available in the [Provider Tools](#) section of our website.

Medical Attachments for Quality and Risk Adjustment Purposes

You can now receive and respond to quality and risk adjustment medical record requests electronically via Availity's Medical Attachments tool. [Learn more about Electronic Quality and Risk Adjustment Medical Records Requests.](#)

Clinical Quality Validation (CQV) Tool

Comply with Healthcare Effectiveness Data and Information Set (HEDIS®) measures using Availity's new Clinical Quality Validation Tool. By using CQV you may document your patients' care and assessments electronically, while closing quality HEDIS gaps. CQV also helps support the Centers for Medicare & Medicaid (CMS) STAR rating for Blue Cross Medicare Advantage HMOSM and Blue Cross Medicare Advantage PPOS plans. [Learn more about CQV.](#)

Claim Encounter Reconciliation Application (CERA)

CERA helps you respond to BCBSTX if potential risk adjustment gaps are identified, based on claims data for members with commercial and on/off-exchange health plans. [Learn more about CERA.](#)

Registered Availity users have access to many other tools and resources. Visit availity.com for more information, including an online application to become an Availity registered user, at no charge.

At this time, electronic medical record request and submission process are not available for medical record requests resulting from utilization review activities or the claims adjudication process.

Reminder for Physicians: Postoperative Care Included in the Global Surgical Reimbursement Rate

The professional reimbursement for a global surgical period includes all the necessary services conducted by a surgeon or by members of the same group within the same specialty before, during and after a procedure.

In order to curb unnecessary costs incurred for follow up care provided in a facility setting, please ensure that your patient is well-informed on **how** and **where** to access postoperative care as part of discharge planning. Payment for postoperative services is included in the global professional reimbursement rate and care should be accessed in the physician office setting.

Postoperative services may include, but are not limited to, the following:

- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals.

- Typical postoperative follow-up care related to the recovery of the surgery.
- Post-surgical pain management by the surgeon.
- Additional medical or surgical services required of the physician during the postoperative period due to complications to the surgery that do not require an additional surgical procedure in the facility setting.
- Miscellaneous services including but not limited to, dressing changes, incision care, removal of operative pack, cutaneous sutures and staples, lines, tubes, wires, drains, casts and splints; the insertion, irrigation and removal of catheters, nasogastric and rectal tubes, routine peripheral intravenous lines, and any changes and removal of tracheostomy tubes.

For more information on the global period of care, refer to the [Global Surgical Package \(CPCP014\)](#) policy in the [Clinical Payment and Coding Policies](#) under [Standards and Requirements](#) on the Blue Cross and Blue Shield of Texas (BCBSTX) [provider website](#) or contact your BCBSTX [Network Management Representative](#).

Notification of Annual Benefit Updates

BCBSTX is continuing to update member files with annual benefit changes. As always, we encourage you to verify your patients' coverage first using [Availity](#) or your preferred vendor portal. In the event you are asked to contact BCBSTX's provider customer service, hold times may be longer than normal due to open enrollment season. For patients who are not scheduled for appointments, plan to defer eligibility and benefit information requests to a later date.

PREAUTHORIZATION INFORMATION

Replacement Codes Updated on ERS Specialty Drug List

Blue Cross and Blue Shield of Texas (BCBSTX) has updated the **Employees Retirement System of Texas (ERS) Specialty Drug Prior Authorization List**. The following drugs codes to reflect their new replacement Healthcare Common Procedure Coding System (HCPCS) codes assigned by the Centers for Medicare & Medicaid Services:

- **Cuvitru** – changed from J3590 to J1555
- **Exondys 51** – changed from J3590 & C9484 to J1428
- **Rituxan** – changed from J9310 to J9312
- **Tecentriq** – changed from C9483 to J9022

The [ERS Specialty Drug Prior Authorization List](#) can be found on the [provider website](#) under [Preauthorizations/Notifications/Referral Requirements](#). These codes continue to require prior authorization for ERS participants.

If you have any questions, please contact your [Network Management Representative](#).

Radiology Quality Initiative (RQI) Program is Business as Usual

As a reminder, AIM Specialty Health® (AIM) administers the RQI Program for Blue Cross and Blue Shield of Texas (BCBSTX) for Blue Choice PPOSM. An RQI number must be obtained through AIM before ordering CT/CTA scans, MRI/MRA scans, nuclear cardiology studies, and PET scans for **most** PPO members.

The RQI requirement applies when non-emergency high-tech imaging services are performed in a physician's office, the outpatient department of a hospital, or a freestanding imaging center. The ordering

physician may obtain an RQI and the rendering provider may verify that an RQI has been issued by logging on to the [AIM Provider Portal](#) or by calling AIM at 866-455-8415.

Obtaining an RQI is not a substitute for checking eligibility and benefits. The RQI is not required if the member's benefit plan has other specific Advanced Imaging benefit preauthorization/prenotification requirements through another vendor. The RQI number is valid for 30 days; there is no grace period if the service is not performed.

To learn more and to see a current list of procedure codes, refer to the [AIM Radiology Quality Initiative \(RQI\) Program](#) section on our [provider website](#), or contact your BCBSTX [Provider Network Representative](#).

BlueCard® (Out-of-area) Reminder

Some Blue Cross and Blue Shield (BCBS) Plans have radiology management programs, other than AIM. Before ordering/rendering services for out-of-area BCBS members, it is important to check eligibility and benefits by calling the BlueCard Eligibility® line at 800-676-BLUE (2583).

AIM is an operating subsidiary of Anthem and an independent third-party vendor that is solely responsible for its products and services. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendors. If you have any questions about the products or services offered by such vendors, you should contact the vendors directly.

Checking Preauthorization Requirements by Procedure Code on Availity

Providers can access preauthorization requirements for specific Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes when conducting an eligibility and benefits inquiry through the Availity® Provider Portal. As a reminder, the CPT/HCPCS code inquiry option is for preauthorization determination only and is not a code-specific quote of benefits. Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized is not a guarantee of payment.

How to determine preauthorization requirements for CPT/HCPCS codes via Availity Portal:

- Eligibility and benefit inquiry entry (270) – Select a benefit/service type and/or enter a valid CPT/HCPCS code(s) and the associated place of service. Providers may enter up to eight CPT/HCPCS codes in the inquiry.
Note: If a benefit/service type is not selected, the place of service and at least one CPT/HCPCS code is required. If a CPT/HCPCS code is not entered, the place of service and benefit/service type is required.
- Eligibility and benefit inquiry response (271) – Displays specific preauthorization requirements in the Pre-Authorization Info tab for the benefit/service type and/or CPT/HCPCS codes entered in the inquiry. This information is organized in two sections:
 - Requested Procedure Code Authorization – Displays preauthorization information for the procedure codes submitted in the inquiry. If no procedure codes are submitted in the request, this section will not display any preauthorization information.
 - Service Level Authorization – Displays preauthorization information for the submitted benefit/service type in the inquiry. This section may also include preauthorization information for procedure codes related to the benefit/service type submitted in the inquiry.

When preauthorization is required for a benefit/service type and/or procedure code, the Pre-Authorization Info tab will display a red "Auth Required" badge. If preauthorization is not required a green "No Auth Required" badge is displayed. In some instances, providers may see a gray "Auth Info Unknown" response for the requested benefit/service type. If preauthorization is required or unknown, contact information for completing the request and other important details are included.

Online CPT/HCPCS code inquiry for preauthorization is not returned for the following Blue Cross and Blue Shield of Texas (BCBSTX) members:

- Federal Employee Program® (FEP®)
- Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM
- Texas Medicaid STAR, STAR Kids and CHIP

Learn More

BCBSTX invites you to join the complimentary webinar training “Back to Basics: Availity 101” which includes how to verify preauthorization requirements for benefits using procedure codes or contact our Provider eBusiness Consultants at PECS@bcbstx.com for specific training needs or additional information. Please visit the [Provider Training](#) page on the BCBSTX provider website to view available training sessions.

BEHAVIORAL HEALTH

Submit Benefit Preauthorization Requests Online for Intensive Outpatient Program and Electroconvulsive Therapy Services

Providers offering behavioral health intensive outpatient program (IOP) or electroconvulsive therapy (ECT) services now have the option to use iExchange® – our online benefit preauthorization tool – to submit benefit preauthorization requests for IOP and ECT services for Blue Cross and Blue Texas (BCBSTX) members with commercial and retail health plans. iExchange is available 24 hours a day, 7 days a week.*

iExchange is accessible to physicians, professional providers, and facilities who have obtained a provider record with BCBSTX. To sign up and gain access, refer to the [iExchange page](#) for more information, including our [online enrollment form](#). Or, if you are already a registered Availity® Provider Portal user, you may enroll to use iExchange via the BCBSTX Payer Spaces – select the Resource tab, then “Pre-auth Registration.” There is no cost to use iExchange or Availity.

Customized training is available for providers who have never used iExchange. To request training, send an email to our Provider Education Consultants at PECS@bcbstx.com. For ongoing support, you may contact the iExchange Help Desk at ExchangeHelpDesk@bcbstx.com or 800-746-4614.

Important Reminder: Always Check Eligibility and Benefits First

It's critical to check eligibility and benefits for each patient to confirm coverage details. This step will also identify benefit preauthorization requirements and specify utilization management vendors that must be used, if applicable. Submit online eligibility and benefits requests (electronic 270 transactions) via the [Availity Portal](#) or your preferred web vendor portal. Obtaining benefit preauthorization is not a substitute for checking eligibility and benefits.

Learn More About iExchange and Availity

BCBSTX offers a variety of webinars with an emphasis on using electronic options:

- Join us for an iExchange webinar to learn how to access and navigate our online benefit preauthorization tool. Dates, times and online registration links for upcoming BCBSTX webinars, visit the [Educational Webinar/Workshop Sessions page](#).
- Also sign up for a BCBSTX Back to Basics: ‘Availity 101’ webinar for an overview of electronic transactions, such as eligibility and benefits that can be conducted via the Availity Portal.

If you have any questions, please contact your BCBSTX [Network Management Representative](#).

**With the exception of the third Sunday of the month from 11 a.m. to 2 p.m.*

EDUCATION & REFERENCE

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.

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, it is imperative that providers check eligibility, benefits, and preauthorization requirements through Availity® or your preferred vendor and also reference the [Preauthorizations/Notifications/Referral Requirements](#) under Clinical Resources on bcbstx.com/provider.

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.

You can 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.

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 PPOSM and Blue Advantage HMOSM (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

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 PPOSM members. Providers should check eligibility, benefits, and preauthorization requirements through Availity® or your preferred vendor 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 an 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 PortalSM 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

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.

**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.*

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 HMOSM, Blue EssentialsSM, Blue PremierSM, 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](#).

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 policies and is not intended to address all reimbursement related issues. New policies have been posted and existing policies will be added over time. We regularly adjust clinical payment and coding policy positions as part of our ongoing policy review processes. Check [this newsletter](#) and the [News and Updates section on our website](#) for newly adapted or revised policies.

Update to After-hours and Weekend Care Codes Payment Policy

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

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

Effective Jan. 1, 2017, BCBSTX will no longer reimburse facility-based or non-office-based providers for CPT Codes 99053, 99056 and 99060. These codes will be considered inclusive of the primary procedure.

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](#).

Additional Code-Auditing Software

Blue Cross and Blue Shield of Texas (BCBSTX) implemented additional code-auditing software, Versend 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.

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.

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 EssentialsSM, Blue Premier and Blue Advantage HMOSM members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) Blue Choice PPOSM subscribers. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

Quest Diagnostics offers:

- Online scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto [QuestDiagnostics.com/patient](https://www.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 [MCG 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. Refer to the [Provider Tools](#) and [Electronic Commerce Solutions](#) on the provider website for additional information on the following services:

- Availity transactions and single sign on
- Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA)
- Benefit Preauthorization via iExchange®
- Electronic Refund Management (eRM)
- Claim Inquiry Resolution (CIR)
- Claims Encounter Reconciliation Application (CERA)
- Clinical Quality Validation (CQV)
- Electronic Quality and Risk Adjustment Medical Record Requests

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

Electronic Replacement/Corrected Claim Submissions

The Blue Cross and Blue Shield of Texas (BCBSTX) claims system recognizes electronic claim submission types by the frequency code submitted. The **ANSI X12 837** claim format allows you to submit changes to claims that were not included on the original adjudication. For additional information, refer to the [Electronic Replacement/Corrected Claim Submissions](#) article on the BCBSTX Provider website.

eviCore™

No articles at this time.

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 AdvantageSM: 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.*

Dispensing QVT (Quantity Versus Time) Limits

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

Prescription Drug Lists

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

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

Provider General Information

Fee Schedule Updates

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

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

Employees Retirement System of Texas (ERS)

Effective Sept. 1, 2017, BCBSTX was awarded the six- year contract for the ERS account. ERS participants covered under HealthSelectSM of Texas and Consumer Directed HealthSelectSM benefit plans will access care through the Blue EssentialsSM provider network in all 254 counties in Texas.

ERS participants can be identified through their BCBSTX ID card:

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

Providers can refer to [ERS Tools](#) on the [provider website](#) under the [Education and Reference](#) section for additional information.

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 PPOSM 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.

 File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at <http://access.adobe.com>.

 By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

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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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.

bcbstx.com/provider

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