August 2019

NOTICES & ANNOUNCEMENTS

Member Letters Have a New, Simpler Look

BCBSTX knows your time is valuable. To make our member letters (that you receive copies of) more straightforward and simple, we will have a fresh, updated look eliminating nonessential information. Best of all, the new layout is now in color and includes symbols that are easy to understand. The changes are designed to make it almost effortless to locate answers for the most common questions about the services your patient received. Both you and your patients can find the information you need fast. As always, you will be copied on member letters related to service request approvals and denials. Keep a lookout for the redesigned letters.

PREAUTHORIZATION INFORMATION

Correction: New Genetic Testing and Revised Sleep Study Preauthorization Requirements for H-E-B Partners with Blue Choice PPO℠

Update 7/31/2019: There has been a delay in transitioning preauthorization requirements for your Blue Cross and Blue Shield of Texas (BCBSTX) patients who are H-E-B partners and have the Blue Choice PPO health plan. The previous effective date of Aug. 1, 2019, for requesting preauthorization from BCBSTX to eviCore healthcare (eviCore), an independent specialty medical benefits management company, has been delayed until **Aug. 31, 2019.**

Correction 7/10/2019: The H-E-B Members Only Additional Preauthorization Procedure Code List Effective 8/1/2019" was updated to indicate genetic testing code **81212** will require preauthorization through eviCore. Procedure code 81213 previously required preauthorization through BCBSTX and will no longer require any preauthorization.

There are important changes to the preauthorization requirements for your Blue Cross and Blue Shield of Texas (BCBSTX) patients who are H-E-B partners and have the Blue Choice PPO health plan. Effective **Aug. 31, 2019**, you will need to obtain preauthorization for an expanded list of molecular and genetic lab procedures through eviCore healthcare **(eviCore)** an independent specialty medical benefits management company. Also, procedure codes 81211, 81213, 81214, and 95805 that previously required preauthorization through BCBSTX for genetic testing or sleep studies have been removed.

The list of procedures* that will require preauthorization through eviCore as of **Aug. 31, 2019**, as well as the codes related to Knee/Hip/Spine, Sleep Study/Sleep Apnea and Specialty Drugs that will continue to require preauthorization through BCBSTX for H-E-B members is on our provider website under Clinical Resources then Prior Authorizations & Predeterminations and refer to "H-E-B Members Only Additional Preauthorization Procedure Code List Effective 8/31/2019".

*__This list is not exhaustive of all codes__. It is imperative to use Availity® or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient and whether preauthorization or prenotification is required. Availity allows you to determine if preauthorization is required based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity.

H-E-B partners can be identified by employer group #**091043** on their BCBSTX identification cards. Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

Once you have determined your service requires preauthorization through eviCore, use one of the following methods to obtain authorizations:

- Go online to the eviCore web portal. After a one-time registration, you can initiate a case, check status, review guidelines, view authorizations and eligibility and more. This is the quickest, most efficient way to obtain information.
- Call eviCore at 855-252-1117 toll-free between 6 a.m. to 6 p.m. CT, Monday through Friday and 9 a.m. to noon CT, Saturday, Sunday and legal holidays.

For other services requiring preauthorization through BCBSTX, continue to use iExchange® to preauthorize those services. For more information or to set up an iExchange account, visit iExchange on the provider website.

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

Notice of Change to Preservice Appeals Process for your Blue Cross Medicare Advantage℠ Patients

Beginning Nov. 1, 2019, eviCore® healthcare (eviCore), an independent medical benefits management company, will no longer administer the appeals process for denied and partially denied Medicare Advantage prior authorization requests. BCBSTX will assume responsibility for conducting the preservice appeals process, from preservice appeal intake to appeal determination. eviCore will, however, continue its role in administering the initial determination of prior authorization requests. These changes are designed to streamline workflows and lead to an improved member and provider experience.

Note: The medical policies being used for these preservice appeal reviews will not change. Remember when submitting a pre-service appeal to always follow the directions included within the denial letter.

Going forward, it is critical to use Availity® or your preferred vendor to check eligibility and benefits, to determine if you are in-network for your patient and to determine whether any preauthorization or prenotification is required. Availity allows you to determine if preauthorization is required based on the procedure code. Refer to "Eligibility and Benefits" on the BCBSTX provider website for more information on Availity. Providers can also refer to the Prior Authorizations & Predeterminations page on our website for assistance.

Payment may be denied if you perform procedures without obtaining prior authorization when prior authorization is required. If this happens, you may not bill your patients.

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

Removal of Prior Authorization Requirements for Your Medicare Advantage Patients

There are important changes to the prior authorization requirements for your Blue Cross and Blue Shield of Texas (BCBSTX) patients enrolled in Blue Cross Medicare Advantage (PPO)SM, Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage Dual Care (HMO SNP)SM.

Beginning Sept. 1, 2019, prior authorization from eviCore®, an independent specialty medical management company, will no longer be required for:

- Cardiology Services
- Specialty Therapy (including Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic Therapy) services

Going forward, it is critical to use Availity® or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient and whether any prior authorization or prenotification is required. Availity allows you to determine if prior authorization is required based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity. You may also refer to our provider web pages for assistance.

Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients. If you need assistance, see our list of our Network Management offices.

UT Select Member Preauthorization Changes Effective Sept. 1

Starting Sept. 1, 2019, there are important changes to the preauthorization requirements for your Blue Cross and Blue Shield of Texas (BCBSTX) patients who are UT SELECT members. These members can be identified by employer group **071778** on their BCBSTX identification cards.

Providers will need to obtain preauthorization for an expanded list of select specialized services and procedures through eviCore® healthcare (eviCore), an independent specialty medical benefits management company, for UT SELECT BCBSTX members effective Sept. 1, 2019.

Here is a list of the categories which will require prior authorization through eviCore:

- Sleep Studies
- Advanced Imaging
- Pain Management
- Joint/Spine
- Cardiology

Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients. Patient eligibility and benefits should be verified before every scheduled appointment. Be sure to include all appropriate documentation to ensure a thorough review of your request.

It is important to use the Availity® Eligibility and Benefits tool or your preferred vendor to check eligibility and requirements for UT patients and determine whether preauthorization is required based on the procedure code. Obtain fast, efficient, detailed information for BCBSTX UT SELECT members by accessing Availity. Please note that you must be registered with Availity to gain access to this free online tool. Additional tip sheets are available on the BCBSTX provider website under Claims and Eligibility. Availity allows you to determine if preauthorization is required based on the procedure code. Refer to "Eligibility and Benefits" for more information on Availity.

Once you have determined your service requires preauthorization through eviCore, use one of the following methods to obtain authorizations:

- Go online to the eviCore web portal. After a one-time registration, you can initiate a case, check status, review guidelines, view authorizations and eligibility and more. This is the quickest, most efficient way to obtain information.
- Call eviCore at 855-252-1117 toll-free between 6 a.m. to 6 p.m. CST, Monday through Friday and 9 a.m. to noon CST, Saturday, Sunday and legal holidays.

If you have any questions or if you need additional information, please contact a Provider Customer Service Representative at **800-451-0287** or your BCBSTX Network Management Representative.

Reminder: Verify Procedure Code Preauthorization Requirements Online

In a December 2018 News & Updates article, Blue Cross and Blue Shield of Texas (BCBSTX) announced a new online capability that allows providers to verify preauthorization requirements for specific Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes via an eligibility and benefits inquiry in the Availity® Provider Portal. Since this implementation, many updates have been made to improve the process.

HOW TO RECEIVE ACCURATE RESULTS

To ensure code-specific preauthorization requirements are returned online, a valid CPT/HCPCS code(s)* and associated place of service must be submitted in the eligibility and benefits inquiry (270). If a CPT/HCPCS code is not entered, then the place of service and benefit/service type are required. If a benefit/service type is not selected, the place of service and at least one CPT/HCPCS code is required. Additionally, no benefit or preauthorization information will return for the benefit/service type if one is not selected.

The eligibility and benefits inquiry response (271) displays preauthorization requirements in the Pre-Authorization Info tab. In some instances, providers may receive an “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.

As a reminder, the CPT/HCPCS code inquiry option is for preauthorization determination only and is not a code-specific quote of benefits.

EXCEPTIONS

Online code-specific preauthorization information is not yet available for the following 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

RESOURCES

Learn how to successfully verify preauthorization requirements for benefits and procedure online by referencing the General Eligibility and Benefits Expanded Tip Sheet located in the Provider Tools section at on the provider website. For additional assistance, contact the Provider Education Consultants.

*Providers may enter up to eight procedure codes in the inquiry.

City of Austin Member Preauthorization Changes

There are important changes to the preauthorization requirements for your Blue Cross and Blue Shield of Texas (BCBSTX) patients who are City of Austin members with one of the following employer group numbers **246681, 246682, 246683 or 246684** on their BCBSTX identification cards.

Effective immediately, preauthorizations for City of Austin members are no longer provided through

eviCore®. Some of these services instead may require a Radiology Quality Initiative (RQI) through AIM Specialty Health® (AIM).

Therefore, going forward, it is imperative to use Availity® or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient, and whether any preauthorization or prenotification is required. Availity allows you to determine if preauthorization is required based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity. You can also refer to the Preauthorizations/Notifications/Referral Requirements page for assistance.

For a list of the services now requiring an RQI through AIM, refer to the AIM page on the BCBSTX provider website. 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.

For other services requiring preauthorization through BCBSTX, continue to use iExchange® to preauthorize those services. For more information or to set up an iExchange account, please go to the iExchange page.

Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

Changes to Specialty Drugs Preauthorization List: Always Check Preauthorization Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) has updated its **Specialty Pharmacy Infusion Site of Care Preauthorization Drug List** for two codes to reflect changes to the Healthcare Common Procedure Coding System (HCPCS) codes assigned by the Centers for Medicare & Medicaid Services (CMS). The following codes have been updated:

- Fasenra – changed from C9466 to J0517
- Radicava – changed from C9493 to J1301

The 2019 Specialty Drugs Preauthorization List for Infusion Site of Care list can be found on the BCBSTX provider website under Clinical Resources, Preauthorizations/Notifications/Referral Requirements.

For these select drugs, you may need to submit a benefit preauthorization request to BCBSTX before administration of the drug and selection of Infusion Site of Care.

We encourage you to check eligibility and benefits via an electronic 270 transaction through the Availity® Provider Portal or your preferred vendor portal. It's also important to check eligibility and benefits for each patient at every visit to confirm coverage details. This step also helps you identify benefit preauthorization/prenotification requirements.

You may also call the number on the member's ID card for assistance.

It is also important to stay current with the BCBSTX Medical Policy, "Specialty Medication Administration Site of Care" RX 501.096.

For more information refer to the Preauthorizations/Notifications/Referral Requirements web page and Specialty Pharmacy Program web page on our provider website or contact your Network Management Representative.

Change for American Airlines Members to Preauthorization Requirements for Spinal Fusion Surgery Procedures to eviCore

There is an important change to the preauthorization requirements for your Blue Cross and Blue Shield of Texas (BCBSTX) patients who are American Airlines members and have the Blue Choice PPOSM health plan.

Effective Aug. 1, 2019, for the spinal fusion surgery codes listed below, instead of requesting preauthorization through BCBSTX, you will need to obtain preauthorization through eviCore healthcare (eviCore) an independent specialty medical benefits management company.

The list of the spinal fusion surgery procedures* that will require preauthorization through eviCore as of Aug. 1, 2019, are listed below:

Spinal Fusion Surgery Procedure Codes				
22533	22558	22630	22842	22847
22534	22585	22632	22843	22848
22551	22600	22633	22844	22853
22552	22612	22634	22845	22854
22554	22614	22841	22846	22859

*Note: This list is not exhaustive of all codes that require preauthorization for American Airlines members. It is imperative to use Availity® or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient and whether preauthorization or prenotification is required. Availity allows you to determine if preauthorization is required based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity.

American Airlines members can be identified by employer group # 120369, 150554, 169026, 169027, 169028, 169029 or 186287 on their BCBSTX identification cards. Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

Once you have determined your service requires preauthorization through eviCore, use one of the following methods to obtain authorizations:

- Go online to the eviCore web portal. After a one-time registration, you can initiate a case, check status, review guidelines, view authorizations and eligibility and more. This is the quickest, most efficient way to obtain information.
- Call eviCore at 855-252-1117 toll-free between 6 a.m. to 6 p.m. CT, Monday through Friday and 9 a.m. to noon CT, Saturday, Sunday and legal holidays.

For other services requiring preauthorization through BCBSTX, continue to use iExchange® to preauthorize those services. For more information or to set up an iExchange account, visit iExchange on the provider website.

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

CLINICAL RESOURCES

eviCore® Preauthorization Training – Obstetrical Ultrasound

eviCore healthcare (eviCore), an independent specialty medical benefits management company, is offering web-based provider orientation sessions to Blue Cross and Blue Shield of Texas providers to

help navigate the eviCore website and submit preauthorization requests for Obstetrical Ultrasounds (OBUS).

Even a simple error can lead to a denial. Learn how to properly submit requests for OBUS services by enrolling in the appropriate training sessions below. This is your chance to have your eviCore questions answered by the experts.

In the training, you'll learn how to electronically submit preauthorization requests to eviCore. You'll also learn how to access and locate required information from the eviCore website and what clinical documentation you need for the top requested services.

Each training session is about an hour. The training is free, but registration is required.

Training Schedule

OBUS	Aug. 6, 2019	Tuesday	1 p.m. CT
OBUS	Aug. 13, 2019	Tuesday	9 a.m. CT

How to Register

- Go to evicore.webex.com.
- Click "WebEx Training" located on the left side of the webpage.
- Click the "Upcoming" tab to select the orientation training session to attend.
- NOTE: Orientation training sessions are shown as "BCBSIL & BCBSTX OBUS Provider Orientation Session" under the "Topic" field.
- Click the "Register" box and enter all required information.
- You'll get a confirmation email with a link to your selected training session and your registration identification number.

Training Documents

If you're unable to attend a training session, go to evicore.com/implementation to download a PDF copy of the presentation or any additional documents. If needed, Adobe Acrobat Reader is available for download.

BCBSTX HEDIS® Tip Sheet for Adult BMI Assessment (ABA)

The benefit of maintaining a healthy weight is one of the key essentials to reducing risks for high blood pressure, high blood cholesterol and developing type 2 diabetes, which can lead to greater risks of heart disease and stroke.

Measuring and documenting your patients' Body Mass Index (BMI) during every office visit can help you address patients at-risk of increased morbidity. To accomplish this goal, Blue Cross and Blue Shield of Texas (BCBSTX) provides a Healthcare Effectiveness Data and Information Set (HEDIS) Adult Body Mass Index Tip Sheet with specific ICD-10 Z codes and charting tips. The Adult BMI Assessment measure applies to patients ages 18-74 who had an outpatient visit and whose BMI was documented during the measurement year or the year before the measurement year.

Submitting the appropriate ICD-10 Z code decreases the likelihood that a medical record will be needed during the HEDIS season for the Adult BMI Assessment HEDIS measure.

Note: The Z code must be used as a secondary code and is non-reimbursable.

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intelliPath℠ Electronic Prior Authorization (ePA) through eviCore®

intelliPath ePA is eviCore healthcare's automated prior authorization solution. It drives efficiency by allowing secure patient data exchange from the provider's Electronic Health Record (EHR) to sync with clinical and administrative workflows. As a Blue Cross and Blue Shield of Texas (BCBSTX) provider, if your practice utilizes an EHR, this enhanced capability allows you to automate your preauthorization processes at no cost to your practice.

Using eviCore's intelliPath ePA solution, BCBSTX providers will experience:

- Seamless launch from the EHR ordering or scheduling application
- Autocase creation for submission management and tracking allowing you to follow preauthorization requests
- Eligibility check and referral management

Expedited case review and immediate communication of decisions logged back in the provider's EHR BCBSTX providers using their EHR connectivity, will have easier submission of clinical information to eviCore, which may improve turnaround times, reduce unnecessary denials/appeals, reduce the need for peer-to-peer consultation and faster treatment for patients. eviCore is committed to transforming prior authorization via the use of advanced technologies to uniquely position providers for success with medical management programs. If you are interested in learning more about intelliPath ePA and signing up, please email eviCore intelliPath.

Watch BCBSTX News and Updates and Blue Review for more information on this innovative program.

While ADHD Diagnosis Rises, Treatment Patterns Fall Short

What else can you do to help your pediatric patients with Attention-Deficit/Hyperactivity Disorder (ADHD)? The American Academy of Pediatrics (AAP) recommends both behavioral therapy and medication for children 6 years of age and older. For preschool children, ages 4 to 5 years, the first line of treatment is behavioral therapy. If the response is not enough, medication may be added.[1]

A Blue Cross Blue Shield Association and Blue Health Intelligence® (BHI) study, The Impact of Attention Deficit Hyperactivity Disorder on the Health of America's Children, looked at claims data among children diagnosed with ADHD. The children were between the ages of 2 and 18 and were covered by commercial health insurance. The findings showed a large gap between what the AAP recommends and actual practice. Of children diagnosed with ADHD in 2017:[2]

- 27% received what the AAP recommends, both behavioral therapy and medication
- 49% received only medication
- 12% received only behavioral therapy

The study revealed trends that show the importance of diagnosis and proper treatment of ADHD[2]:

- ADHD is one of the most common behavioral health conditions affecting kids in the U.S.
- Diagnosis increased 31% from 2010 to 2017 in children 2 to 18 years old
- ADHD is considered the second-most impactful condition affecting children's health in the U.S. It accounts for 16% of the impact of all health conditions on Generation Z (0-19 years old).
- Four in 10 children with ADHD also have at least one other behavioral health condition, including:
    - Depression
    - Anxiety
    - Learning disorders
    - Disruptive behavioral disorders
    - Autism spectrum disorder (ASD)

Rates of depression and anxiety increase in children with ADHD from preschool to middle school. The rates increase sharply in high school students. Rates of learning disorders, disruptive behavioral disorders and ASD are most common in preschool children with ADHD. The rates decrease sharply from preschool to elementary school and continue to decrease in high school kids.

What you can do to help your pediatric patients with ADHD:

- Search for other common behavioral health conditions that may benefit from treatment
- Consider adding either behavioral therapy or medication when appropriate

[1]AAP. *ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*, November 2011.
[2]Blue Cross Blue Shield Association. *Health of America Report: The Impact of Attention Deficit Hyperactivity Disorder on the Health of America's Children*, March 28, 2019.

Helping Patients Find Cost-Effective Knee/Hip Replacements

Premium Care Without Breaking the Bank

A surprising number of younger Americans are choosing to have knee and hip replacement procedures. But they might be shelling out more cash - between 30 to 40 percent more - than they really need to. Those are just two of the unexpected findings from a new report by the Blue Cross Blue Shield Association (BCBSA). The data show that 242,000 Americans spent $25 million replacing their worn-out or damaged joints during 2017. Those under 65 are the primary market.

The report entitled "Planned Knee and Hip Replacement Surgeries Are on the Rise in the U.S.," describes a growing national market for shiny new hips and knees.

Interestingly, the exact same procedures cost 30 to 40 percent less in outpatient settings than inpatient venues. Yet only 11 percent of knee replacements happened in outpatient locations during 2017. Hip replacements were even lower at 8 percent.

- An inpatient knee replacement costs around $30,249, while an outpatient procedure runs about $19,002.
- An inpatient hip replacement costs $30,685, compared to $22,078 at an outpatient setting.

It's also worth noting that prices can vary dramatically, even in the same city. In Dallas, for example, some hip replacement patients paid nearly four times the lowest price available.

Why are prospective patients missing out on these big savings? Given today's health care complexities, they simply might not know where to look. That's where you come in. They trust their providers to help them make informed, well-educated choices. And that's where BCBSTX comes in. We can help you direct your patients to affordable, high-quality care designed to meet their needs.

Patient safety, of course, dictates where these procedures should best take place. But the report notes that safety is comparable in both inpatient and outpatient settings. In some instances, outpatient complication rates are actually lower than inpatient.

So how can BCBSTX and providers help guide patients to the best solution for their individual needs? You can start by steering them to Blue Distinction Centers+®. It's an elite distinction awarded to health care facilities for high-quality, cost-efficient specialty care. Savings can be as high as 24 percent compared to non-Blue Distinction Centers+.

Texas has 12 Blue Distinction Centers+ specializing in knee and hip replacements.

There's also Blue Access for Members℠, a 24/7 online service with, among other features, cost

estimates, quality rankings and patient reviews of hospitals nationwide. We've made it a priority to give members advanced, easy-to-use tools and options that will help them make informed decisions about the best care choices for their specific needs.

So, the next time a patient comes to you with questions about the ups and downs of hip or knee replacement, isn't it nice to know you can give them resources and savings as well as peace of mind? Blue Distinction Center+ designation, visit the Blue Cross Blue Shield Association website.

CLAIMS & ELIGIBILITY

Reporting On-Demand Application Now Available for Medicare Advantage via Availity® Provider Portal

This notice applies to providers submitting claims for the following government programs Blue Cross and Blue Shield of Texas (BCBSTX) members:

- ***Blue Cross Medicare Advantage (HMO)SM***
- ***Blue Cross Medicare Advantage (PPO)SM***

As of May 20, 2019, for the above-referenced members, registered Availity users may access Reporting On-Demand to view, download, save and/or print the Provider Claim Summary (PCS) for claims processed on or after April 12, 2019. Reporting On-Demand is located in the BCBSTX-branded Payer Spaces section on the Availity Portal. This online application gives you a way to get claim outcome results for multiple patients, in one central location.

For instructions on how to use this application, you'll find a Reporting On-Demand tip sheet in the Provider Tools section of the BCBSTX provider website.

Attend a Webinar
BCBSTX is hosting one-hour educational **Reporting On-Demand: Obtaining Provider Claim Summaries** webinars for you to learn how to obtain government programs PCS reports through this application. New and existing Availity users are highly encouraged to attend. To sign up now for a free online training session, select a date and time below.

July 17, 2019 – 2 to 3 p.m. (CT)
July 18, 2019 – 3 to 4 p.m. (CT)
July 19, 2019 – 10 to 11 a.m. (CT)

In addition to Reporting On-Demand, BCBSTX supports an array of online tools that are available to registered Availity users, at no additional cost. To register, simply go to availity.com, select "Register," and complete the online application today.

Availity® Claim Research Tool Offers Enhanced Claim Status Results

One of the most convenient, efficient and secure methods of requesting detailed claim status from Blue Cross and Blue Shield of Texas (BCBSTX) is by using an online option such as the Availity Claim Research Tool (CRT)*. The CRT helps providers manage account receivables by viewing details of a single claim or statuses of multiple claims for a specific member in one view.

The CRT allows registered Availity users to search for claims by patient ID, group number and date of service, or by National Provider Identifier (NPI) and specific claim number, also known as a Document Control Number (DCN). The CRT also enables users to obtain real-time claim status, with detailed ineligible reason code descriptions.

The search results page delivers the rendering provider ID and name submitted on the claim. Additionally, the claim status service line breakdown returns:

- Service Date
- Revenue/Procedure Code
- Diagnosis Code
- Ineligible Reason Code and Amount
- Copay, Coinsurance and Deductible
- Modifier
- Unit or Time or Mile

This important information is available within a few clicks, lessening the need to speak with a Customer Advocate. For additional information, refer to the CRT tip sheet in the Education and Reference Center/Provider Tools section of our provider website. As a reminder, you must be registered with Availity to utilize the CRT. For registration information, visit availity.com, or contact Availity Client Services at 800-282-4548.

Join us for a webinar! BCBSTX hosts complimentary Back to Basics: 'Availity 101' Webinars for providers to learn how to use the CRT and other electronic tools to the fullest potential. You do not need to be an existing Availity user to attend a webinar. To register online now for an upcoming webinar, visit the Educational Webinar/Workshop Sessions page in the Education and Reference Center section of our Provider website.

*The CRT is not yet available for government programs claims. To check claim status in the Availity portal for government programs (Medicare Advantage and Texas Medicaid) claims, providers should use the Claim Status & Remittance Inquiry tool, instead of the CRT.

Clinical Payment and Coding Policy Updates

BCBSTX publishes Clinical Payment and Coding policies on our website that describe payment rules and methodologies for Current Procedural Terminology (CPT®), HCPCS and ICD-10 coding when applied to claims submitted as covered services. This information is offered as a resource regarding BCBSTX payment policies and is not intended to address all reimbursement related issues. We regularly add and modify clinical payment and coding policy positions as part of our ongoing policy review processes.

EDUCATION & REFERENCE

The Keys to Unlocking a Great Discharge Summary

Physicians and other practitioners need to know details about the care a patient receives during an inpatient hospital stay. The hospital discharge summary is an invaluable source for this information. Discharge summaries may improve patient outcomes by providing for continuity and coordination of care, and a safe transition to other care settings and providers.

Researchers in the field of Transitions of Care look at various approaches to improve the discharge process. For example, they categorize interventions as pre-discharge interventions that may include patient education, discharge planning, medication reconciliation, and scheduling a follow-up appointment; post-discharge interventions could involve a follow-up phone call, communication with the ambulatory provider, or home visits; and finally bridging interventions that may involve transition coaches, patient-centered discharge instructions, and clinician continuity between inpatient and outpatient settings.

The primary mode of communication between the hospital care team and aftercare providers is often

the discharge summary, raising the importance of successful transmission of this document in a timely manner. Important elements in the discharge summary, as mandated by the Centers for Medicare and Medicaid Services, are:

- The outcome of the hospitalization
- The disposition of the patient
- Provisions for follow-up care including appointments, statements of how care needs will be met, and plans for additional services (e.g., hospice, home health assistance, skilled nursing)

This minimal content should be augmented by information critical to the aftercare providers. An essential component is identifying those laboratory or other tests for which final results remain pending at the time of discharge[1].

The Blue Cross and Blue Shield of Texas (BCBSTX) Provider Satisfaction Survey includes questions about PCPs' satisfaction with hospital discharge summaries. In 2018, we see a dramatic drop in PCPs receiving a hospital discharge summary after discharge compared to 2017. Of those received, the timeliness and content remained consistent and overall satisfaction with continuity of care slightly improved. The results demonstrate opportunities for improvement across the board, but most importantly making sure the PCP receives a timely discharge summary.

BCBSTX Provider Satisfaction Survey – Hospital Discharge Summary Feedback

Survey Questions	BCBSTX 2015 (Goal 85%)	BCBSTX 2016 (Goal 90%)	BCBSTX 2017 (Goal 90%)	BCBSTX 2018 (Goal 90%)
When your patients are admitted to a hospital, are you sent summary information after the discharge?	**72%**	**80%**	**72%**	**59%**
When you receive hospital discharge information, does it reach your office within a timely manner?	**80%**	**84%**	**83%**	**83%**
When you receive hospital discharge information, does it contain adequate information about medications at discharge?	**88%**	**89%**	**87%**	**89%**
Overall satisfaction with continuity of care	**76%**	**80%**	**74%**	**79%**

Communications between the hospital and PCP are critical to helping provide a smooth and long-lasting transition of the patient to the next level of care. Continuity and coordination of care may avoid miscommunication or delays in care that may lead to poor outcomes.

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

[1] *Hospital discharge and readmission* [Online] / auth. Eric Alper MD, Terrence A O'Malley, MD, Jeffrey Greenwald, MD // UpToDate. - January 2019.

Attend Free 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.

HEALTH & WELLNESS

2018 In-home Colorectal Cancer Screening Testing Quality Improvement Initiative

In August 2018, Blue Cross and Blue Shield of Texas (BCBSTX) continued a colorectal cancer screening initiative launched initially in 2017. Our goal was to increase colorectal cancer screening by providing access to a test that may be completed in the comfort of a member's home. Select Blue Advantage HMO℠ and Blue Advantage Plus℠ HMO (BCBSTX HMO Consumer Solutions) members identified with a gap in care for colorectal cancer screening, received an introductory letter notifying them of the program and how to opt out if they did not want to participate.

The communications were provided in both English and Spanish with easy-to-understand information about colorectal cancer screening. Spanish translation addressed the potential language barrier as a social determinant of health. For those members who did not opt out, a Fecal Immunochemical Test (FIT) in-home test kit was mailed to them with instructions on how to use the kit and return it to the vendor.

BCBSTX worked with an independent company that provides laboratory testing to distribute the kits. The vendor processed the FIT samples and mailed results to both the members and the Primary Care Providers (PCP) identified by the member.

Program Name	Total Number of FIT Kits Shipped		Number of FIT Kits Returned		Response Rate	
	2017	2018	2017	2018	2017	2018
FIT Kit In-home Testing	1,899	9,285	364	1,706	19.2%	18.6%

Colorectal Cancer Screening QRS Rate	Report Year 2017	Report Year 2018	Report Year 2019
Goal Quality Compass (QC) 50th percentile	2016 59.51%	2017 60.07%	2018 61.07%
BCBSTX HMO Consumer Solutions	37.50%	45.01%	48.18%

The program ended on Dec. 31, 2018, with an 18.6% response rate. The Colorectal Cancer Screening Quality Rating System (QRS) rate is showing a steady improvement since the initiative started in 2017, but still below the Quality Compass National benchmark.

Further analysis includes:

- Multiple social determinants of health were addressed in this program, such as access to services, language and financial barriers
- Female members were more likely to participate as shown by a 20% participation rate as compared to a male participation rate of 16%.
- A total of 1,304 households had more than one member sampled with a 19.33% participation rate

- Members ages 60-64 had the highest return rate

The 2019 Colorectal In-home Testing Quality Improvement Initiative has begun. We are continuing to evaluate social determinants of health, targeting members living in the same household and educating our members about their health care benefits.

We will begin shipping the FIT Kits earlier in the year to avoid major holidays.

How Can Providers Help?
Discuss the importance of colorectal cancer screening and healthy lifestyle choices to promote wellness. Should your patients call your office with questions, please encourage them to participate and complete the FIT kit as soon as possible.

If you receive a FIT result from Home Access Health, please place it in the patient's medical record and discuss the results with your patient.

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

In-home Colorectal Cancer Screening Test Provided to Select Members

The Centers for Disease Control and Prevention says one-third of adults age 50 or older have not been screened for colorectal cancer as recommended.[1] Together, we can help our members at the greatest risk of developing colorectal cancer get the screening they need by making it easier and more convenient. Some of your patients in the Blue Cross and Blue Shield of Texas (BCBSTX) Blue Advantage HMO℠ and Blue Advantage Plus℠ HMO networks who are 51 to 75 years old with no claim history of having a colorectal screening, may receive a Fecal Immunochemical Test (FIT) Kit. The FIT Kit allows our members to complete the test in the comfort and privacy of their homes at no additional charge.

We let our members know they will receive the test and that taking the test is voluntary. Members who complete the test at their home will send their completed test kits to Home Access Health Corporation, an independent company specializing in in-home diagnostic testing. Home Access Health Corporation will process the tests and send results to the member and their Primary Care Provider. Members have until Nov. 15, 2019, to complete and submit their test for processing.

How You Can Help:

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

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

[1]CDC, Screen for Life: National Colorectal Cancer Action Campaign, October 29, 2018, https://www.cdc.gov/cancer/colorectal/sfl/index.htm.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2019

Review drug list changes, updates and revisions that go into effect July 1.

BCBSTX Now Offers a Choice in Pharmacies for Specialty Medications

We are happy to let you know that both Accredo and AllianceRx Walgreens Prime are now in-network pharmacies for specialty medications covered under the medical benefit for the 2019 calendar year.

Please note: This only applies to specialty medications that are covered under a medical benefit plan and are administered by a provider and does not apply to self-administered drugs covered under a pharmacy benefit. Additionally, certain new-to-market or limited distribution drugs may require an alternative specialty pharmacy. Please call the number on the members' ID card to verify coverage or for questions about their benefits.

Specialty medication coverage is based on the member's benefit plan. This network update does not impact specialty medications that are covered under the pharmacy benefit plan. Members may need to meet select prior authorization criteria before coverage consideration is approved. Providers can find referral forms and additional information at bcbstx.com/provider.

The relationship between BCBSTX and specialty pharmacies is that of independent contractors. Prime Therapeutics has an ownership interest in AllianceRx Walgreens Prime, a central specialty and home delivery pharmacy. BCBSTX contracts with Prime Therapeutics 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 Therapeutics.

NETWORK PARTICIPATION

Network Participation Page Revisions are Here!

Blue Cross and Blue Shield of TX (BCBSTX) welcomes providers to apply to join our networks. We've enhanced the Provider Onboarding Process experience to obtain a provider record ID and get contracted. You will notice updates to the following processes on the Network Participation webpage:

- Provider Onboarding Process
- How to Join BCBSTX Provider Networks
- Request Contract/Agreement/Network Participation

We hope that you find these changes to be helpful. Watch for upcoming improvements to the Credentialing and Recredentialing portions of the website too.

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

New BCBSTX Network MyBlue Health℠

We are excited to announce that Blue Cross and Blue Shield of Texas (BCBSTX) has developed a new network to be effective January 1, 2020 in Dallas and Harris Counties only. MyBlue Health members in these areas will access care through providers contracted in the MyBlue Health network. Some of these providers may join us as part of our partnership with Sanitas.

With Sanitas, we will be building 10 new, advanced primary care medical centers in the Houston and Dallas communities. Construction on these medical centers will begin in spring 2019 and they will be fully functional and open for appointments beginning Jan. 1, 2020.

The new medical centers will feature convenient hours for working families and offer a variety of services. They will offer extended hours on weekdays and weekends with same-week appointments available for routine care and walk-ins for urgent care. Services will vary based on the center but will deliver primary care, urgent care, lab and diagnostic imaging services, care coordination and wellness and disease management programs.

If you have any questions, please contact your Provider Network Representative. Continue to watch for additional information regarding MyBlue Health in future editions of this newsletter and on our website.

BEHAVIORAL HEALTH

Clarification: Updates to Behavioral Health Claim Review Process

Beginning Aug. 26, 2019*, Blue Cross and Blue Shield of Texas is updating its internal review process for behavioral health claims that require benefit preauthorization. Please note that only the claim review process is being updated. The specific services requiring benefit preauthorization and the process for submitting benefit preauthorization requests are **not** changing.

How Does This Impact You?
We need your help to ensure claims are billed properly. Please remember, for all claims to:

- Check eligibility and benefits via an electronic 270 transaction through the Availity® Provider Portal or your preferred vendor portal for each patient before rendering services. This will help you determine if benefit preauthorization is required.
- Obtain any required benefit preauthorization before care is rendered.
- Bill industry standard codes to help expedite claim payment.

Our May and June *Blue Review* newsletters included an article titled, “Check Your Patients' Behavioral Health Benefit Preauthorization Requirements.” This same article was also posted April 5, 2019, in News and Updates. In this article, we told you that claims without the appropriate benefit preauthorization would be denied for payment. We want to clarify that statement, as follows: **Billing treatment for our members without the required benefit preauthorization may delay payment of your claim. If delayed, you will have an opportunity to submit medical records for further review.**

For more information on behavioral health benefit preauthorization requirements, visit the Behavioral Health Program section of our Provider website.

The updated claim review process referenced above, does not affect claims submitted for HMO, government programs or Federal Employee Program® (FEP®) members.

*The original effective date published in the May *Blue Review* and April News and Updates was **July 15, 2019**.

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

BCBSTX Plans and Referral Requirements

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

Blue Choice PPO℠
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 HMO℠
- Blue Advantage Plus℠*
- Blue Essentials℠
- Blue Essentials Access℠*
- Blue Premier℠
- Blue Premier Access℠*

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.

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 PPO℠ and Blue Advantage HMO℠ (for Blue Advantage Plus)

Prior to referring a Blue Choice PPO or Blue Advantage HMO (for Blue Advantage Plus point-of- service benefit plan) member to an out-of-network provider for non-emergency services – if such services are also available through an in-network provider – the referring participating network provider must complete the appropriate Out-of-Network Care – Enrollee Notification form below.

- Out-of-Network Care - Enrollee Notification Form for Regulated Business (Use this form if "TDI" is on the member's ID card.)

- Out-of-Network Care - Enrollee Notification Form for Non-Regulated Business (Use this form if "TDI" is not on the member's ID card.)

The referring network physician must provide a copy of the completed form to the enrollee and retain a copy in the enrollee's medical record files.

It is essential that Blue Choice PPO and Blue Advantage Plus enrollees fully understand the financial impact of an out-of-network referral to a physician, professional provider, hospital, ambulatory surgery center or other facility that does not participate in their Blue Cross and Blue Shield of Texas provider network. Blue Choice PPO and Blue Advantage Plus enrollees have out-of-network benefits and may choose to use out-of- network providers, however they will be responsible for an increased cost-share under their out-of-network benefits.

For additional information, refer to the Provider Manual section D Referral Notification Program on the bcbstx.com/provider website.

AIM RQI Reminder

Physicians, professional providers, and facility and ancillary providers must contact AIM Specialty Health (AIM) first to obtain a Radiology Quality Initiative (RQI) for most Blue Choice PPO℠ members. 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 Portal℠ uses the term "Order" rather than "RQI."

Notes:

- Facilities cannot obtain a RQI from AIM on behalf of the ordering physician, professional provider, facility or ancillary provider.
- The RQI program does not apply to Medicare enrollees with Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.

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

Are Utilization Management Decisions Financially Influenced?

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

BCBSTX does not specifically reward practitioners or clinicians for issuing denials of coverage, nor is

there compensation based on the number or frequency of telephone calls or other contacts that occur with health care providers, members or subscribers. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)SM

All Blue Cross and Blue Shield Medicare AdvantageSM (BCBS MA PPO) plans participate in reciprocal network sharing. This network sharing allows 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.

For detailed information on BCBS MA PPO network sharing, refer to the Blue Cross Medicare Advantage (PPO) Provider Manual Supplement located under Standards and Requirements/Manuals on the BCBSTX provider website.

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 1-877-774-8592.

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 HMO℠, Blue Essentials℠, Blue Premier℠, Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ plans effective Sept. 15, 2017, as reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual in Section F Filing Claims posted on bcbstx.com/provider under Standards and Requirements/Manuals.

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, Verscend ConVergence Point™ BCBSTX implemented this code- auditing software in June 2017*.

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

the Claim Inquiry Resolution Tool, which is available on the Availity Provider Portal to research specific claim edits.

**The above notice does not apply to government program claims.*

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.

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.

Avoidance of Delay in Claims Pending COB Information

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

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

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

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

Hospitals, and Routine Services and Supplies

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

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

Clinical Resources

BCBSTX Lab Guidelines

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

Quest Diagnostics offers:

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

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

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

**Note: Physicians, professional providers or facility and ancillary providers who are contracted/affiliated with a capitated IPA/medical group and physicians, professional providers or facility or ancillary providers who are not part of a capitated IPA/medical group but who provide services to a member/subscriber*

whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.

Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

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

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

For locations or questions contact:

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

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

Medical Necessity Review of Observation Services

As a reminder, it is the policy of Blue Cross and Blue Shield of Texas (BCBSTX) to provide coverage for observation services when it is determined to be medically necessary based on the medical criteria and guidelines as outlined in the 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.

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eviCore™

Use eviCore® Web Portal for Preauthorization Requests

Blue Cross and Blue Shield of (BCBSTX) contracts with eviCore (eviCore), an independent specialty medical benefits management, for select specialty utilization management services.

After you use Availity® – or your preferred vendor – and determine the service for a member requires preauthorization through eviCore, you should submit preauthorization requests through eviCore's provider portal.

Using the eviCore provider portal to submit requests for preauthorization allows you to:

- **Save time** - an authorization request initiated on the eviCore provider portal is three times faster than a phone request
- **Access requests** - submit requests and check their progress when it is convenient
- **Stop and start as needed** - save your authorization request and return to it later
- **View and print authorization information** - see details for the approval and the case number
- **Review clinical** - see what is required to secure a preauthorization, including what procedures codes require preauthorization
- **Upload member's medical records** - upload clinical information if needed
- **Schedule consultations** - schedule a Clinical Consultation through the portal if you have questions.

To begin managing eviCore authorizations, go to eviCore.com and register. Training sessions are available through the eviCore training center. For provider portal help, portal.support@evicore.com or call 800-646-0418 and select option 2.

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 HealthSelect℠ of Texas and Consumer Directed HealthSelect℠ benefit plans will access care through the Blue Essentials℠ provider network in all 254 counties in Texas.

ERS 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 PPO℠ Physician, Professional Provider and Facility and Ancillary Provider Manual (Section B) and Blue, Blue Premier Physician, Professional Provider, Facility and Ancillary Provider Manual (Section B) available in the Education & Reference section of our provider website. Click on the “Manual” link (note, a password is required).

Medical Record Requests: Include Our Letter as Your Cover Sheet

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

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

Medical Policy Disclosure

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

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

Draft Medical Policy Review

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

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

Annual Rights and Responsibilities Notification

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

Your Rights

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

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

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

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.

eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.

iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

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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