December 2019

NOTICES & ANNOUNCEMENTS

Fee Schedule Update March 1, 2020

Effective March 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule for Blue Choice PPO℠, Blue Essentials℠ (including HealthSelect℠ of Texas Network), Blue Premier℠, Blue High Performance℠, Blue Advantage HMO℠, MyBlue℠ Health and ParPlan networks (collectively referred to as "Networks").

The specific changes and effective dates for the Network fee schedules and files will be posted on the BCBSTX provider website under the Standards & Requirements tab then select General Reimbursement Information. To access this area, please obtain the password from your Network Management Office. General reimbursement information policies and fee schedule information will be posted under "Reimbursement Changes/Updates" in the Reimbursement Schedules section.

The methodology used to develop the maximum allowable fee schedules for BCBSTX reimbursement will be based on **2019 CMS values** and posted on the provider website. The conversion factor for certain codes may vary by place of service.

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

2020 Blue Cross Medicare Advantage℠ Expansion Service Areas

Applies to: Blue Cross Medicare Advantage (HMO)℠, Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage Dual Care Plus (HMO SNP)℠

Effective Jan. 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) announces that Blue Cross Medicare Advantage HMO, PPO and HMO SNP networks are expanding its service areas across Texas. The expansion builds on strong networks already in place in Texas and is part of our commitment to providing members with access to affordable health care.

Blue Cross Medicare Advantage (HMO)℠ Expansion Areas:
Collin, Dallas, Denton, Tarrant and Travis counties.

Plan highlights include:

- $0 premiums
- $0 PCP visits
- Over-the-counter quarterly mail order benefit
- Cost-free SilverSneakers® gym membership
- Cost-free transportation for travel to/from doctors' visits
- Some supplemental vision, dental and hearing benefits

Blue Cross Medicare Advantage (PPO)℠ Expansion Areas:
Atascosa, Bandera, Comal, Cooke, Fannin, Guadalupe, Hill, Johnson, Kendall, Llano, Medina, Navarro, Rockwall, Wilson and Wise counties.

Plan highlights include:

- Cost-free SilverSneakers® gym membership
- Some plans offer supplemental vision and dental
- Dallas Choice Premier PPO plan offers a supplemental hearing aid allowance

Blue Cross Medicare Advantage Dual Care Plus (HMO SNP)℠ Expansion Areas:
Atascosa, Bandera, Bastrop, Bexar, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Collin, Colorado, Comal, Coryell, Dallas, Denton, Falls, Fayette, Gonzales, Grimes, Guadalupe, Hays, Hill, Kendall, Lampasas, Lavaca, Lee, Leon, Limestone, Llano, Madison, Medina, Milam, Mills, Navarro, Robertson, Rockwall, San Saba, Somervell, Tarrant, Travis, Williamson and Wilson counties.

Plan highlights include:

- Cost-free SilverSneakers® gym membership
- Cost-free transportation for travel to/from doctors' visits
- Some supplemental vision and dental benefits
- Some plans offer Zero-Cost Sharing

View the Blue Cross Medicare Advantage HMO SNP provider training here.

Have questions?
Call 1-972-766-7100, email TexasMedicareAdvantageNetwork@bcbstx.com or reference the Medicare Advantage Provider Quick Reference Guide.

†SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company.

HMO Special Needs Plan provided by Blue Cross and Blue Shield of Texas, which refers to GHS Insurance Company (GHS), an Independent Licensee of the Blue Cross and Blue Shield Association. GHS is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in GHS' plan depends on contract renewal.

Provider Manual Updates

Blue Cross and Blue Shield of Texas (BCBSTX) makes periodic updates and clarifications related to operational changes and regulatory mandates to the provider manual, processes and policies and procedures that you comply with as a network provider. We continue to share these changes in our monthly *Blue Review* and also communicate these changes in the News and Updates and/or Provider Disclosures section of our provider website or via mail.

We have added our new MyBlue Health℠ network, which becomes effective Jan. 1, 2020, to the Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual.

We will continue to provide disclosures on our website and encourage you to review it and future *Blue Review* issues as you provide care to your patients. **As a provider, it is your responsibility to review and comply with these changes**.

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

BEHAVIORAL HEALTH

Behavioral Health Program Changes for AT&T Members, Effective Jan. 1, 2020

Effective Jan. 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) will become the administrator of behavioral health benefits for our members enrolled in an AT&T health plan; replacing their current behavioral health administrator, Beacon Health Options. This means for dates of service beginning on or after Jan. 1, 2020:

- AT&T members will need to refer to BCBSTX's online Provider Finder® to identify in-network providers for behavioral health care services
- Claims must be submitted to BCBSTX, rather than Beacon Health Options for reimbursement.

AT&T members have the three-character prefix **PAS** on their member ID card. AT&T notified its members of this change in October 2019.

It is critical to use the Availity® Provider Portal or your preferred web vendor to check eligibility and benefits for all of our members, before rendering services. This will help you determine coverage details and other important information, such as benefit prior authorization/prenotification requirements.

For more information, refer to the Eligibility and Benefits and Behavioral Health Program sections of our provider website. If you or your patients have questions, contact the number on the back of the member's ID card for assistance.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been prior authorized/pre-notified for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

Beacon Health Options is an independent company that is contracted through AT&T. Beacon Health Options does not provide BCBSTX products or services. Beacon Health Options is solely responsible for the products and services it provides.

CLAIMS & ELIGIBILITY

Change to Online Enrollment Process for 835 EFT & ERA through Availity®

A new online setup tool to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) is coming soon to Blue Cross and Blue Shield of Texas (BCBSTX) through Availity. It will be available in the Availity Provider Engagement Portal using the multi-payer Transaction Enrollment tool.

This enrollment tool will allow providers to submit their EFT and ERA enrollments electronically to multiple payers at the same time. Providers can also monitor the status of the enrollment using Availity's Transaction Enrollment option.

EFT and ERA enrollment online via Availity is easy to complete. Once the enrollment is processed, providers will receive a confirmation letter acknowledging the enrollment effective date along with other important details.

Advantages of enrolling for EFT:

- Quicker receipt of payments
- Greater security – no more risk of lost or stolen paper checks
- Direct deposit into the bank account of your choice

Advantages of enrolling for ERA:

- Faster remittance delivery
- Automatic posting capabilities
- Designate delivery to a specific clearinghouse or vendor

How to access Availity's Transaction Enrollment Option:

1. Log in to Availity
2. Select My Account Dashboard on the Availity homepage
3. Select Enrollments Center
4. Select Transaction Enrollment*
5. Complete and submit

Online EFT and ERA enrollment are available to registered Availity users. To register, simply go to Availity And sign up, at no cost. The Availity EFT and ERA Tip Sheets located under the Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) page in Related Information our provider website are currently being updated to reflect the new enrollment process.

Note: BCBSTX's current online EFT and ERA enrollment option available in our Availity Payer Spaces section will be removed once the transition to the new tool is complete.

Have questions or need additional education?

Email Electronic Commerce Services and be sure to include your name, direct contact information & Tax ID or Billing NPI.

**The EFT Transaction Enrollments option is only available to the Availity administrator and/or users who have been granted access.*

Availity® Remittance Viewer Upgrade

The Availity Remittance Viewer Tool has been upgraded to better assist you with viewing, searching and reconciling Electronic Remittance Advices (835 ERA). It is available to providers who are enrolled to receive 835 ERA files from Blue Cross and Blue Shield of Texas (BCBSTX). If you have not yet enrolled, you can register online via the Availity Portal. Refer to the Availity ERA Tip Sheet for enrollment instructions.

Remittance Viewer upgraded features:

- Displays the last 48 hours of remittances upon opening the tool.
- New search functionality is available to locate specific information with advanced filtering.

A search can be done by check number, Electronic Funds Transfer (EFT) trace number or BCBSTX claim number. When entering a check number, claim number or patient/member ID, this tool presents applicable options using the characters entered by the user. Also, the Claim Search option now offers filter fields, which allows users to specify the exceptions and adjustment code(s), as needed.

How to access Remittance Viewer via the Availity Portal:

1. Log in to Availity
2. Select “Claims & Payment” from the navigation menu
3. Select “Remittance Viewer”

What to do if you can’t access Remittance Viewer

Contact your Availity administrator if Remittance Viewer is not available in your Claims & Payments menu. You must be registered with Availity to use Remittance Viewer. To register for free, visit Availity, select register and completed the online guided process.

Additional Support

Attend a Remittance Viewer training webinar hosted monthly by BCBSTX. To register for a session, refer to BCBSTX Provider Training. Also, the updated Remittance Viewer Tip Sheet is available for navigational assistance.

If you have additional questions or would like customized training, email the Provider Education Consultant team.

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

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

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

Reversals and corrections may occur when claim adjudication results have been modified from a previous claim report. The method for revision is to reverse the entire claim and resend with modified data.

Provider-level adjustments are reported in the Provider Level Balance (PLB) segment within the 835 ERA from BCBSTX.

As of Dec. 5, 2019, the following information will change in the 835 ERA PLB segment for the above-referenced members’ claims:

- Adjustment Reason Code (PLB03-1) – qualifier FB (Forward Balance) will be replaced with qualifier WO (Overpayment Recovery – negative amount).

- Provider Adjustment Identifier (PLB03-2) – this field currently contains check number and will be replaced with patient control number and payer document control number (DCN) of the overpaid claim.
    - *Example:* PLB*15483NN082*20191231*WO:JONES001 181580099999*-1156

We encourage you to refer to the Medicare Advantage: Interpreting the PLB Segment on the 835 ERA resource document on our Provider website. This document provides additional details regarding adjustment codes that may appear in the PLB segment, in accordance with the requirements as specified within the Health Insurance Portability and Accountability Act of 1996 (HIPAA)-mandated Technical Report Type 3 (TR3).* The document also includes information on PLB segment definitions and examples, as well as how to locate overpaid claims on the ERA and paper Provider Claim Summary (PCS).

Please share the document with your practice management/hospital information system software vendor, and/or your billing service or clearinghouse, if applicable.

*The HIPAA mandated ASC X12 Health Care Claim / Payment Advice (835) TR3 is available for purchase on the X12 website at x12.org.

References to other third-party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly.

Medicare Advantage Additional Payment for Medication Reconciliation Post Discharge

Blue Cross Blue Shield of TX will reimburse contracted providers who conduct medication reconciliation within 30 days of hospital discharge for Medicare Advantage members and submit a professional claim with Current Procedural Terminology (CPT®) II code 1111F.

Performing medication reconciliation after every discharge ensures that patients understand any new medications as well as any medications that should no longer be taken.

Who conducts medication reconciliation?
Medication reconciliation can be conducted by the prescribing physician, clinical pharmacist or registered nurse.

What are CPT II codes?
CPT Category II codes are supplemental tracking codes that facilitate data collection. CPT II codes are released annually as part of the full CPT code set and are updated semi-annually by the American Medical Association.

What is the description for CPT II code 1111F?
CPT II code 1111F is described as discharge medications -current medication merge.

What are the requirements to receive this payment?

- The provider must be contracted with Blue Cross Medicare Advantage.
- The CPT II code 1111F charged at $10 must be billed for a member on the discharge day or within 30 days after an inpatient discharge. The inpatient discharge can be acute or non-acute or non-acute hospitalizations.
- This cannot be paid on the facility claim.
- The rendering provider for this service must be documented on the professional claim.

What are the medical record documentation requirements?

- The hospital discharge date.
- The date the medication reconciliation was completed.
- Documentation indicating that the patient's current medication list was reconciled against the hospital discharge list of medications.

Can CPT II code 1111F be billed alone?

- Yes, the code can be billed alone. However, we encourage a face-to-face office visit.
- If the code is billed alone or with a telephonic CPT code, medical records must include the medication reconciliation documentation.

Can this be billed back to Jan. 1, 2019?
Yes, if within the timely filing rules indicated in the provider's contract.

Proper Coding of Adult BMI Assessments

Proper coding of Adult BMI Assessment (ABA) decreases the need for medical record review requests and audits by Blue Cross and Blue Shield of Texas (BCBSTX) to comply with Healthcare Effectiveness Data and Information Set (HEDIS®) requirements. The National Committee for Quality Assurance (NCQA) requires ABA and documentation every **two years** based on the following:

- Ages 18 to 19 years: height, weight and BMI percentile
- Ages 20 to 74 years: weight and BMI

Proper Coding – Tip Sheet

To help with coding, BCBSTX provides a HEDIS BMI Assessment Tip Sheet to know when to submit ICD-10 Z codes for HEDIS BMI reporting in claims.

When are the ICD-10 Z codes used?

Avoid common coding errors from improper use of the Z codes with the following tips:

- Use an ICD-10 Z code as a secondary code along with a reportable weight diagnosis code such as overweight or obesity.
- Do not use an ICD-10 Z code as a stand-alone code, they are not reimbursable.
- If a weight diagnosis cannot be documented, do not use the ICD-10 Z codes.

We appreciate your help in caring for our members, documenting HEDIS data and properly using the associated ICD-10 Z codes for our members.

Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding policies published on our website describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is offered as a resource for our payment policies; it 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 process. The following policies have been – or will be – added or updated:

- Evaluation and Management (E/M) Coding – Professional Provider – Added effective Jan. 25, 2020
- Emergency Department Services Evaluation and Management (E/M) Services Coding – Facility Services – Changes effective Jan. 25, 2020

Changes to Medicare Advantage Payment Models for Skilled Nursing Facility and Home Health Care Claims

On Sept. 9, 2019, we published an article related to the changes to the Centers for Medicare and Medicaid Services (CMS) Notice of Change to Reimbursement System for skilled nursing facilities (SNF) and Home Health. CMS launched new payment models for skilled nursing facilities and home health care. Blue Cross and Blue Shield of Texas (BCBSTX) is aligning its payment models with CMS for Medicare Advantage claims.

These changes will help support patient-focused, streamlined claims processes for skilled nursing facilities and home health agencies that are contracted to provide care and services for our Blue Cross Medicare Advantage (PPO)SM (MA PPO) and Blue Cross Medicare Advantage (HMO)SM (MA HMO) members.

What Is Changing?

- Beginning **Oct. 1, 2019**, BCBSTX will transition to CMS's Patient Driven Payment Model, which classifies skilled nursing facility claims into payment groups based on patient characteristics. This model replaces the Resource Utilization Group, Version IV (RUG-IV), which we will no longer support.

- Beginning **Jan. 1, 2020**, BCBSTX will adopt CMS's Patient-Driven Groupings Model for home health patients, as part of the Home Health Prospective Payment System. Under this new model, payment is based on 30-day periods rather than 60 days, and therapy service thresholds are eliminated.

Medicare Advantage providers should use the new CMS classifications when submitting claims for skilled nursing facility and home health services.

Learn More
Visit the CMS website for more information, including answers to frequently asked questions about CMS's payment model for skilled nursing facilities. Also, refer to the CMS website for access to an interactive grouper tool and other details on the home health patient-driven groupings model.

Laboratory Benefit Cost-share Change

Currently, Blue Cross and Blue Shield of TX (BCBSTX) covers many non-preventive lab services without any member cost-share when billed with a preventive diagnosis.

Beginning Jan. 1, 2020, or upon a member's renewal date, non-preventive labs will no longer be covered at the no member cost-share level for some BCBSTX PPO and HMO members but will instead be treated as a standard medical benefit regardless of diagnosis code. Any applicable cost-sharing (copay, coinsurance and deductible) may apply, based on the member's health plan.

What does this mean for you?

- You may have to seek payment from both BCBSTX and the member.
- You may want to alert members that they could have to pay any applicable cost share (copayment, coinsurance, deductible) for laboratory services.

Please refer to the **Clinical Payment and Coding Policies** page on the provider website for the Preventive Services Policy that contains the list of lab procedures that are considered preventive and will process at the no cost share benefit level when billed with a preventive diagnosis.

As a reminder, it is important to check member eligibility and benefits through Availity® Provider Portal or your preferred vendor web portal before every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as an applicable copayment, coinsurance and deductible amounts. Checking eligibility and benefits also helps providers confirm benefit prior authorization requirements. Providers must also ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly. Obtaining benefit prior authorization is not a substitute for checking member eligibility and benefits.

To confirm how a lab will process if it's not identified on the **Preventive Clinical Payment and Coding Policy**, please call the number on the member's ID card and ask about their non-ACA (Affordable Care Act) wellness benefit.

Note: This information does not apply to members who have BCBSTX Medicaid or Medicare Advantage plans.

Review of Implant Claims from Stand-Alone ASCs

Blue Cross and Blue Shield of Texas (BCBSTX) is changing the way we review claims for implants performed at free-standing ambulatory surgery centers (ASCs). On behalf of BCBSTX, EquiClaim currently reviews implant claims submitted by hospitals and hospital outpatient departments for services provided to our members. As of Dec. 15, 2019, EquiClaim will also provide post-payment review for all ASC claims with implant charges.

Claims containing implant charges in any combination of revenue and procedure codes will be reviewed for:

- Consistency with the provider agreement
- Consistency with Clinical Payment and Coding Policies
- Accuracy of payment

EquiClaim will let you know if your claim for an implant was incorrectly paid. They will tell you how to repay the funds or appeal the decision.

As stated in the BCBSTX recoupment guidelines, we may recoup payment for any implant that does not meet our requirements. Providers can refer to the Clinical Payment and Coding Policies and the provider manuals under Standards and Requirements on the provider website.

If you have any questions or concerns, contact Provider Customer Service at **1-800-451-0287**.

EquiClaim, a Change Healthcare Solution, an independent company, provides payment integrity solutions for Blue Cross and Blue Shield of Texas.

Risk Adjustment IVA Important Information

The height of Affordable Care Act **Risk Adjustment Data Validation – Initial Validation Audit (ACA-RADV IVA)** season is here. As a result, your office may have received requests for medical records on behalf of Blue Cross and Blue Shield of Texas (BCBSTX).

For some practitioners, the demands of fulfilling these medical records requests can be overwhelming as well as being a disruption for physicians and office staff.

Lessen the Burden

BCBSTX would like to recommend some best practices such as conducting internal audits and implementing checks that could reduce inefficiencies during the ACA-RADV IVA audit. These recommendations could increase promptness in receipt of medical records, as well as identify opportunities for billing and coding improvements.

The following best practices could potentially lessen the burden presented by additional requests and statements of attestation:

- **Medical Records Requests –** Be sure to send all medical records requested for the audit calendar year, ensuring the following documents are included for all dates of service with the providers timely signature:
    - Physician's Progress Notes
    - Discharge Summaries
    - Operative Reports
    - A&P Notes
- **Review provider signature authentication before submission.** All medical record entries must be complete and must be authenticated by the physician or practitioner who was responsible for ordering, providing or evaluating the service furnished. Acceptable physician/practitioner authentication comes in the form of handwritten signatures or electronic signatures and would include the following requirements:
    - Legible typed or printed name with handwritten signature
    - Provider's credentials
    - Date of authentication

IMPORTANT NOTE: Attestations will be required if the above-mentioned requirements are not included on the patient's medical records or if the physician's signature on the medical record is more than 180 days after the actual date of service.

If you have any questions, please contact your Network Management Representative, email the BCBSTX IVA team or contact the BCBSTX IVA Hotline at **972-766-2838**. For additional resources please visit CMS or the BCBSTX provider website.

Texas House Bill 29 – Referrals for Physical Therapy

Texas House Bill (HB) 29, changed the **Texas Occupation Code** that required a physician to diagnose the need for physical therapy before a physical therapist can treat a patient for services rendered as of Nov. 1, 2019.

HB29 expands a physical therapist's scope of licensure to remove this requirement, allowing patients to access a physical therapist without a prescription for a limited number of visits.

However, the bill did not modify the **Texas Insurance Code**. Therefore, if the Blue Cross and Blue Shield of Texas (BCBSTX) member's health plan requires a referral or prior approval and use of in-network physical therapists, those requirements still apply.

It is imperative that physical therapists obtain eligibility and benefits to confirm membership, verify coverage, determine if they are in-network for the member's policy and determine whether prior authorization is required through Availity® or their preferred vendor before treating any member without a referral. Availity allows prior authorization determination by procedure code. Refer to the BCBSTX Eligibility and Benefits page for more information on Availity.

If you have any questions, contact your Provider Network Representative.

Itemized Bills Required for BlueCard® Claims Over $200k

Beginning **Jan. 1, 2020**, we will require facilities to submit an itemized bill for any inpatient institutional claim for BlueCard members billed at or more than $200,000. The Blue Cross and Blue Shield Association requires an itemized bill to complete your claim. An itemized bill helps ensure accurate claim payments and reduces the need to submit more information after claims are paid.

What has Changed?
The claim amount requiring itemization is down from the $250,000 threshold in 2019.

How to Submit Itemized Bills
You may submit itemized bills electronically using our Claim Inquiry Resolution Tool. Be sure to include the corresponding claim number.

More Information
Refer to the "Inpatient/Outpatient Unbundling Policy" on our Clinical Payment and Coding Policy page located on the provider website for more information. If you have any questions, please contact your Blue Cross and Blue Shield of Texas Provider Network Representative.

What Is BlueCard?
BlueCard is a national program that enables members of one Blue Cross and Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan's service area. BlueCard members have a suitcase logo on their identification card.

Time-based Measurement Standard to Follow AMA

As of July 22, 2019, we changed our time measurement standard for billing physical medicine services. We will now follow the American Medical Association (AMA) guidelines for time-based services. These are time-based codes within the Physical Medicine and Rehabilitation section of the Current Procedural Terminology (CPT®) code book.

When billing for time-based services use the CPT codes in the AMA code book, except as required by federal law for Medicare and Medicaid patients. The AMA guidelines will apply to these physical medicine services:

- 97110
- 97113
- 97116
- 97530
- 97533
- 97535
- 97537
- 97542
- 97750
- G0515

As always, it is critical to check eligibility and benefits first, before rendering care and services to confirm coverage, network status and other important details. When you check eligibility and benefits online by submitting an electronic 270 transaction through the Availity® Provider Portal or your preferred web vendor portal, you may determine if benefit prior authorization may be required based on the procedure code.

Payment may be denied if you perform procedures without benefit prior authorization when benefit prior authorization is required. If this happens, you may not bill our members.

Chimeric Antigen Receptor T-cell Therapy for Cancers Decision Memo from CMS

There are important changes to the CAR T-cell therapy for certain types of cancer considered a significant cost for contract years 2019 and 2020.

The Centers for Medicare & Medicaid Services (CMS) announced that the National Coverage Determination (NCD) requiring coverage of chimeric antigen receptor (CAR) T-cell therapy for certain types of cancer is a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2019 and 2020 only, original fee-for-service Medicare will pay for CAR T-cell therapy for cancer obtained by beneficiaries enrolled in Medicare Advantage plans when the coverage criteria outlined in the NCD is met.

Consistent with §1862(t)(2) of the Act, Medicare Administrative Contractors will pay for CAR T-cell therapy for cancers for Medicare beneficiaries enrolled in Medicare Advantage plans in contract year (CY) 2019 and 2020.

For more information, see the decision memo on the CMS website.

ELECTRONIC OPTIONS

Medicare Advantage: Electronic Payment Summary Now Available for 835 ERA Receivers

This notice applies to providers submitting claims to Blue Cross and Blue Shield of Texas (BCBSTX) for Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM members.

As of Nov. 18, 2019, providers enrolled to receive Electronic Remittance Advices (835 ERA) from BCBSTX for Medicare Advantage members will begin receiving electronic provider claim summary (PCS) files, the electronic version of the remittance advice (RA), in conjunction with the ERA. The 835 ERA and PCS/RA files are delivered to your designated clearinghouse or vendor. Therefore, ERA receivers will no longer receive paper remittance advices delivered by mail.

As an additional option, provider claim summaries and/or remittance advices are available online in the Reporting On-Demand application via the Availity® Provider Portal. This application allows providers to view, download, save and/or print claim remittances for claims processed on or after April 12, 2019. For instructions on how to use this application, you'll find a Reporting On-Demand tip sheet in the Provider Tools section of our Provider website.

Not yet enrolled for ERA?

Online ERA enrollment is available to registered Availity users. If you have not yet registered, simply go to availity.com and sign up today, at no cost. To learn more about ERA enrollment through Availity, refer to the Availity ERA tip sheet. Providers who are not registered with Availity have the option to download and fax the ERA enrollment form located in the Forms section on our Provider website.

Medicare Advantage: New Claim Status Tool via Availity® Provider Portal

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

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

As of Oct. 31, 2019, a new and improved Availity Claim Status Tool is available for providers to verify status online for the above-referenced members. The Claim Status Tool is found in the Claims & Payment menu in the Availity portal and allows providers to search for claims by member ID or specific claim number.

The claim status results are real-time and provide more detailed information than the HIPAA-standard 277 claim status transaction. In addition, this new claim status option returns the following details:

- patient and provider data submitted on claims
- in-network and out-of-network patient liability breakdown
- billing and rendering provider name and NPI
- check number, check date and payee name
- other carrier payment amount
- ineligible reason codes and associated descriptions

Resources Coming Soon
For additional instructions, watch for the new **Government Programs: Claim Status Tool Tip Sheet** that will soon publish in the Provider Tools section of our provider website. As a reminder, you must be registered with Availity to utilize the Claim Status Tool. For registration information, visit availity.com, or contact Availity Client Services at 1-800-282-4548.

If you have additional questions, contact the Provider Education Consultants at PECS@bcbstx.com.

CLINICAL RESOURCES

Critical Details to Include in Hospital Discharge Summary

It is important for primary care providers (PCPs) to include detailed information when discharging Federal Employee Program® (FEP) members.

Critical Information to Include in Discharge Summary

- Course of treatment
- Diagnostic test results
- Follow-up plans
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes/medication reconciliation

Why is it important?
Communication between the inpatient medical team and the PCP helps ensure a smooth transition of the patient to the next level of care. We applaud PCPs who have adopted the best practice of receiving discharge summaries for their patients' inpatient admissions.

Studies have shown that providing timely, structured discharge summaries to PCPs helps reduce readmission rates, improves patient satisfaction and supports continuity of care. One study found that, at discharge, approximately 40 percent of patients typically have test results pending and 10 percent of those results require action. PCPs and patients may be unaware of these results.[1,3]

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

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

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

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

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment.

Important Pre- and Post-Natal Care Information

To help you provide effective coordination and continuity of care for pre- and post-natal care and services for our Federal Employee Program® (FEP) members, we are providing the following important information.

Documentation to Include in Patient's Chart

When you are providing care, please document the following information in the patient's chart:

Prenatal Visit in First Trimester

- Prenatal risk assessment should include complete medical and obstetrical history, physical exam (e.g., American College of Obstetrics and Gynecology (ACOG) Form) and patient education/counseling
- Prenatal lab reports (e.g., obstetric (OB) panel/toxoplasmosis, rubella, cytomegalovirus, herpes simplex and HIV antibody (TORCH) panel/rubella antibody test/ABO (O, A, B or AB blood group testing)/Rh factor testing)
- Ultrasound, estimated due date (EDD)

Duration of Prenatal Visits

- Prenatal flow sheet (e.g., ACOG, Electronic Health Record (EHR)) All Progress/visit notes for duration of pregnancy
- Ultrasound reports and all consult reports

Delivery

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

Postpartum

- Documentation of a postpartum visit on or between 7 to 84 days after delivery
- Postpartum office visit progress notation that documents an evaluation of weight, blood pressure, breast exam, abdominal exam and pelvic exam

Communication between health care professionals during a patient's pre-pregnancy, pregnancy and postpartum medical journey is important. Thank you for your help supporting positive outcomes for our FEP members.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment.

Antibiotic Use in Outpatient Settings

Over prescribing of antibiotics has increased antibiotic resistance. We can work together to combat antibiotic resistance and appropriately prescribe these important medications. According to a Pew[1] Charitable Trust report regarding Antibiotic Use in Outpatient Settings, 30% of antibiotics prescribed are found to be unneeded for treating conditions like viral illnesses and asthma exacerbation.

The Center for Disease Control and Prevention (CDC)[2] and other reliable sources have suggested antibiotics are most often inappropriately prescribed for conditions like:

- Asthma
- Flu
- Common cold
- Bronchitis

Using antibiotics when they are not needed can do more harm than good.

Providers should consider other remedies when treating conditions that don't need antibiotics, like:

- Getting adequate rest

- Increasing oral fluids
- Using a humidifier or cool mist vaporizer and ensuring they have been properly cleaned
- Inhaling hot shower steam or other sources of hot vapor
- Taking throat lozenges for adults and children, ages five years and older
- Considering over-the-counter medications to treat symptoms

The CDC has a poster on this topic that can be downloaded and displayed in the exam room to inform patients of your commitment to their health.

If you have any questions about the appropriate use of antibiotics, please email the Federal Employee Program Quality Improvement Department at Blue Cross and Blue Shield of Texas.

[1] *Pew Charitable Trust*
[2] *CDC is the official website of the Centers for Disease Control and Prevention (CDC). It is a public domain website, which means you may link to it at no cost and without specific permission.*

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

Recommendations and Reminders for Eye Care Professionals

Many primary care providers (PCPs) refer our diabetic Federal Employee Program® (FEP) members to eye care specialists for annual eye examinations. PCPs then need to receive communication about the eye care their patients receive from the patients' eye care specialists. We encourage providers who do not routinely share results to consider doing so.

For quick reference, below is the 2017 American Diabetes Association (ADA) updated position statement on diabetic retinopathy and screening recommendations[1] to assist eye care specialists when providing annual eye exams to diabetic FEP members.

Screening	• Comprehensive evaluation by an eye care specialist should not be substituted by retinal photography. However, retinal photography with remote reading by retinal specialist is acceptable where eye care professionals are not readily available.
Initial Exam	• Within five years of diagnosis for adults who have Type 1 diabetes • At the time of diagnosis for adults with Type 2 diabetes
Routine Exams	• Every two years in the absence of retinopathy • Annually in the presence of retinopathy • At more frequent intervals in the presence of progressive retinopathy and/or deterioration of vision due to disease progression
Pregnancy	• Educate women who are planning to be or are pregnant and who also have diabetes about the risk of diabetic retinopathy developing or progressing • Perform an eye exam prior to or at the time of diagnosis of pregnancy, during every trimester, and one year after delivery in the presence of pre-existing Type 1 or Type 2 diabetes

To help improve patient outcomes, please consider the following:

- **Incorporate ADA recommendations into practice.** Follow the above screening recommendations to ensure best practice for patients.
- **Gather patient information.** Ask the patient about their diabetes history, medications they are taking, symptoms they are experiencing and if they have any questions.
- **Educate your patients.** Help them understand why a retinal exam for patients with diabetes is different from an eye exam for glasses and why it is essential to help prevent future problems.
- **Remind your diabetic patients to contact the number on their member ID card if they have any questions about their health care coverage details.** A yearly retinal exam may be a covered benefit for

patients with diabetes.
- **Submit claims accurately.** When submitting a claim for a diabetic patient eye exam, be sure to include "diabetes" as a diagnosis to help ensure proper application of benefits.

We thank you for collaborating with us to support the health and wellness of our FEP members. Working together, we can help support improved outcomes for people with diabetes.

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

The information in this article is being provided for educational purposes only and is not the provision of medical care or advice. Physicians and other health care providers are to their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

Congenital Syphilis Health Advisory Alert

Reported syphilis and congenital syphilis (CS) cases are increasing nationally and in Texas. In 2018, there were 367 cases of CS reported in Texas, which includes confirmed and probable (suspected) cases, as well as syphilitic stillbirths.

New state legislation was enacted Sept. 1, 2019, to increase syphilis testing in pregnant women and mandated testing:

- At first prenatal care examination
- During third trimester (no earlier than 28 weeks gestation)
- At delivery

As a Texas health care provider, you are urged to:

- Screen all pregnant women for syphilis according to new testing requirements.
- Look for clinical signs/symptoms of syphilis in all patients.
- Treat patients with evidence of syphilis or recent exposure to syphilis on-site when possible. Document stage of syphilis and treatment administered.
- Report syphilis cases to your local or regional health department at the time of diagnosis. Include pregnancy status and treatment in the report.
- Test and evaluate newborns potentially exposed to syphilis *in utero*.
- Update electronic health record/electronic medical record systems to reflect new testing requirements.

For additional information, refer to the Texas Health and Human Services' Health Advisory Alert - Congenital Syphilis.

What You Need to Know About the 2019-2020 Flu Season

The Centers for Disease Control and Prevention (CDC) recommends yearly flu shots for all patients 6 months and older without vaccine contraindication. Providers may administer any U.S. Food and Drug Administration (FDA) approved, age-appropriate flu shot. Remember to review the current flu vaccine product table for the most recent updates on available products and their approved age ranges.[1]

What's Different this Flu Season?[1]

- All standard adult and pediatric dose flu vaccines will be quadrivalent; no trivalent regular dose flu shots are available this season.
- Afluria Quadrivalent® is now licensed for children 6 months of age and older.

- Baloxavir (Xofluza™) is a new single-dose antiviral drug approved by the FDA for people 12 years and older who have had flu symptoms for less than 48 hours. Baloxavir (Xofluza) is not a substitute for early vaccination with the annual seasonal flu vaccine.

Reminders this Flu Season[2]

- Trivalent high dose or adjuvant containing flu vaccines for the elderly (65 and older) are made specifically to create a better or stronger immune response.
- Oseltamivir (Tamiflu®) is used for the treatment of influenza for patients 2 weeks or older who have had flu symptoms for less than 48 hours, as well as the prophylaxis of influenza in patients 1 year and older. Oseltamivir (Tamiflu) is not a substitute for early vaccination with the annual seasonal flu vaccine.
    - Oseltamivir (Tamiflu) is also available as a generic medication, which may have a lower cost to the member compared to a branded medication.

Coding Reminders

- Please file your claims with correct coding*
    - The American Academy of Pediatrics (AAP) coding chart recommends which billing code to use based on the vaccine administered. (This chart is not a comprehensive list.)
- Code descriptions are specific to the vaccine product.
- Code descriptions may include:
    - Dosage amounts
    - Trivalent versus quadrivalent formulations
    - Distinctive features (i.e., preservative-free, split virus, recombinant DNA, cell cultures or adjuvanted).

***Correct coding requires services to be reported with the most specific code available that appropriately describes the service.*

[1]CDC, Frequently Asked Influenza (Flu) Questions: 2019-2020 Season, Sept. 16, 2019.
[2]CDC, Antiviral Drugs for Seasonal Influenza: Additional Links and Resources, Nov. 29, 2018.

Reminder: CMS Requires Insurers to Conduct ACA Risk Adjustment Program Audit

The Centers for Medicare and Medicaid Services (CMS) is conducting an Initial Validation Audit (IVA) to validate the data used when assessing the payment transfers for the Affordable Care Act's (ACA) Risk Adjustment (RA) program. The provider's role is essential to the success of the IVA. Therefore, if any of your patients are selected to be included in the IVA, Blue Cross and Blue Shield of Texas (BCBSTX) is asking for your cooperation and commitment to fulfilling the requirements of the IVA.

The IVA began in June 2019 and will review claims with dates of service in 2018. The IVA will be performed on a sample of members enrolled in ACA-compliant individual and small group plans, both on and off-exchange. Our IVA auditor will validate medical claims of the sampled members from the previous calendar year. For example, this IVA will be conducted in 2019 but will review claims with dates of service in 2018. Please be aware some of these claims may have been paid in 2019 and are likely to be included in the IVA sample.

BCBSTX is working to retrieve the requested medical records that we must submit to our IVA auditor. Our IVA auditor requires medical records to validate the sampled member's risk score calculation which is based on the diagnosis codes submitted on a member's claims, as well as through supplemental diagnosis submissions based on medical record review. As BCBSTX providers, you will be asked to provide medical records to validate all of the diagnosis codes used in the ACA RA risk score calculation. It is of utmost importance that you respond to these requests in a timely manner.

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

If you have any questions, please contact your Network Management Representative or email the IVA team at BCBSTX directly at IVA_Records_Texas@bcbstx.com.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes – Part 1

Review drug list changes, updates and revisions that go into effect Jan. 1, 2020.
Read More

HEALTH & WELLNESS

New Programs Help Members Lead Healthier Lives

A complex combination of factors affects each person's health journey. Some of our Blue Cross and Blue Shield of Texas (BCBSTX) members are navigating critical health concerns. They may be struggling to combat chronic conditions such as diabetes, obesity, substance abuse disorder or depression. Our Wellbeing Management and Health Advocacy Solutions programs help empower our members to improve their own health and wellness.

Wellbeing Management and Health Advocacy Solutions

Employers can offer BCBSTX Wellbeing Management and Health Advocacy Solutions to their BCBSTX insured employees. Members have access to components of these programs depending on their benefit plans. We have relationships with several companies to increase member participation in programs that target critical health issues. We've seen positive results so far.

Options for Member Engagement

Some of your patients with Wellbeing Management or Health Advocacy Solutions may mention the programs listed below. These programs combine data sciences with cognitive behavioral therapy coaching techniques and may use internet-connected biometric devices to help our members achieve health improvement goals.

- Well on Target's Wellness Portal gives eligible members an online platform to find support for chronic conditions. They can also use the portal to help establish lifelong wellness goals.
- Livongo is an end-to-end diabetes management solution. It combines the use of a connected glucose meter with personal support by Certified Diabetes Educators.
- Omada is an obesity-related prevention program. It uses remote monitoring tools, education and social community support to improve health and reduce chronic disease risk.
- Naturally Slim is an online weight loss and metabolic syndrome management solution and coaching program. It teaches healthy eating behaviors via a behavior modification structure.
- Hinge Health is new for 2020 and it provides a musculoskeletal program that takes proven nonsurgical care guidelines and turns them into a coach-led program. It is delivered remotely using mobile and wearable technology.

We encourage you to talk with your patients about available programs and resources. Members with questions can call the number on their BCBSTX ID card or log in to their Blue Access for Members℠ account for more information.

This material is meant for informational purposes only. It includes only a brief description of some plan benefits. Not all benefits are offered by all plans. For details, including benefits, limitations and exclusions, refer patients to their certificate of coverage.

Livongo is an independent company that has contracted directly with BCBSXX to provide a diabetes management program that is covered under some of the health benefit plans. Naturally Slim is an independent company that has contracted directly with BCBSXX to provide a weight loss and metabolic syndrome reduction program that is covered under some of the health benefit plans. Omada is an independent company that has contracted directly with BCBSXX to provide an obesity-related chronic conditions (type 2 diabetes and heart disease) risk reduction program that is covered under some of the health benefit plans. Hinge Health offers digital care programs for people with chronic musculoskeletal conditions, such as back or joint pain, using technology to create a delightful participant experience by combining sensor-guided exercise therapy with health coaching and education. This material is meant for informational purposes only. BCBSXX makes no endorsement, representations or warranties regarding any products or services offered by independent companies such as Livongo, Naturally Slim, Omada and Hinge Health. These companies are solely responsible for the products or services they provide. If you have any questions regarding the services described here, you should contact Livongo, Naturally Slim, Omada or Hinge Health directly.

Be Covered – Increasing Coverage for the Uninsured and Underinsured

More than 5 million people in Texas do not have health insurance. Approximately 61% of those qualify for Medicaid or a federal subsidy to help reduce the cost of coverage. Affordable care and better health outcomes start with health care coverage.

To help address this issue, Blue Cross and Blue Shield of Texas (BCBSTX) is promoting Be Covered, our grassroots campaign to educate, engage and enroll the uninsured and underinsured in our communities.

How can you help?

- If you have patients who are underinsured or uninsured, tell them about Be Covered and the available resources (like the subsidy calculator).
- Providers should encourage patients to use the education tools available on Be Covered so they are better informed about their coverage options.

Our goal is to help people understand their coverage options and how to make the most of what is available to them – no matter their stage of life.

Through Be Covered, BCBSTX is working with trusted community partners to reach areas with the highest concentration of uninsured people. Local events will offer resources in English and Spanish, and many will provide wellness screenings, family activities and healthy food giveaways.

Visit Be Covered for more information.

PRIOR AUTHORIZATION INFORMATION

New Prior Authorization Requirements for Blue Cross Medicare Advantage℠ Beginning Jan. 1, 2020

There are important updates to the Prior Authorization Procedure Code List for patients enrolled in Medicare Advantage plans offered by Blue Cross and Blue Shield of Texas (BCBSTX) effective **Jan. 1, 2020**.

These updates are due to changes from the American Medical Association, eviCore® as well as the internal BCBSTX review processes. Remember, please 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 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 under the Claims and Eligibility tab 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. Remember when submitting a pre-service appeal to always follow the directions included within the denial letter.

The updated **Blue Cross Medicare Advantage Prior Authorization Requirements List** is included below. **Watch for the updates to the Prior Authorization Procedure Code List reflecting the 2020 changes**. It will be posted **by Nov. 1, 2019** on the BCBSTX provider website on the Clinical Resources page under Prior Authorizations and Predeterminations.

If you need assistance or do not have internet access, below is a list of our Network Management offices by location to contact:

Network Management Office	Telephone Number
Blue Cross Medicare Advantage Network Management	972-766-7100
Ancillary – Statewide	Refer to the **Contact Us** page on the provider website at www.bcbstx.com/provider and locate phone and fax by specialty.

2020 New Prior Authorization Requirements and Introduction of MyBlue Health℠

There are important changes coming to the prior authorization requirements for members with Blue Choice PPO℠, Blue Essentials℠, Blue Advantage HMO℠ and Blue Premier℠. In addition, we are implementing our new focused network – MyBlue Health – effective Jan. 1, 2020. The prior authorization requirements for MyBlue Health will be the same as our Blue Advantage HMO plan.

Beginning Jan. 1, 2020, prior authorization will be added or expanded on the above benefit plans for the following services:

- Outpatient provider administered drug therapies, including cellular immunotherapy, gene therapy and other medical benefit drug therapies.

Providers can locate a list of the procedure codes being added for these drug therapies by reviewing the "Specialty Drugs Prior Authorization List" located on the provider website under Clinical Resources/Prior Authorization & Predeterminations then select **Prior Authorization Requirements for Commercial and Retail Plans**.

It is critical that providers 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.

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

To prior authorize services through BCBSTX, use iExchange® or call the phone number listed on the member's ID card. For more information or to set up an iExchange account, refer to iExchange on the provider website.

If you need assistance, view the list of our Network Management offices to contact.

NETWORK PARTICIPATION

New Blue Cross Medicare Group Plan Names and ID Cards

Beginning Jan. 1, 2020, health care providers will notice new Blue Cross Medicare and Medicare Supplement **group** plan names and ID cards. Blue Cross Medicare Advantage℠ plan names for **individuals** will remain the same.

While the group plan names have changed, your experience as a health care provider will be the same. This name change will not affect member benefits.

New Group Plan Names:

- **Blue Cross Group Medicare Advantage (HMO)℠** is the new name of Blue Cross Medicare Advantage (HMO)℠ for group Medicare members. This plan provides members access to providers within a defined network, with no out-of-network benefit.

- **Blue Cross Group Medicare Advantage (PPO)℠** is the new name of Blue Cross Medicare Advantage (PPO)℠ for group Medicare members. This traditional PPO allows members to seek care in-network and out-of-network, typically providing cost savings for in-network care.

- **Blue Cross Group Medicare Advantage Open Access (PPO)℠** is the new name of Blue Cross Medicare Advantage (PPO) Employer Group℠. This plan offers members access to willing providers nationwide who accept assignments from Medicare and are willing to bill Blue Cross and Blue Shield of Texas (BCBSTX). Coverage levels are the same for in-network and out-of-network care.

- **Blue Cross Group MedicareRx℠** is the new name of Blue Cross MedicareRx (PDP)℠. It provides Medicare Part D prescription drug coverage.

- Groups with the BlueStages℠ Plan are transitioning to the name **Blue Cross Group Medicare Supplement℠**. This plan helps members cover some costs not covered by Original Medicare, such as copayments and deductibles. Group Medicare Supplement members can see providers nationwide who accept Medicare Assignment and are willing to bill BCBSTX.

Questions? Please refer to the Customer Service number on the back of the new group plan cards.

EDUCATION & REFERENCE

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.

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 health care 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℠*
- MyBlue Health℠

Blue Advantage HMO, Blue Essentials, Blue Premier and MyBlue Health 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, Blue Premier and MyBlue Health** 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, prior authorization 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
MyBlue Health	Yes	Yes	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 prior authorization or prenotification.
- It is imperative that providers use Availity® or their preferred vendor to obtain eligibility and benefits, determine if they are in- or out-of-network for their plan, and whether prior authorization/ prenotification is required. Availity allows prior authorization determination by procedure code. Refer to the BCBSTX Eligibility and Benefits web page for more information on Availity.

- Utilize iExchange® or call the prior authorization 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 Prior Authorization/Referral

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

To determine if a service requires a referral or prior authorization, it is imperative that providers check eligibility, benefits, and prior authorization requirements through Availity® or your preferred vendor and also reference the Prior Authorizations & Predeterminations under Clinical Resources on bcbstx.com/provider.

Prior authorizations/referrals may be required 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 prior authorization/referral is also needed for an initial stay in a facility and any additional days or services added on.

Prior authorizations are required to allow for medical necessity review. If a member/subscriber does not obtain a prior authorization/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 prior authorization/referral does not guarantee payment. All payments are subject to determination of a member'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 prior authorization/referral request is received from an out-of-network (OON) provider and the member does not have an OON benefit, BCBSTX will contact the ordering provider to discuss network options. However, if a member 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

Health care 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 prior authorization 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 health care 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 health care 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.

Access the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network® Medicare Preventive Services for detailed information on Medicare Preventive Services for detailed information on Medicare Preventive Services.

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

Annual Health Assessment Coding*

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

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

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

Billing and Documentation Information and Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) has implemented changes to clarify existing policies related to billing and documentation requirements for the BlueChoice® PPO, Blue Advantage HMOSM, Blue EssentialsSM, Blue PremierSM, MyBlue HealthSM, Blue Cross Medicare Advantage (PPO) SM and Blue Cross Medicare Advantage (HMO) SM plans. These updates are reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Heath Provider Manual in Section F Filing Claims posted on bcbstx.com/provider under Standards and Requirements/Manuals.

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.

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 under the Education and Reference then Provider Tools or Claims and Eligibility then Claims Filing Tips in the Bundling section 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, Cotiviti formerly known as Verscend Technologies, Inc. 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 Research Tool (CRT), which is available on the Availity Provider Portal to research specific claim edits.

**The above notice does not apply to government program claims (Medicare Advantage and Texas Medicaid).*

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 health care 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.

Contracted Providers Must File Claims

As a reminder, health care 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 health care 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℠, Blue Advantage HMO℠ and MyBlue Health℠ 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 health care 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 and 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: Health care providers who are contracted/affiliated with a capitated IPA/medical group and health care providers who are not part of a capitated IPA/medical group but who provide services to a member 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.

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 Prior Authorization 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.

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eviCore®

Use eviCore Web Portal for Prior Authorization 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 prior authorization through eviCore, you should submit prior authorization requests through eviCore's provider portal. Using the eviCore provider portal to submit requests for prior authorization 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 prior authorization, including what procedures codes require prior authorization
- **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 Advantage SM: getbluetx.com/mapd/druglist
   - Blue Cross Medicare Advantage Dual Care (HMO SNP) SM: getbluetx.com/dsnp/druglist
   - Texas STAR: bcbstx.com/star/prescription-drugs/drug-coverage
   - Texas CHIP: bcbstx.com/chip/prescription-drugs/drug-coverage
   - Texas STAR KIDS: bcbstx.com/starkids/plan-details/drug-coverage.html

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

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

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

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

Visit the Pharmacy Program page for more information.

**Not available for all plans. Members should call the customer service number on their ID card to help determine what benefits may be available, including any requirements, limitations or exclusions that apply. Please refer to the member's certificate of coverage and prescription drug list as there may be coverage for additional products beyond these lists.*

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

After-hours Access Is Required

Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians/providers,
Specialty care health care 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℠ Provider Manual (Section B) and Blue Essentials, Blue Advantage HMO, Blue Premier, MyBlue Health Provider Manual (Section B) available in the General Reference Information section of our provider website.

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 prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

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

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

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

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

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
Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association