April 2020

NOTICES & ANNOUNCEMENTS

Provider Information on COVID-19 Coverage

Blue Cross and Blue Shield of Texas (BCBSTX) is covering testing to diagnose the 2019 Novel Coronavirus (COVID-19) for most members with no prior authorization needed and no member copays or deductibles when using in-network providers. For **treatment of COVID-19**, we cover medically necessary health benefits, including physician services, hospitalization and emergency services consistent with the terms of each member's benefit plan. Members should always call the number on their ID card for answers to their specific benefit questions.

Note: Many of our members are covered under a health plan that is self-insured by their employer. **Some of these members may be responsible for copays or deductibles.**

Check Members Eligibility and Benefits
Use the Availity® Provider Portal or your preferred vendor to check eligibility and benefits.

Claims for COVID-19 Testing
If you test a member when it's medically necessary and consistent with CDC guidance, submit the claim to us using the appropriate code:

- HCPCS code U0002 (Non-CDC lab test)
- CPT code 87635 (American Medical Association (AMA) code for SARS-2-CoV-2 lab test)

The Centers for Medicare and Medicaid Services (CMS) has set the price for the COVID-19 diagnostic tests at $51.33 for U0002 and 87635. We will follow CMS pricing and apply the terms of our contracts.

Out-of-Network Providers
If you are not in our networks, our allowed amount for U0002 is consistent with Medicare pricing.

Telemedicine and Telehealth
Many members have telehealth benefits. For those members, telehealth visits will be covered as a regular office visit for providers who offer the service through 2-way, live interactive telephone or digital video consultations. Some plans also provide access to MDLive or a similar vendor with a network of physicians who provide telehealth services. For more details, refer to the Using Telemedicine and Telehealth in Response to COVID-19 article in News and Updates as well as our Telemedicine and Telehealth Services page.

Pharmacy
For members who have BCBSTX pharmacy benefits administered through Prime Therapeutics, BCBSTX will allow members to receive an early fill of their medication for the same quantity as the last prescription filled. We also encourage members to use their 90-day mail order benefit, if applicable. All pharmacy practice safety measures, as well as prescribing and dispensing laws, will remain.

We are also prepared for medication shortages or access issues. Patients will not be liable for additional charges that may stem from obtaining a non-preferred medication if the preferred medication is not available due to shortage or access issues.

What is the risk of COVID-19?
According to recent reports from the CDC, the immediate health risk from COVID-19 is low. We are ready to help you serve our members and the community in understanding, preventing and potentially treating people who have been affected by the COVID-19.

We've developed a member-facing flier about COVID-19 that you may share with your patients.

More Information
Because this is a rapidly evolving situation, you should continue to use Centers for Disease Control guidance on COVID-19, as the CDC has the most up-to-date information and recommendations. In addition, watch for updates on BCBSTX News and Updates.

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

Telemedicine and Telehealth Coverage Expansion in Response to COVID-19 | Updated 04/01/2020

In response to the coronavirus (COVID-19), Blue Cross and Blue Shield of Texas (BCBSTX) is temporarily expanding coverage for medical and behavioral health telemedicine and telehealth visits. For insured plans regulated by the State of Texas – identified by a "TDI" or "DOI" printed on the member identification card – BCBSTX will cover telemedicine medical services and telehealth services in accordance with the temporary emergency rules adopted by the Texas Department of Insurance March 17, 2020.

We are continuing to evaluate the evolving state and federal legislative and regulatory landscape relating to COVID-19 and will continue to update our practices accordingly.

Expansion of telemedicine/telehealth coverage:
With the temporary enhancements to existing in-network telemedicine/telehealth benefits, the coverages below will apply for state-regulated, fully insured members who receive covered telemedicine/telehealth services. This applies to claims with dates of service beginning March 10, 2020.

Telemedicine/telehealth visits covered as a regular office visit for providers who offer the service through 2-way live interactive telephone or digital video consultations. Please note that on a temporary basis in response to COVID-19, audio-only consultations will be covered when provided in accordance with applicable regulations and rules. Continued access to MDLive or a similar telemedicine/telehealth vendor, with a network of physicians who provide telemedicine/telehealth services.

No member cost-sharing for covered, medically necessary medical and behavioral health services delivered via telemedicine or telehealth by a qualified in-network provider.

BCBSTX will reimburse in-network professionals at least the same rate for a telemedicine/telehealth service as it reimburses for the same service when provided in- person, including covered mental health services.

Effective March 18, 2020, The Families First Coronavirus Response Act (FFCRA) requires employer-funded health plans to provide coverage for COVID-19 testing and related services. Some benefits may be different depending on the decisions the employer makes about expanding telehealth services at no-cost share to members.

Resources: For more information refer to our Telemedicine and Telehealth Services page.

The following telemedicine/telehealth codes are accepted by BCBSTX for use by physicians and other health care providers including behavioral health therapy services:

Code	Description
90791*	Psych diagnostic evaluation
90792*	Psych diagnostic evaluation w/medical services
90832*	Psychotherapy 30 min

90833*	Psychotherapy 30 min w/e&m evaluation
90834*	Psychotherapy 45min
90836*	Psychotherapy 45 min w/e&m evaluation
90837*	Psychotherapy 60min
90838*	Psychotherapy 60 min w/e&m evaluation
90847*	Family psychotherapy
97151	Behavior identification assessment, administered by a phys/QHP
97152	Behavior identification-supporting assessment by 1 tech
97153	Adaptive behavior treatment by tech
97154	Group adaptive behavior treatment by tech
97155	Adaptive behavior treatment phys/QHP
97156	Family adaptive behavior treatment phys/QHP
97157	Multiple family adaptive behavior treatment
97158	Group adaptive behavior treatment phys/QHP
98966	Nonphysician telephone assessment 5-10 min
98967	Nonphysician telephone assessment 11-20 min
98968	Nonphysician telephone assessment 21-30 min
98970	QNHP online digital E/M SVC EST PT <7 D 5-10 min
98971	QNHP online digital E/M SVC EST PT <7 D 11-20 min
98972	QNHP online digital E/M SVC EST PT <7 D 21+ min
99201*	Office visit new patient
99202*	Office visit new patient
99203*	Office visit new patient
99204*	Office visit new patient
99205*	Office visit new patient
99213*	Office visit established patient 15 min
99214*	Office visit established patient 25 min
99215*	Office visit established patient 40 min
99421	Physician /Qualified Health Professional telephone evaluation 5-10 min
99422	Physician /Qualified Health Professional telephone evaluation 11-20 min
99423	Physician/Qualified Health Professional telephone evaluation 21-30 min
99441	Physician/Qualified Health Professional online digital evaluation 5-10 min
99442	Physician/Qualified Health Professional online digital evaluation 11-20 min
99443	Physician/Qualified Health Professional online digital evaluation 21-30 min

*Providers submitting claims for telemedicine/telehealth services using these codes must append with modifier 95.

For Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) services, providers can bill for those services using the appropriate HCPCS codes (e.g., H0035 and S0201 for PHP and H0015 and S9480 for IOP) and attach the 95 modifier when delivering these services via telehealth.

Note: This list is not inclusive of all telemedicine/telehealth codes. Other services may be eligible for telemedicine/telehealth reimbursement when billed with the appropriate CPT®/HCPCS codes and any applicable modifiers.

Because this is a rapidly evolving situation, you should continue to use the Centers for Disease Control Guidance (CDC) on COVID-19, as the CDC has the most up-to-date information and recommendations. Additionally, watch for updates on BCBSTX News and Updates and our COVID-19 Preparedness pages.

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

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iExchange® Deactivates April 15, 2020 – Use Availity Authorization & Referrals

iExchange is being deactivated on April 15, 2020. Be sure to transition to Availity Authorizations & Referrals for online prior authorization and referral submissions. Check News and Updates on our provider website for additional information.

BEHAVIORAL HEALTH

2019 Behavioral Health Quality Improvement Program Evaluation Executive Summary

This Executive Summary provides an analysis and evaluation of the overall effectiveness and key accomplishments of the Behavioral Health (BH) Quality Improvement (QI) Program for Health Care Service Corporation (HCSC), Inc.

2019 Accomplishments

1. Content was added to the BH landing page on the Connect Community site to provide members with access to BH content and information regarding multiple topics, including loneliness, depression and anxiety, substance abuse and attention-deficit/hyperactivity disorder (ADHD).
2. Federal Employee Program developed a Follow-Up After Emergency Department Visit for Mental Illness (FUM)/Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Incentive Program for select high volume emergency departments, which began Q1 2019
3. Continued an awareness campaign regarding the use of telehealth services with ten facilities and community providers across Illinois, Montana, Oklahoma and Texas.
4. Partnered in the successful completion of six (6) Utilization Review Agent (URA) certificate renewals with BCBSTX and one (1) with BCBSOK.
5. Launched the Follow-Up After Hospitalization (FUH) 30-day Facility Incentive Program across the enterprise, which includes ten facilities.

Program Focus for 2020

Based on the review of the 2019 program goals, an increased understanding of barriers to improvement, and attention to lessons learned during the year, the following primary areas for focus of the HCSC BH Quality Improvement Work Plan for 2020 include:

1. Measure, monitor, and continuously improve performance of behavioral health care in key aspects of clinical and service quality for members, providers and customers.
2. Maintain a high level of satisfaction among providers and members.
3. Focus continuous quality improvement efforts on those priority areas defined in the annual BH QI Work Plan.
4. Continue to explore social determinants of health and focus on implementing new initiatives to address identified areas of concern, increase member resources and improve access.
5. Facilitate rounds, annual trainings and other activities as necessary to optimally manage behavioral health complaints and adverse incidents.
6. Increase the 7-day and 30-day rates for Follow-Up After Hospitalization (FUH), Follow-Up After Emergency

Department Visit for Alcohol and Other Drug Dependence (FUA) and Follow-Up After Emergency Department Visit for Mental Illness (FUM).

CLAIMS & ELIGIBILITY

Clarification: New BCBSTX 837 Commercial Claim Validation Edits Effective April 1, 2020

This is a follow-up to provide clarification on a previous notice, posted Feb. 27, 2020.

As of April 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) is implementing enhancements to our electronic claim submission validation edits for commercial Professional and Institutional claims (837P and 837I transactions). *These enhancements allow claim edits to be applied to claims during the pre-adjudication process, giving you the ability to identify errors earlier in the process and make necessary corrections more quickly.

- Prior to April 1, 2020, electronic claim submissions were accepted into the BCBSTX adjudication system for processing and then denied when needed data elements are not included.
- When you submit claims electronically on or after April 1, 2020, you may see new edit messages on the response files from your practice management system or clearinghouse vendor(s) **before** the claim is adjudicated. These responses will specify if additional data elements are required.
- If you receive claim rejections, the affected claims must be corrected and resubmitted with the needed information as specified.
- If you have questions regarding an electronic claim rejection message, contact your practice management/hospital information system software vendor, billing service or clearinghouse for assistance.

**These new validation edits apply to Blue Advantage HMO℠, Blue Choice PPO℠, Blue Essentials℠, Blue Premier℠ and MyBlue Health℠. They do not apply to Blue Cross Medicare Advantage℠ or Texas Medicaid electronic claims.*

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 have been recently added:

- Medical Record Documentation Guideline – Effective 3/10/2020
- Telemedicine and Telehealth Services – Effective 5/10/2020
- Inpatient Readmissions – Effective 6/20/2020

Three New ClaimsXten™ Rules to be Implemented June 2020

On or after June 15, 2020, we will update the following three rules in the ClaimsXten software database to better align coding with the reimbursement of claim submissions.

Revenue Codes Requiring Healthcare Common Procedure Coding System (HCPCS) Code	This rule recommends the denial of claim lines if they are: • Submitted with a revenue code that requires a HCPCS code, and • No HCPCS code is present. If a claim is missing an HCPCS code, the claim line will be denied.

Lifetime Event	This rule audits claims to determine if a procedure code has been submitted more than once or twice on the same date of service or across dates of service when it can only be performed once or twice in a lifetime for the same member. The Lifetime Event is the total number of times that a procedure may be submitted in a lifetime. This is the total number of times it is clinically possible or reasonable to perform a procedure on a single member. After reaching the maximum number of times, additional submissions of the procedure are not recommended for reimbursement.
Multiple Medical Same Day Visits	This outpatient facility rule identifies and recommends the denial of claims with multiple Evaluation & Management (E&M) codes and other visit codes that are: • Submitted on the same date of service, • Performed at the same facility, • Submitted with the same revenue code, and • Where the second and subsequent E&M code submitted lacks the required modifier –27.

To determine how coding combinations may be evaluated during claim adjudication, use Clear Claim Connection™ (C3). Refer to the Clear Claim Connection page for answers to frequently asked questions about ClaimsXten and details on how to gain access to C3.

Two New ClaimsXten™ Rules to be Implemented in 2020

Blue Cross and Blue Shield of Texas (BCBSTX) will soon update our ClaimsXten software to better align coding with the reimbursement of claim submissions.

Update Schedule

On April 20, 2020, BCBSTX will update two rules:

1. Bilateral Services for Professional Claims
2. Modifier to Procedure Validation Filter – Non-payment Modifiers

Update Details

Bilateral Services for Professional Claims	This rule identifies claim lines where the submitted procedure code was already billed with a modifier –50 for the same date of service. The same service performed bilaterally should not be billed twice when reimbursement guidelines require the code to be billed once with a bilateral modifier. The rule denies the second submission.

Modifier to Procedure Validation Filter – Non-payment Modifiers	For non-payment modifiers, this rule identifies claim lines with an invalid modifier to procedure code combination. It recommends the denial of procedure codes when billed with any non-payment affecting modifier that is not likely or appropriate for the procedure code billed. When multiple modifiers are submitted on a line, all are evaluated and if at least one is found invalid with the procedure code, the line is recommended for denial.

To determine how coding combinations may be evaluated during claim adjudication, use Clear Claim Connection™ (C3). Refer to the Clear Claim Connection page for answers to frequently asked questions about ClaimsXten and details on how to gain access to C3.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2020 — Part 2

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

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2020 — Part 1

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

HEALTH & WELLNESS

New Annual Wellness Visit Resources for Medicare Providers

We have two new resources to help you care for our Medicare Advantage members during their annual wellness visits: an Annual Wellness Visit guide and Annual Wellness Visit form. These resources can help you document our members' visits to more easily meet Medicare requirements.

The guide and form are for your use only and do not need to be returned to us.

What's New?

The **Annual Wellness Visit Guide** includes a wellness visit checklist and information on:

- Medicare coverage for wellness visits
- Correct coding for wellness visits
- Guidance to help ensure all member conditions are correctly coded each year
- Coding for other evaluation and management services, such as lab tests
- Preventive services and screenings
- Closing care gaps by performing Healthcare Effectiveness Data and Information Set (HEDIS®) measurements
- Coding tips to help minimize requests for medical records and help expedite claims processing

You may use the new **Annual Wellness Visit form** during wellness visits. It includes sections for members' medical history, risk factors, conditions, treatment options, coordination of care and advance care planning. It can be used as a digital fillable form or printed and completed by hand during the visit.

Annual Wellness Visits Help Our Members Stay Healthy

Wellness visits provide opportunities to screen for health conditions and manage chronic ones. To support our members' health, you can:

- Remind them to schedule their annual wellness visit for 2020.
- Discuss behavioral and physical health and preventive measures such as healthy weight, fall prevention, diet and exercise.

Members may be able to earn a reward for getting an annual wellness exam and other screenings. An initial preventive visit and subsequent annual wellness visits have no copay and are provided at no additional out-of-pocket cost for Medicare Advantage members. See our guide for more information. Additional services may result in member cost-sharing.

It is important that you use the Availity® Provider Portal or your preferred vendor to check eligibility and benefits before every scheduled appointment. Eligibility and benefit quotes include membership confirmation, coverage status and applicable copayment, coinsurance and deductible amounts. Ask to see the member's Blue Cross Medicare Advantage Member ID card and a driver's license or other photo ID to help guard against medical identity theft.

NETWORK PARTICIPATION

Using the Online Tool to search for Doctors and Hospitals

Has it been awhile since you checked your online office location information? Our online search tool helps members and providers easily find in-network physicians, specialists and other health care providers.

Get started now:

1. Select Find a Doctor or Hospital from the bcbstx.com website.
2. Choose Guest Search. Select the "Search All Providers" link in the "Are You Shopping? Find a Provider by Name or Location" section
3. **To check your own information for accuracy**, enter your name and your location and select "Find a Doctor or Hospital" at the bottom of the page. Then in the search results, select your name to view your record, which will include the BCBSTX group and retail networks with which you are contracted.

   To search for other providers who are in-network for one of your patients, go back to the "Find a Doctor or Hospital" screen, then:
4.
   - Enter a provider's name and location in the "Search All Providers" link in the "Are You Shopping? Find a Provider by Name or Location" section. Then select "Find a Doctor or Hospital" at the bottom of the page.
     Or
   - Enter the location information then choose "More Search Options" to reveal other search options. Choose a provider type or a specialty from the dropdown box. Then select "Find a Doctor or Hospital" at the bottom of the page.

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

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

CMS Star Ratings Matter: Survey to Assess Medicare Advantage Members' Experiences

As a Medicare provider, you play an important role in an annual survey to assess our members' experiences with their health plans and prescription drug services. The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey will be sent to a random sample of members enrolled in our Blue Cross Medicare Advantage℠ and/or

prescription drug plans. The survey will be conducted from March through June 2020. If your patients receive a CAHPS survey, please encourage them to respond.

The CAHPS survey evaluates how our members interact with their health plan, including with you, their Medicare provider. Survey results identify opportunities to improve member satisfaction. Results also affect the Centers for Medicare & Medicaid Services (CMS) Star Ratings, which rate Medicare Advantage plans on a scale from one to five stars. More information on the Star Ratings is available on the CMS Medicare website.

CAHPS Survey Questions
The CAHPS survey asks members to rate their last six months of care. Examples of survey topics and questions include:

- Getting needed care – Did you receive the care you felt you needed quickly and were you able to get urgent appointments with a specialist if needed?
- Provider communication – Did your provider show respect, spend enough time and explain things in a way you could understand?
- Customer service – Did you receive helpful information from office staff?
- Care coordination – Was your provider informed and up-to-date about the care you received from other providers?
- Flu vaccination – Did your provider educate you on the benefits and importance of a yearly flu vaccination?
- Smoking cessation – Did your provider ask if you smoke or use tobacco and if so, advise you to quit and discuss medications and strategies?

How You Can Help Improve Members' Experiences
You and your staff can help improve members' experiences year-round. Questions to consider include:

- Do you or your office staff assist patients in scheduling appointments with specialists?
- Are urgent care walk-in appointments available in the morning and evening hours?
- Do you spend time explaining things to patients in a way they can easily understand?
- Do you provide patients with educational materials?
- Do you discuss treatment and medication options with patients?
- Do you educate patients about preventive illnesses?

Learn More
See this flier to learn more about the CAHPS survey and steps you can take to improve results. More information is available on the CMS website.

This information is for informational purposes only and is not a substitute for the sound medical judgment of a provider. Members are encouraged to talk to their provider if they have any questions or concerns regarding their health.

Medicare Advantage plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC) (HMO, PPO and HMO Special Needs Plans), and also to GHS Insurance Company (GHS) (HMO Plans). HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC, HISC and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and HISC are Medicare Advantage organizations with a Medicare contract. GHSIC is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in these plans depends on contract renewal.

Prescription drug plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plans depends on contract renewal.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

EDUCATION & REFERENCE

Complimentary Webinar Trainings Available
Do you have new staff or need a refresher about electronic options? If yes, we have added complimentary educational webinar sessions on the BCBSTX provider website for provider billers, utilization areas and administrative departments.

Topics include:

- Availity® 101
- Availity Authorizations & Referrals
- Remittance Viewer

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

PRIOR AUTHORIZATION INFORMATION

New Prior Authorization & Referral Submission Tool via Availity® Provider Portal

The big picture: As of Feb. 17, 2020, providers can submit prior authorizations and referrals online using Avality's Authorizations & Referrals tool (HIPAA-standard 278 transaction). The tool is accessible through the Availity Portal.

The Authorizations & Referrals tool has improved functionality, making submitting and receiving confirmation from Blue Cross and Blue Shield of Texas (BCBSTX)[1] faster and easier.

The bottom line is that the tool will allow providers to:

- Access and verify the status of requests
- Upload clinical medical records
- Edit and/or extend requests
- Obtain printable confirmation number for your records

Get Started!
Begin using the Authorizations & Referrals tool in place of iExchange®. Providers not yet registered with Availity can sign up today at Availity.com, at no charge. For registration assistance call Availity Client Services at 1-800-282-4548.

Submitting online prior authorization requests using this new tool is easy and consists of only five steps:

1. Log in to Availity.
2. Select the **Patient Registration** menu option, choose **Authorizations & Referrals**, then Authorizations*.
3. Select **Payer BCBSTX**, then choose your organization.
4. Select **Inpatient Authorization** or **Outpatient Authorization**.
5. Review and submit your authorization.

*Choose "**Referrals**" instead of "**Authorizations**" if you are submitting a referral request.

Deeper Dive

- BCBSTX's current electronic prior authorization tool, iExchange, will be deactivated April 15, 2020.
- As of April 15, all electronic prior authorization requests and referrals should be submitted using the new tool. This includes:
    - Inpatient admissions
    - Select outpatient services
    - Behavioral health services
    - Referral requests handled by BCBSTX
- Medical and surgical predetermination of benefits requests should be submitted via fax or mail by using the Predetermination Request Form, along with the pertinent medical documentation.

Note: The process of submitting prior authorization requests to eviCore® or Magellan Healthcare® is not changing.

For More Information
Review Availity Authorizations & Referrals, added to the Provider Tools section of our website. If you need further assistance or customized training, contact our Provider Education Consultants.

[1]Providers should continue to use their current prior authorization process until this new application becomes available for Federal Employee Program® (FEP®) members and all plans requiring a BCBSTX prior authorization for behavioral health services.

Change to Prior Authorizations for HealthSelect of Texas® Effective March 1, 2020

There are important changes to the prior authorization requirements for the HealthSelect of Texas and Consumer Directed HealthSelectSM plans administered by Blue Cross and Blue Shield of Texas (BCBSTX). The list of services requiring prior authorization has not changed; however, beginning March 1, 2020, prior authorizations for services previously managed by eviCore healthcare® will now be managed through BCBSTX.

What's changing? You must contact BCBSTX to prior authorize the following services as of March 1, 2020:

- High-Tech Radiology (CT, PET Scans, MRI, MRA and Nuclear Medicine)
- Molecular and genomic testing
- Radiation oncology for all outpatient and office services
- Sleep studies and sleep durable medical equipment

Please reference the most up-to-date HealthSelect of Texas Prior Authorization & Referral Requirements Lists located under Clinical Resources on the provider website.

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 decide whether any prior authorization is required. Availity allows you to confirm if prior authorization is required based on the procedure code. For more information on Availity, refer to "Eligibility and Benefits" located on the provider website.

To prior authorize services through BCBSTX, submit online using Availity Authorizations & Referrals or call the phone number listed on the member's BCBSTX ID card. Providers who are not yet registered with Availity can sign up by visiting the Availity website. There is no charge for this service. If you need assistance, call Availity Client Services at 1-800-282-4548.

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

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

Importance of Obtaining a Prior Authorization/Referral

A prior authorization/referral is required for certain types of care and services. Although BCBSTX participating health care providers are required to obtain prior authorizations/referrals, it is also the responsibility of the member 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 Prior Authorizations & Predeterminations under Clinical Resources on bcbstx.com/provider. In addition, providers can submit needed prior authorizations managed by BCBSTX via Availity Authorizations & Referrals.

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 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.

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 forms for Regulated Business (used when "TDI is on the member's ID Card) or Non-Regulated Business (No "TDI on member's ID card). Locate them under Forms on the provider website.

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 health care provider that does not participate in their BCBSTX provider network. They

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 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.

Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)℠

All Blue Cross and Blue Shield Medicare Advantage℠ (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 Advantage℠

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

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

BCBSTX has implemented changes to clarify existing policies related to billing and documentation requirements for the BlueChoice® PPO, Blue Advantage HMO℠, Blue Essentials℠, Blue Premier℠, MyBlue Health℠, Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ 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.

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 on a quarterly basis and are not considered changes to the software version.

BCBSTX will normally load this additional data to the BCBSTX claim processing system within 60 to 90 days after receipt from the 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 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*.

Cotiviti Code-Auditing Software

In addition to ClaimsXten℠, BCBSTX uses Cotiviti code-auditing software. 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 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.

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 Choice PPO℠ members. 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 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:

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

CMS Guidance Notifications

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

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®

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
- Authorizations & Referrals
- Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA)
- Electronic Refund Management (eRM)
- Claim Inquiry Resolution (CIR)
- 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

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 view and print information, review clinical to determine what is needed, and schedule consultations for 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 BCBSTX members with prescription drug benefits administered by Prime Therapeutics®, providers can ensure appropriate utilization of prescription drugs. 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, 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. For current drug updates, visit Pharmacy Program/Prescription Drug List and Prescribing Guidelines 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.*

Provider General Information

After-hours Access Is Required

BCBSTX requires that primary care,and specialty care health care providers provide urgent, and emergency 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 SM 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.

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 does not 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.

Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the 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 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.

Rights and Responsibilities Notification

Thank you for choosing to be a participating practitioner with 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 or other important details on file with BCBSTX? Do we have the most current email address for you and your staff? 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.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third-party vendor that is solely responsible for its products and services. CPT copyright 2015 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

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. 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