June 2020

NOTICES & ANNOUNCEMENTS

Provider Information on COVID-19 Coverage

Get information all in one place. We appreciate the care you are providing our members during the COVID-19 pandemic. With the evolving changes, you can use the Provider Information on COVID-19 Coverage page to get the most current information.

COVID-19 Initiatives Extended into June

Blue Cross and Blue Shield of Texas (BCBSTX) has taken steps to make access to the testing and treatment for our members easier and less expensive during this national health emergency. We have extended the duration of these measures to continue serving our members.

The chart below details those dates. We will continue to monitor the situation and update as needed. Check our provider site and our COVID-19 Related News for the latest information on each initiative.

Initiative	Start Date	End Date
Chest CT Scan without Prior Authorization	March 2, 2020	Open ended*
COVID-19 Testing Cost-Share Waiver	March 7, 2020	End of Health and Human Services (HHS) public health emergency
COVID-19 Testing-Related Visits Cost-Share Waiver	March 18, 2020	End of HHS public health emergency
COVID-19 Treatment Cost -Share Waiver	April 1, 2020	June 30, 2020*
Credentialing Simplified	April 3, 2020	End of HHS public health emergency
Interfacility Transfer without Prior Authorization	April 1, 2020	May 31, 2020**
Prior Authorization Extension	Services scheduled between Jan. 1 and June 30, 2020	Dec. 31, 2020
Telemedicine/Telehealth Expansion, Cost-Share Waiver	March 18, 2020	June 30, 2020*

*Services that were originally scheduled to end May 31, 2020
**Service originally scheduled to end May 15, 2020

New Group – Teacher Retirement System (TRS) Effective Sept. 1, 2020

What's new? We are excited to announce that Blue Cross and Blue Shield of Texas (BCBSTX) was awarded the contract for the Teacher Retirement System (TRS) ActiveCare account, effective Sept. 1, 2020. TRS participants will be offered benefit plans using the statewide Blue Choice PPO℠ or Blue Essentials℠ provider networks.

What's Next? As additional details become available related to benefits, prior authorization requirements and ID cards, we will share them in News and Updates and our Blue Review newsletter. We look forward to providing health care services to our TRS-ActiveCare participants.

Have You Heard About the New Texas Surprise Billing Law?

Overview: A new Texas law, Senate Bill (SB) 1264, protects health plan members who receive medical care on or after Jan. 1, 2020, from surprise bills in many situations where a member doesn't have a choice in where to get care.

The law outlaws surprise medical bills from various Texas health care providers, including:

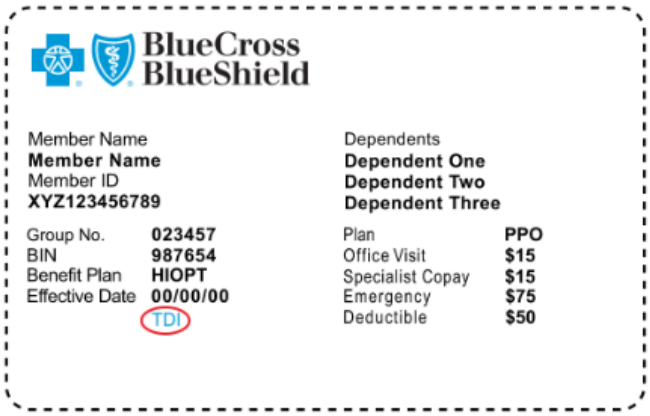
- Out-of-network physicians and facilities, including hospitals and free-standing emergency medical care facilities that provide emergency services and supplies
- Out-of-network providers who are practicing at in-network hospitals, birthing centers, ambulatory surgical centers and free-standing emergency medical care facilities
- Out-of-network diagnostic imaging and laboratory services that are provided in connection with a service from an in-network provider

Under this law, a member must not be billed above their cost-share for non-network emergency care, facility-based care or lab/diagnostic imaging.

What does this mean for in-network providers? You should refer Blue Cross and Blue Shield of Texas (BCBSTX) members to in-network doctors, specialists, hospitals, labs and imaging centers, when applicable.

Which members does it apply to? It applies to members who are covered by fully-insured plans, the Employee Retirement System (ERS) and the Teacher's Retirement System (TRS).

Note: Members with fully-insured plans will have "TDI or DOI" printed on their member ID cards.



This law does **not** apply to members covered by self-funded (administrative services only) health plans, Blue Cross Medicare Options℠, the Federal Employee Plan (FEP) and plans issued by health plans outside of Texas.

Dispute Resolution: In the event, an out-of-network provider and insurer cannot agree on payment for services provided, an independent reviewer selected by the out-of-network provider and insurer is used to help resolve the payment dispute.

Waiver: Members covered by SB 1264 can opt to have services provided by out-of-network providers by signing the Balance Billing Waiver form. This form waives the protections against balance billing and allows the provider to bill members over deductible, copayments and coinsurance. The waiver cannot be used in an emergency or when an out-of-network provider was assigned to a case, such as an anesthesiologist during surgery.

Have questions? Contact our Provider Services line at **800-451-0287**.

Please help your patients and our members by referring or recommending BCBSTX in-network providers.

Refer to Find a Doctor or Hospital on the provider website.

CLAIMS & ELIGIBILITY

Billing and Documentation Information Requirements Reminder

Below is a summary of billing and documentation information and 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)℠, as reflected in the Provider Manuals in Section F Filing Claims posted on the provider website under Standards and Requirements/Manuals.

Permissible Billing

BCBSTX does not permit pass-through billing, splitting all-inclusive bills, under-arrangement billing, and any billing practices where a provider or entity submits claims by or for another provider not otherwise provided for in the provider's agreement or in this policy.

Pass-through Billing

Pass-through billing occurs when the ordering health care provider requests and bills for a service, but the service is not performed by the ordering health care provider.

The performing health care provider is required to bill for the services they render unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

- the service of the performing health care provider is performed at the place of service of the ordering physician or professional provider and billed by the ordering physician or professional provider;
- the service is provided by an employee of a physician, professional provider, facility or ancillary provider (i.e., physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse-midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider); and
- the service is billed by the ordering physician or professional provider.

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

AS modifier: A physician should use the AS modifier when billing on behalf of a PA, APN or CRNFA, including that provider's National Provider Identifier (NPI), for services provided when the PA, APN, or CRNFA is acting as an assistant during surgery. Modifier AS is to be used ONLY if the PA, APN or CRNFA assists at the surgery.

SA modifier: A supervising physician should use the SA modifier when billing on behalf of a PA, APN or CRNFA for nonsurgical services. Modifier SA is to be used when the PA, APN, or CRNFA is assisting with any other procedure that DOES NOT include surgery.

Under Arrangement Billing

Under-arrangement billing and other similar billing or service arrangements are not permitted by BCBSTX. Under-arrangement billing refers to situations where services are performed by a physician, facility, or ancillary provider but the services are billed under the contract of another physician, facility or ancillary provider, rather than under the contract of the physician, facility, or ancillary provider that performed the services.

All Inclusive Billing

Any testing performed on patients treated by a physician, professional provider, facility, or ancillary provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services. The Physician, professional provider, facility or ancillary provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to BCBSTX.

For all-inclusive billing, all testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

Other Requirements and Monitoring CLIA Certification Requirement
Facilities and private providers who perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Therefore, any provider who performs laboratory testing, including urine drug tests, must possess a valid CLIA certificate for the type of testing performed.

Review of Codes
We may monitor the way test codes are billed, including the frequency of testing. Abusive billing, insufficient or lack of documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100% review of medical records for such claims submitted.

Limitations and Conditions
Reimbursement is subject to:

- Medical record documentation, including appropriately documented orders
- Correct CPT/HCPCS coding
- Member Benefit and Eligibility
- Applicable BCBS Medical Policy(-ies)

Obligation to notify BCBSTX of Certain Changes
Physicians, facilities, and ancillary providers are required to notify BCBSTX of material changes that impact their contract with BCBSTX including the following:

- Change in ownership
- Acquisitions
- Change of billing address
- Change in billing information
- Divestitures

Assignment
As a reminder, no part of the contract with BCBSTX may be assigned or delegated by a physician, facility or ancillary provider without the express written consent of both BCBSTX and the contracted provider. If you have any questions or if you need additional information, please contact your local BCBSTX Network Management Office.

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:

- Corrected Claim Submission – Effective 8/15/2020
- Global Surgical Package – Effective 8/15/2020

Billing for Point-of-Use Convenience Kits

Blue Cross and Blue Shield of Texas (BCBSTX) regularly reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our member's benefit plan and meet our guidelines. Some providers are submitting claims for point-of-use convenience kits used in the administration of injectable medicines. These prepackaged kits contain not only the injectable medicine, but also supply items, such as, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. **As a reminder, only the drug component(s) of the kit will be reimbursable to the provider.**

Why it Matters
We periodically check availability and pricing of these kits to better manage costs. Often, the cost of these convenience kits is more than the cost of its components when purchased one item at a time. Non-drug supplies in the kits are

inclusive of the medical practice expense for the procedure performed and no added compensation is warranted to the provider. Reimbursement for these point-of-use convenience kits may be updated based upon the U.S. Food and Drug Administration (FDA) approved drug component.

Remember to provide the most appropriate care in the most cost-effective manner.

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.

EDUCATION & REFERENCE

Resources for Providers/Members

Providers can refer to Resources for Providers/Members for information available to assist members in accessing care using the following resources:

- Telemedicine/Telehealth
- Language line

- Crisis line
- 24/7 Nurseline

For your convenience, this resource is located on the provider website under **Education & Reference** on the Provider Tools page then **Related Resources**.

Blue Cross Medicare Advantage® Orientation Training Webinar

Medicare Advantage (MA) plans are health plan options approved by Medicare and administered by private companies as part of their retiree plan options. The plans cover all of the services that original Medicare covers, however, **MA plans may offer extra coverage**, for services such as:

- Dental
- Vision
- Hearing
- Health and wellness programs

What's new?
We are providing a Blue Cross Medicare Advantage orientation training webinar.

- Visit our website at www.bcbstx.com.
- Choose the provider tab
- Open Education and Reference dropdown
- Select Provider Training
- **Scroll** to Medicare Advantage Training
- **Click** Medicare Advantage Orientation
- Fill in your provider information and click submit

Why it matters: This training is offered for all contracted providers in the Blue Cross Medicare Advantage networks to ensure we are giving the highest quality of care possible to our Medicare Advantage members and providing timely plan updates.

We appreciate the quality care you provide to our members and your support in our efforts to simplify payer relations. If you have any questions, please contact the BCBSTX Medicare Advantage Network Management office at 972-766-7100.

NETWORK PARTICIPATION

Join ParPlan

ParPlan is a program open to physicians and other providers whether you are contracted in our Blue Cross and Blue Shield of Texas (BCBSTX) provider networks or not. The ParPlan contract is a legal contract designed for the mutual protection of members, providers and our company. The common objective of ParPlan is to offer convenient, cost effective medical services to our company's subscribers.

The advantages of ParPlan:

- Does not require credentialing
- Provider will file the member's claims
- The member's out of pocket expenses are limited to the deductible and cost share amounts (coinsurance and copayments)
- Providers will accept BCBSTX allowable amounts and not bill the member over the allowable amount
- You will be included in the directory of ParPlan Providers

The ParPlan contract agreement can be obtained and the signed contract submitted as follows:

- Physicians, professional providers and hospital/facility-based providers. will use the Provider Onboarding Form. If you want to review and sign the Par Plan contract later, you can submit it by email to the TX_Standard_contracting_team@bcbstx.com or your local Network Management Office
- Ancillary and Hospital providers should contact their appropriate Network Management Office location

The ParPlan contract must be signed by the:

- authorized signatory for group providers and hospitals providers
- provider for solo practitioners

Note: By signing a ParPlan contract, the provider is only active in ParPlan, not any other networks. Providers would need to sign the appropriate network agreements to be active in those networks. We appreciate your consideration in becoming a ParPlan provider and for participating, if you are already contracted.

Changes to Contacting Electronic Commerce Services

As of June 15, 2020, providers and/or clearinghouses calling **1-800-746-4614** for Electronic Commerce Services will be directed to email inquiries to Electronic Commerce Services instead of calling.

Electronic Commerce Services will quickly respond to your email requests to assist you with the following Electronic Data Interchange (EDI) transactions:

- Electronic professional and institutional claim submission (837P and 837I transactions)
- Claim payment via 835 Electronic Funds Transfer (835 EFT)
- 835 Electronic Remittance Advice (835 ERA) or delivery of claim payment information

For more information on EDI transactions and other online tools and resources, refer to the Electronic Commerce section of our Provider website.

PRIOR AUTHORIZATION INFORMATION

eviCore® Prior Authorization Code Changes Effective April 20, 2020

What's new: We have updated the procedure code list for services prior authorized by eviCore healthcare (eviCore) for fully insured members effective April 20, 2020. These code changes were a result of new, replaced or removed codes implemented by the American Medical Association (AMA). The procedure code list is located on the Prior Authorizations & Predeterminations page under Prior Authorization Procedure Codes List for Fully-Insured Members Effective 1/1/2020. Refer to the Updates column for the changes.

What you need to do: You should 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 is required for your patient. Availity allows you to determine if prior authorization is required through BCBSTX medical management, or another vendor such as eviCore, based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity.

When the procedure, such as these new changes, requires you to prior authorize through eviCore, you can:

- Enter online using the eviCore Healthcare Web Portal which is available 24/7
- Call 1-855-252-1117 between 6 a.m. to 6 p.m. (CST) Monday through Friday and 9 a.m. - noon Saturday, Sunday and legal holidays.
- Refer to the eviCore implementation site for more information.

Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients. If you need assistance, view the list of our Network Management offices to contact.
As a reminder, it is important to check eligibility and benefits before rendering services. This step will help you determine if benefit prior authorization is required for a member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

BlueCard® Alert: Prime Healthcare Member Required Authorizations for Care

Prime Healthcare's employees and their dependents are covered by Blue Shield of California through our BlueCard program. When a Prime Healthcare member seeks emergency care at a Blue Cross and Blue Shield of Texas (BCBSTX) facility, **you must contact Prime Healthcare for authorization of services once they are stabilized**.

To obtain authorization from Prime Healthcare, contact:

Prime Healthcare Central UM
Phone **1-877-234-5227**
Option 1, Inpatient Emergency Admission, Transfer or Discharge
Available 7 days a week, 24 hours a day

You can identify Prime Healthcare members by the Prime Healthcare logo and the three-character prefix "PHU" on their ID card.

Why is this important?
Prime Healthcare is a national health system with hospitals in 14 states. When Prime Healthcare members seek treatment outside of its network of facilities, it requires **providers to seek authorization for post-stabilization care** from Prime Healthcare Utilization Management.

According to Prime Healthcare, **facilities not contracted with Prime Healthcare who don't comply** with their notification policy **are prohibited** by law **from billing the patient** for the **cost of any post-stabilization care**, unless the patient has accepted responsibility for the cost in writing. The facility may collect from the member, only his or her cost-sharing amount.

Checking eligibility and/or benefits information is not a guarantee of payment. The fact that a service has been prior authorized/pre-notified 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 member's ID card.

CLINICAL RESOURCES

In-home Colorectal Cancer Screening Test for Eligible Members

Members in our Blue Advantage HMO℠, Blue Advantage Plus℠ HMO and MyBlue Health℠ networks may be able to receive free colorectal cancer screening kits through their local Walmart pharmacy or mailed to their home.

About the FIT Kit
This is a pilot program to encourage our members age 50 to 75 to be screened for colorectal cancer. We are working with BioIQ, an independent company to provide the in-home Fecal Immunochemical Test (FIT) Kits. In-home screening may be a good option for those at risk during the COVID-19 pandemic. FIT tests are one of the most accurate and recommended screening tests[1]. Studies have shown that the FIT is significantly less likely to indicate a false positive[2] than similar tests. This may lead to fewer invasive tests and harmful complications.

How it works
Eligible members who use certain Walmart pharmacies will be flagged in the Walmart Pharmacy system. When a selected member visits Walmart to pick up their prescriptions, pharmacy staff will talk to them about colorectal cancer screening and the pilot program.

If the member chooses to participate, the pharmacy staff will either give them a free FIT Kit or one will be mailed to their home. The member will complete the Kit at home. The FIT Kit has easy-to-follow directions for collecting a fecal sample and sending it for processing. LabCorp will process the tests and BioIQ will mail the results to the member and their primary care provider (PCP).

How You Can Help
- Discuss the importance of colorectal cancer screening and a healthy lifestyle with our members.
- If members call your office with questions about the FIT Kit, encourage them to complete the screening as soon

as possible.
- If you receive a result from BioIQ, save it in the member's medical record and discuss with the member.

Information about Colorectal Cancer Screening
About one-third of adults 50 years or older have not been screened as recommended[3]. This is about 22 million people in the age group at greatest risk of developing colorectal cancer. The American Gastroenterology Association classifies colorectal cancer screenings into three tiers[1]:

- **First-tier**, the cornerstones of screening:
  - Colonoscopy (every 10 years)
  - **Annual fecal immunochemical test (FIT)**
- Second-tier, appropriate screening tests that have disadvantages to the first-tier tests:
  - CT colonography every five years
  - FIT-fecal DNA test every three years
  - Flexible sigmoidoscopy every five to 10 years
- Third-tier, limited evidence and obstacles to use:
  - Capsule colonoscopy, every five years

Have questions?
Contact your local Network Management Office. Members can call the number on their member ID card.

[1]Colorectal Cancer Screening: Recommendations for Physicians and Patients from the U.S. Multi-Society Task Force on Colorectal Cancer
[2]U.S. Preventive Task Force – Colorectal Cancer: Screening
[2] CDC, Screen for Life: National Colorectal Cancer Action Campaign, July 1, 2019,

BioQ is an independent company that provides health screenings for Blue Cross and Blue Shield of Texas.

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.

BEHAVIORAL HEALTH

Behavioral Health Program Changes for HealthSelect of Texas® Effective Sept.1

As previously announced Feb. 19, starting **June 1, 2020**, Blue Cross and Blue Shield of Texas (BCBSTX) will administer behavioral health benefits for members enrolled in our **Blue Essentials℠, Blue Essentials Access℠, Blue Premier℠** and **Blue Premier Access℠** provider networks. Magellan Healthcare® will no longer administer behavioral health benefits for these members.

In addition, behavioral health services for **HealthSelect of Texas** and **Consumer Directed HealthSelect℠** (HealthSelect) participants will transition from Magellan to BCBSTX effective **Sept. 1, 2020**.

How Does This Affect You?

For care of Blue Essentials and Blue Premier members on or after June 1 and HealthSelect participants on or after Sept. 1:

- Direct eligibility and claims inquiries to BCBSTX. Please call the number on the member's ID card.
- Obtain prior authorizations online using Availity® Authorizations & Referrals or call the number on the member's ID card.
- Submit behavioral health claims to BCBSTX for reimbursement.
- For these members to receive in-network benefits, you must be in our Blue Essentials or Blue Premier provider networks. HealthSelect of Texas and Consumer Directed HealthSelect plans use the Blue Essentials provider network.
- For more information, refer to the Behavioral Health Changes FAQs.

It's important to use the Availity Provider Portal or your preferred vendor to check eligibility and benefits for our members before rendering services. This will help you confirm coverage details and prior authorization requirements and determine if you are in-network for the member's policy. Refer to Eligibility and Benefits for details.

How Does This Affect Members?

We do not expect member benefits to be affected by this change. Members will be notified of the change before their transition date, and some members will receive new BCBSTX ID cards.

Questions?

If you have questions or would like information about joining our networks, contact your local Network Management Representative. Information also is available on the Network Participation page.

PHARMACY

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

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)SM

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 HMOSM, 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)℠ 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)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®

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.

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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.

Aerial and Medecision® are trademarks 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 Availity or Medecision. The vendors are solely responsible for the products or services

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.

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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