March 2020

NOTICES & ANNOUNCEMENTS

Thanks for Responding to the HHS-RADV Initial Validation Audit

Blue Cross Blue Shield of Texas (BCBSTX) would like to thank all our providers for their contribution to the successful closure of another Health and Human Services Risk Adjustment Data Validation (HHS-RADV) Initial Validation Audit (IVA) season. The responsiveness shown by our provider community has yielded another outstanding year for medical record retrievals required for this mandated Centers for Medicare & Medicaid Services (CMS) audit.

The quick responses to our requests by the amazing staff employed by our facilities and physicians truly make a difference as we partner together to stand with our members in sickness and in health. We thank you for your care of our members and look forward to another successful HHS-RADV IVA record retrieval season in 2020.

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).

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.

BEHAVIORAL HEALTH

Updates to Behavioral Health Clinical Practice Guidelines for 2019-2020

Blue Cross and Blue Shield of Texas (BCBSTX) has updated the Behavioral Health Clinical Practice Guidelines for 2019-2020. The Behavioral Health Care Management Programs offered by BCBSTX serve members suffering from Depression, Alcohol/Substance Abuse Disorders, Anxiety/Panic Disorders, Attention Deficit/Hyperactivity Disorder, Bipolar Disorder, Eating Disorders, Schizophrenia and other Psychotic Disorders.

When a professional provider has a patient, who may benefit from participating in one of the above-mentioned programs, please call their Behavioral Health Member Services using the number on the back of the Member's ID card to have the patient screened and considered for enrollment in a Case Management Program.

Refer to the provider website for more information on the Behavioral Health Care Management Program and the Behavioral Health Clinical Practice Guidelines.

CLAIMS & ELIGIBILITY

New BCBSTX 837 Commercial Claim Validation Edits

As of April 1, 2020, Blue Cross and Blue Shield of Texas will implement new electronic claim submission validation edits* for commercial professional and institutional claims (837P and 837I transactions).

What it means:

- The new claim edits will be applied during the pre-adjudication process
- Help increase efficiencies; while providing you a quicker notification to correct claims
- Comply with Centers for Medicare & Medicaid (CMS) data reporting requirements

What should you do?

- Review the new edit messages on the response files from your practice management/hospital information system or clearinghouse vendor(s).
- Determine if additional data elements are necessary.
- Correct and resubmit affected claim(s) with needed information as specified in the rejection message.

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 BCBSTX Medicare Advantage and Texas Medicaid electronic claim submissions.*

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.

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 policy was recently added:

- Drug Testing Clinical Payment and Coding Policy.

Reminder: Medicare Beneficiary Identifier Must be Submitted on Claims

The Centers for Medicare & Medicaid Services (CMS) began mailing new Medicare Identification (ID) cards in April 2018. The new ID cards for Medicare beneficiaries replaced the formerly utilized social security numbers-based Health Insurance Claim Number (HCIN) with the new Medicare Beneficiary Identifier (MBI) number.

This is a reminder that Dec. 31, 2019, was the last date that claims may be submitted using the old HCINs. Effective Jan. 1, 2020, regardless of date of service, all claims must be submitted using the new MBI.
The CMS has published several helpful handouts for providers and their staff. We encourage you to discuss this change with all staff to ensure you are ready for this change in January.

Please review the new Medicare card guidance and the new Medicare card for Providers and Office Managers articles as well as the mInconnects as soon as possible.

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.

Reminder: Fee Schedule Update March 1, 2020

Blue Cross and Blue Shield of Texas (BCBSTX) is implementing changes in the maximum allowable fee schedule for Blue Choice PPO℠, Blue Essentials℠ (including HealthSelect℠ of Texas Network), Blue Premier℠, Blue Advantage HMO℠, MyBlue Health℠ and PAR Plan networks (collectively referred to as "Networks") effective March 1, 2020.

The specific changes and effective dates for the Network fee schedules and files are posted on the BCBSTX provider website under the Standards & Requirements tab then select General Reimbursement Information. To access this area, please obtain the password from your Network Management Office. General reimbursement information policies and fee

schedule information will be posted under "Reimbursement Changes/Updates" in the "Reimbursement Schedules" section.

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

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

Medicare Providers May Not Bill Participants in the Qualified Medicare Beneficiary Program

As a Medicare provider, you may not bill individuals enrolled in the Qualified Medicare Beneficiary Program (QMB), a federal Medicare Savings Program.

Individuals enrolled in QMB are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a State Medicaid benefit, QMB covers the Medicare premiums, deductibles, coinsurance and copayments of QMB beneficiaries. QMB beneficiaries are not responsible for Medicare cost-sharing, or out-of-pocket costs.
Your Responsibility

Providers participating in Blue Cross Medicare Advantage℠ plans may not bill their QMB patients for services provided to them, regardless of whether the State reimburses the full Medicare cost-sharing amounts. You must bill both Medicare and Medicaid and accept Medicare payments and any Medicaid payments as payment in full.

Federal Law
Please ensure that you and your staff are aware of the federal billing law and policies governing QMB. It is against federal law for any Medicare provider to bill QMB patients, whether or not the provider accepts Medicaid. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB patients for Medicare cost-sharing.

Helpful Tips
To avoid billing QMB patients, please take these precautions:

- Identify QMB patients by looking for Blue Cross Medicare Advantage Dual Care℠ on their ID cards
- Check the Texas Medicaid portal to confirm QMB beneficiary status
- Understand the Medicare cost-sharing billing process
- Be sure your billing software and staff remove QMB patients from Medicare cost-sharing billing and related collections efforts

More Information
Call Customer Service at 1-877-774-8592 to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.

HMO, PPO, and HMO Special Needs Plans are provided by HCSC Insurance Services Company (HISC). HMO plans are provided by GHS Insurance Company (GHS). 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. GHS 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.

The information provided here is only intended to be a summary of the law that has been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

National Coordination of Care℠ Program for Group Medicare Advantage PPO Members

Beginning Jan. 1, 2020, we will participate in a new Blue Cross and Blue Shield Association National Coordination of Care program to help improve care and services for Blue Cross Group Medicare Advantage (PPO)℠ (MA PPO) members nationwide. This program also will help streamline administrative processes for providers.

As we announced in October, Blue Cross Group Medicare Advantage (PPO)SM is the new name of Blue Cross Medicare Advantage (PPO)SM for Blue Cross and Blue Shield of Texas (BCBSTX) members who purchase MA PPO coverage through their employers or other groups. While the name has changed, the program retains its traditional PPO network that allows members to seek care in-network and out-of-network, typically providing cost savings for in-network care.

Through the National Coordination of Care program, BCBSTX will collaborate with you to identify gaps in care and retrieve medical records for claims you submit to BCBSTX for Group MA PPO members living in Texas. This includes BCBSTX members with Group MA PPO coverage, as well as Group MA PPO members enrolled in other BCBS Plans who are living in Texas.

You will receive requests only from BCBSTX or our vendor when medical records are needed, or when potential gaps in care or risk adjustment gaps are identified related to claims submitted to BCBSTX for these members. You will no longer receive these requests from multiple BCBS plans or their vendors.

This program is part of our ongoing initiative to support our members in receiving the right care at the right time and place. As a result of concerns about gaps in care, this program may help encourage members to come into your practice more frequently, allowing for greater continuity of care. For out-of-area members with Group MA PPO coverage, this program will help BCBSTX give these members' BCBS Plans a fuller understanding of their members' health status.

Questions? Call the Customer Service number on the member's ID card.

Important Reminders:

- Per your contract, you are required to respond within the requested timeframe to requests for risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®) and other government-required activities including this program.
- Use Availity® or your preferred vendor to check eligibility and benefits for Group MA PPO members. Eligibility and benefit quotes include membership confirmation, coverage status, copayment, coinsurance, deductible amounts and applicable benefit prior authorization requirements.
- Ask to see the member's BCBSTX ID card and a driver's license or other photo ID to help guard against medical identity theft. See our Eligibility and Benefits page for more details.
- Consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any other applicable laws and regulations, BCBSTX or BCBSTX's vendor is contractually bound to preserve the confidentiality of members' protected health information (PHI) obtained from medical records and provider engagement on Stars and/or risk adjustment gaps. You will only receive requests from BCBSTX or BCBSTX's vendor that are permissible under applicable law. Consistent with your current practices, patient-authorized information releases are not required in order for you to fulfill medical records requests and support closure of Stars and/or risk adjustment gaps received through this care coordination program.

Reminder of Change to the Preservice Appeals process for your Blue Cross Medicare Advantage℠ Patients

This is a reminder that important changes to the preservice appeals process recently occurred for patients enrolled in Medicare Advantage plans offered by Blue Cross and Blue Shield of Texas (BCBSTX), as previously communicated on July 22, 2019.

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

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

Going forward, it is critical to use Availity® or your preferred vendor to check eligibility and benefits, to determine if you are in–network for your patient and to determine whether any preauthorization or prenotification is required for services.

Refer to "Eligibility and Benefits" on the BCBSTX provider website for more information on Availity. Providers can also refer to the Prior Authorizations & Predeterminations page on our website for assistance.

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

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

PRIOR AUTHORIZATION INFORMATION

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.

HMO Plans – PCP Selection and Referral Requirements 2020

Blue Cross and Blue Shield of Texas (BCBSTX) HMO plans are:

- Blue Advantage HMO℠* and Blue Advantage Plus℠ HMO*
- Blue Essentials℠** and Blue Essentials Access℠**
- Blue Premier℠** and Blue Premier Access℠**
- MyBlue Health℠ (effective 1/1/2020 and only available in Dallas and Harris counties)

* Providers who sign a Blue Advantage HMO agreement are also in-network for Blue Advantage HMO Plus

** Providers who sign a Blue Essentials or Blue Premier agreement are also in-network for the Blue Essentials Access or Blue Premier Access networks

Blue Essentials Access and Blue Premier Access are considered "open access" HMO plans. Therefore, no Primary Care Provider (PCP) selection or referrals are required when the member uses participating providers in their network.

For Blue Advantage HMO, Blue Advantage Plus HMO, Blue Essentials and Blue Premier when referrals are required, it must be initiated by the member's designated PCP and must be made to a participating physician or professional provider in the same provider network.

The table below defines when a PCP and referrals to specialists (except OB-GYN) are required and when they are not required. (Note: Members can self-refer to in-network OB/GYNs – no referrals are required.) If an in-network physician, professional provider, ambulatory surgery center, hospital or other facility is not available in the member's applicable provider network, prior authorization is required.

HMO Plan	Designated PCP Required	Referrals Required for In- Network Providers	Out-Of-Network Benefits Available with Higher Member Cost Share[1]
Blue Advantage HMO	Yes	Yes	No
Blue Advantage Plus HMO	Yes	Yes	Yes
Blue Essentials	Yes	Yes	No
Blue Essentials Access	No	No	No
Blue Premier	Yes	Yes	No
Blue Premier Access	No	No	No
MyBlue Health	Yes	Yes	No

Additional services for all HMO plans may require prior authorization. A complete list of services that may require prior authorization or referral for in and out-of-network benefits and how to submit requests electronically is available on the BCBSTX provider website under Clinical Resources/Prior Authorizations and Predeterminations. You can also contact the prior authorization number on the back of the member's ID card.

Reminders:

- The Blue Essentials, Blue Essentials Access, Blue Advantage HMO, Blue Premier, Blue Premier Access and MyBlue Health providers are required to admit a patient to a participating facility, except in emergencies.
- Blue Advantage Plus HMO is a benefit plan that allows members to use out-of-network providers. However, members must understand the financial impact of receiving services from an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility.

Sample HMO ID cards and other benefit plan ID cards are available on the BCBSTX provider website.

Additional information on the HMO plans and other BCBSTX plans are available on the Network Participation page on the provider website.

[1]Before referring a Blue Advantage Plus HMO member to an out-of-network provider for non-emergency services, please refer to Section D Referral Notification Program, of the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual for more detail including when to utilize the Out-of-Network Enrollee Notification forms for Regulated Business and Non-Regulated Business.

Prior Authorization Changes for Certain BCBSIL Members in Texas

Effective March 1, 2020, some Blue Cross and Blue Shield of Illinois (BCBSIL) members in Texas will have new prior authorization requirements through **eviCore healthcare (eviCore)®**. The members affected have the following three-character prefixes in front of their ID number:

- BBE
- BHP
- BNK
- BRG
- BYR

Services Requiring Prior Authorization
The new prior authorization requirements through eviCore, for these prefixes, apply to the following outpatient services:

- Advanced Imaging
- Cardiology
- Genetic Testing
- Joint and Spine Surgery
- Pain Management
- Radiation Therapy
- Sleep Studies

eviCore Instructions
There are two ways to secure a prior authorization through eviCore:

- **Online** – The eviCore web portal is the quickest way to open a case, check status, review guidelines and more.
- **By phone** – Call eviCore at **1-855-252-1117** between 7 a.m. and 7 p.m. (CST), Monday through Friday.

Requirements Vary by Member
Prior authorization requirements are specific to each member based on their benefit plan. Check eligibility and benefits before rendering services. Submitting an electronic 270 transaction via the Availity® Provider Portal or your preferred vendor portal provides information about:

- Coverage
- Network status
- Prior authorization requirements
- Other important details

PHARMACY

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

Get the Conversation Started on Colorectal Cancer

Don’t assume your patients know about colorectal cancer.

Talk to your patients about the importance of having a screening and the different screening options available. Your discussion is the number one influence on compliance.

Talk to your patients about preventing colorectal cancer before it starts by finding and removing polyps, which can reduce their risk.

Talk to your patients about how early-stage colorectal cancer may have no symptoms but is highly treatable and beatable.

Start the conversation with all your patient's ages 50 to 75 who have an average risk of developing colorectal cancer or at an earlier age for those who have high-risk factors. There are simple, affordable tests available.

If Blue Cross and Blue Shield of Texas members have questions on which tests are covered, ask them to call Customer Service using the number on the back of their ID cards. Let your patients know they can find additional information on colorectal cancer at the American Cancer Society, Colorectal Cancer Alliance and the National Cancer Institute.

CLINICAL RESOURCES

Coordinating Care Between Behavioral Health and Medical Providers

To help deliver the best health care for our members, it's important that there is coordination and sharing between behavioral health and medical providers. Our surveys consistently show providers appreciate this interaction. Consulting and referring providers should share information such as diagnoses, medications, treatment plans and recommendations.

We've provided a simple form to help providers request information from each other. Members should sign a release to allow you to share information with other providers before using this form.

Coordination of Care Form

This Coordination of Care Form is useful for both referring and consulting providers. To request patient visit information from a consulting provider, complete the Patient Information and Referring Provider sections before sending it to the consulting provider. The consulting provider can use the form to communicate information about the visit to the referring provider. Do not send this form to Blue Cross and Blue Shield of Texas. It is for your use with other providers only.

Need help finding a Behavioral Health Provider?

Call the number on the back of the member's ID card to find outpatient providers or behavioral health facilities. You can also search for providers with our online Provider Finder®.

Have a member with complex health needs?

Additional support and resources from a behavioral health or medical clinician are available. Call the number on the back of the member's ID card to refer members to Case Management and learn about other resources.

Annual Medical Record Data Collection for Quality Reporting Begins Feb. 1, 2020

Blue Cross and Blue Shield of Texas (BCBSTX) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS) and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS). HEDIS is the most widely used and nationally accepted effectiveness of care measurement available. Additionally, HHS requires reporting of QRS measures for accredited Qualified Health Plans. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule and patient authorization for release of information is not required. Texas state law (Chapter 108 of the Texas Health and Safety Code) requires Health Maintenance Organizations in Texas to report HEDIS data, by service area to the Department of State Health Services (DSHS) on an annual basis.

To meet these requirements, BCBSTX will be collecting medical records using CIOX, an independent contracted third-party vendor, as well as BCBSTX staff. If you receive a request for medical records, we encourage you to reply within 3 to 5 business days. Cooperation with the collection of HEDIS and QRS data or any quality improvement activities are

required under the providers' contractual obligation at no cost to BCBSTX or as stated within the provider's individual contract.

A representative from CIOX, our contracted vendor or BCBSTX staff may be contacting your office or facility anytime between February 2020 through May 2020 to set up appointments for on-site visits or to set up an expected delivery date via fax, provider portal and if necessary U.S. Mail. As part of the request you will receive a letter introducing the background and authorizing agencies for the HEDIS and QRS data request, a medical record request list with members' names and other identifying demographics, and the medical record information needed for identified measures. If you have any questions about medical record requests, please contact a representative that will be listed on the provider letter requesting the medical record information.

HEDIS is a registered trademark of NCQA.

CIOX is an independent third-party vendor that is solely responsible for the products or services they offer. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendors. If you have any questions regarding the services they offer, you should contact the vendor directly.

Reminder Medicare Advantage Program 30-Day Readmission Facility

Consistent with the Centers for Medicare & Medicaid Services (CMS) guidelines, **beginning March 1, 2020**, Blue Cross and Blue Shield of Texas (BCBSTX) will review acute hospital claims, to determine if such readmissions to the same facility within 30 days of discharge are related and may deny payment to the facility for related admissions. These changes help support quality of care improvement efforts by linking payment to the quality of facility care for our Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM members.

As a provider what should I expect?

- Beginning March 1, 2020, BCBSTX will perform a clinical review of acute care facility readmissions that occur within 30 days of discharge from the same facility.
- If BCBSTX determines that a provider has submitted a second claim after a patient has been discharged from an acute in patient stay, BCBSTX may request medical records from the provider.

As a provider what should I do?

- Upon request of medical records, the facility must forward related medical records and any documents involving the admissions.
- If it is determined that the acute stays were clinically related, BCBSTX may deny payment to the facility for the readmission.
- Providers may dispute determinations through existing processes, which can be found in the provider manual located on our website.

Learn More

- Visit the CMS website.
- If you have questions, contact your Network Management Consultant.

NETWORK PARTICIPATION

Physician Efficiency, Appropriateness, and Quality (PEAQ) Program Methodology

At Blue Cross Blue Shield of Texas (BCBSTX) we do everything in our power to stand with our members in sickness and in health.

We take the quality and affordability of the care provided to our members very seriously. As a part of this commitment, one of BCBSTX's core objectives as a health plan is to maximize and improve the value of care our members receive. To further this commitment, we are implementing our BCBSTX Physician Efficiency, Appropriateness, and Quality (PEAQ) Program as of Jan. 1, 2020. The current methodology for the PEAQ Program can be found here. This program will evaluate provider performance in a transparent and multidimensional way. Measurement periods may vary for each of the three components of the PEAQ program.

Our goal is to measure and maximize physician efficiency, appropriateness, and quality. This includes initiatives designed to improve member health, increase transparency around provider quality, and promote the efficient use of member and employer dollars by guiding members to high-quality, affordable care.

Watch our provider website for updates to the PEAQ methodology. Comments and feedback are welcome and can be submitted to your local Blue Cross Blue Shield Network Representative or emailed to PEAQ_Analytics.

EDUCATION & REFERENCE

Attend Free Provider Training Webinars

Do you have new staff? Or just need some refreshers? Blue Cross and Blue Shield of Texas (BCBSTX) has posted complimentary educational webinar sessions on the BCBSTX provider website. These online training sessions give you the flexibility to attend live sessions. Provider billers, utilization areas, and administrative departments will benefit from these webinars. New sessions have been added to the Educational Webinar/Workshop sessions for the following topics:

- Back to Basics: Availity® 101
- iExchange®
- Remittance Viewer

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

DID YOU KNOW?

The following is information that Blue Cross and Blue Shield of Texas (BCBSTX) is required to provide in all published correspondence with health care providers. It includes a collection of articles to assist provider offices in servicing BCBSTX patients. For the latest updates, visit the News and Updates area of the BCBSTX provider website.

Topics:

- Authorizations and Referrals
- Benefits and Eligibility
- Claims
- Clinical Resources
- CMS Guidance Notifications
- Education & Reference
- Electronic Options
- eviCore®
- Pharmacy
- Provider General Information
- Rights and Responsibility

Authorizations and Referrals

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 form below.

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

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

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

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

AIM RQI Reminder

Health care providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for most Blue Choice PPO℠ members. Providers should check eligibility, benefits, and prior authorization requirements through Availity® or your preferred vendor for applicable members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in health care provider's office, the outpatient department of a hospital or a freestanding imaging center:

- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study
- PET scan

To obtain an RQI, log into AIM's provider portal at aimspecialtyhealth.com, and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an RQI. If criteria are not met, or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM's Provider Portal℠ uses the term "Order" rather than "RQI."

Notes:

- Facilities cannot obtain a RQI from AIM on behalf of the ordering health care provider.
- The RQI program does not apply to Medicare enrollees with 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

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.

Avoidance of Delay in Claims Pending COB Information

BCBSTX receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our health care providers is a possible delay, or even denial of services, pending receipt of the required information from the member/subscriber.

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

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

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

Hospitals, and Routine Services and Supplies

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

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

Clinical Resources

BCBSTX Lab Guidelines

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for Blue Essentials℠, Blue Premier℠, Blue Advantage HMO℠ and MyBlue Health℠ members* and the preferred statewide outpatient clinical reference laboratory provider for Blue 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)
- Claims Encounter Reconciliation Application (CERA)
- Clinical Quality Validation (CQV)
- Electronic Quality and Risk Adjustment Medical Record Requests

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

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eviCore®

Use eviCore Web Portal for Prior Authorization Requests

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:

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

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

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.

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℠ 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.

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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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