October 2020

NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

As the COVID-19 crisis evolves, we continue to make updates on our COVID-19 Preparedness page and our COVID-19 Related News. Be sure to check these pages frequently for updates.

Updated Codes

On our COVID-19 Preparedness page, we updated our Claims for COVID-19 testing section. You can now find updated collection codes, lab codes and antibody testing codes.

Extended End Dates

We extended the end dates for the treatment and telehealth/telemedicine cost-share waiver. Our state-regulated fully insured HMO and PPO members have access through Aug. 31, 2020. Our Medicare members have access through Dec. 31, 2020.

More information is available on our COVID-19 Initiatives Extended article.

Provider Finder® Gets an Upgrade; View Our Network of Providers for Your Patients' Needs

Do you need help finding a specialist or facility for a consultation or procedure for a Blue Cross and Blue Shield of Texas patient? This October, our enhanced online Provider Finder will make finding care for our members a lot easier.

What's new? The new Provider Finder we believe is visually appealing and easy to navigate with a streamlined menu and filter options. The filter and sort options include:

- Specialty
- Accepting new patients
- Distance (with map tool)
- Member rating
- Gender of provider
- Quality metrics & awards
- Best match (weighted by quality and accessibility)

Update Your Info

Please help our members find you by making sure your information is accurate and up-to-date by visiting the current Provider Finder and reviewing your information. If you have any changes, use our Demographic Change Form.

BEHAVIORAL HEALTH

Behavioral Health HEDIS® Tip Sheets: FUA and FUM

We've added two additional behavioral health tip sheets to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code claims appropriately:

1. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
   This measure evaluates members 13 years old and older who had an emergency department (ED) visit with the principal diagnosis of alcohol and other drug (AOD) abuse or dependence. It evaluates the percentage of members who had follow-up visits within 7 and 30 days of the ED visit.

2. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
   This measure evaluates members 6 years old and older who had an ED visit for mental illness. It evaluates the percentage of members who had follow-up visits within 7 and 30 days of the ED visit.

These measures from the National Committee for Quality Assurance (NCQA) serve as a quality improvement tool to help ensure our members receive appropriate care.

The tip sheets include measurement requirements, medical record best practices and billing codes.

Mental Health Program Changes Reminder

As of Sept. 1, 2020, we are managing mental health services for HealthSelect of Texas® and Consumer Directed HealthSelect℠ (HealthSelect) participants. Magellan Healthcare® is no longer administering mental health benefits for these participants.

As of Sept 1, 2020, Psychological and Neuropsychological Testing mental health services for HealthSelect participants no longer requires prior authorization by BCBSTX medical management. The 9/1/2020 HealthSelect prior authorization lists have been updated to reflect this change.

For more information about the HealthSelect and Consumer Directed HealthSelect plans, visit the Employees Retirement System of Texas (ERS) section on our provider website.

If you have questions about these changes, please contact your local Network Management Office.

CLAIMS & ELIGIBILITY

Obtain BCBSTX Patient ID Number Online

To help you obtain a Blue Cross and Blue Shield of Texas (BCBSTX) patient insurance ID number, we recently implemented a new online tool called Patient ID Finder located in our BCBSTX-branded Payer Spaces section via the Availity® Provider Portal.

The Patient ID Finder tool allows you to receive the patient ID number and group number by entering patient-specific data elements. This new and exciting tool is available for BCBSTX commercial, Federal Employee Program® (FEP®) and marketplace health plan members as of Sept. 2, 2020, making it easier to obtain the patient ID number for your records. The Patient ID Finder tool is currently unavailable for Medicare Advantage and Texas Medicaid members.

How do you use the Patient ID Finder via Availity?
Searching online for BCBSTX patient ID number consists of only four steps:

- Log in to Availity
- Select Payer Spaces from the navigation menu
- Select Patient ID Finder from the Applications tab, then complete and submit the request
- Patient ID and group numbers are returned

Note: This tool does not reflect the patient's eligibility or benefits. Refer to the Availity Eligibility and Benefits User Guide for assistance with obtaining real-time eligibility and benefits information via Availity.

Providers not yet registered with Availity can sign up at Availity, at no charge. For registration assistance call Availity Client Services at 1-800-282-4548.

Training
BCBSTX is hosting complimentary webinars for you to learn how to utilize the new Patient ID Finder tool. To register for an upcoming session, simply click on your preferred date and time below.

Sept. 1, 2020 – 9 to 9:30 a.m.
Sept. 2, 2020 – 3 to 3:30 p.m.
Sept. 8, 2020 – 10 to 10:30 a.m.
Sept. 9, 2020 – 2 to 2:30 p.m.

For More Information
Watch for the new Patient ID Finder User Guide coming soon to the Provider Tools section of our website. If you need further assistance or customized training, contact our Provider Education Consultants.

Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding policies on our website describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is 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 or updated:

- Multiple Surgical Procedures - Professional Provider Services – Effective 11/10/2020

Learn More About TRS-ActiveCare Plans

On May 13, we announced we were awarded the contract to administer medical and behavioral health benefits for the Teacher Retirement System of Texas (TRS), effective Sept. 1, 2020. TRS-ActiveCare participants will be offered health plans that use either the nationwide Blue Choice PPOSM or statewide Blue EssentialsSM provider networks.

TRS-ActiveCare Plans
Statewide Blue Essentials network – providers who are contracted under the Blue Essential network can see participants on these plans:

- TRS-ActiveCare Primary and TRS-ActiveCare Primary+
  - Copays for doctor visits before meeting deductibles.
  - Primary care provider (PCP) selection and referrals to specialists are required.
  - No out-of-network coverage, except for true emergencies.

Nationwide Blue Choice PPO network plans – providers who are contracted under the Blue Choice PPO network can see participants on these plans:

- **TRS-ActiveCare HD**
  - High deductible plan which may include a health savings account (HSA) to pay for medical care.
  - Does not require PCP selection or referrals.
  - Deductibles must be met before the plan pays for diagnostic care.
  - Includes out-of-network coverage. Participants have a lower cost share when using in-network providers.

- **TRS-ActiveCare 2**
  - Copays for doctor visits before meeting deductibles.
  - Does not require PCP selection or referrals.
  - Includes out-of-network coverage. Participants have a lower cost share when using in-network providers.

Identifying TRS-ActiveCare Participants
TRS-ActiveCare participants can be identified by the following on their BCBSTX ID card:

- The TRS-ActiveCare logo will be displayed on the participants' ID card.

- TRS-ActiveCare Primary and TRS-ActiveCare Primary+ plan holders will have ID cards with a three-character prefix of T2U.
- TRS-ActiveCare HD and TRS-ActiveCare 2 plan holders will have ID cards with a three-character prefix of T2S and a network ID of BCA.

For patients on TRS-ActiveCare Primary and TRS-ActiveCare Primary+, you must be their assigned provider to provide primary care services. Patient eligibility and benefits should be checked using Availity® or your preferred vendor before every scheduled appointment. Eligibility and benefit quotes include patients' coverage status and other important information, such as applicable copays, coinsurance and deductibles. It's strongly recommended that providers ask to see patients' ID card and photo ID to guard against medical identity theft. If services may not be covered, patients should be notified that they may be billed directly.

Prior Authorization
You can check the Prior Authorization and Predeterminations page for the list of Administrative Services Only (ASO) services and procedure codes that require prior authorization for TRS participants. Refer to How to Submit a Prior Authorization or Prenotification to learn about submission processes.

Reminders
TRS will continue to use CVS Caremark as their pharmacy benefit manager. We encourage you to attend provider training sessions related to TRS-ActiveCare benefits, prior authorization requirements and ID cards. Continue to watch News and Updates and our Blue Review newsletter for more details on TRS-ActiveCare.

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

Submit Predetermination Requests Online via Availity®

A predetermination of benefits is a voluntary request for written verification of benefits before rendering services. We recommend submitting a predetermination of benefits request if the service may be considered experimental, investigational or unproven, as specified within the BCBSTX Medical Policy.

To make the process faster and easier, a new Attachments Tool is available though the Availity Provider Portal.

How does the new online process work?

1. Log in to Availity
2. Select **Claims & Payments** from the navigation menu
3. Select **Attachments – New**
4. Within the tool, select **Send Attachment** then **Predetermination Attachment**
5. Download and complete the Predetermination Request Form
6. Complete the required data elements
7. Upload the completed form and attach supporting documentation
8. Select **Send Attachment(s)**

You must be registered with Availity to use the new Attachments Tool. You can sign up today at Availity, **at no charge**. For registration assistance, call Availity Client Services at **800-282-4548**.

Note: If you don't have online access, you may continue to fax and/or mail predetermination of benefit requests along with a completed Predetermination Request Form and pertinent medical documentation.

For More Information
If you need further assistance or customized training, contact our Provider Education Consultants. Also watch for a new **Electronic Predetermination Request User Guide**, coming soon to the Provider Tools section of our website.

The information in this notice does not apply to requests for Texas Medicaid or Medicare Advantage members.

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 provided by third

party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

---

iExchange® Deactivation Aug. 17, 2020

The deactivation of our current electronic prior authorization, referral and predetermination of benefits request tool, iExchange is August 17, 2020. As of this date, all electronic prior authorization, referral and predetermination requests handled by Blue Cross and Blue Shield of Texas (BCBSTX) should be submitted online via the Availity® Provider Portal using A

Submitting Online Prior Authorization and Referral Requests

You can submit required requests for prior authorizations and referrals for inpatient and outpatient services managed by BCBSTX medical management online using **Availity's Authorizations & Referrals tool**. Refer to the educational Availity Authorizations User Guide and Availity Referrals User Guide located in the Provider Tools section of our website for navigational assistance. Prior authorization requests managed by eviCore healthcare® (eviCore), AIM Specialty Health® or other vendors through their provider portals or channels has not changed.

It's imperative to check the patient's eligibility and benefits online first to determine if the service requires prior authorization. For online assistance, refer to the General Eligibility and Benefits Expanded User Guide.

How to Submit Online Predetermination of Benefits Requests

As of July 30, 2020, predetermination of benefit requests handled by BCBSTX can be submitted electronically using **Availity's Attachments tool**. Watch for the new Electronic Predetermination Request user guide coming soon to the Provider Tools section and refer to the Predetermination of Benefits page for more information.

If you don't have online access, you may continue to fax and/or mail predetermination requests along with a completed Predetermination Request Form and supporting medical documentation. If faxing supporting medical documentation for a previously submitted request, please include the request number.

Submitting predetermination of benefits via Availity does not apply to requests for Texas Medicaid or Medicare Advantage members.

For More Information

You must be registered with Availity to use the Authorizations and Attachments tools. You can sign up today at Availity , at no charge. For registration assistance, call Availity Client Services at 800-282-4548. Training sessions are also available on our Educational Webinar/Workshop Sessions page.

If you need further assistance or customized training for these Availity solutions, contact our Provider Education Consultants.

TRS-ActiveCare Plans

Statewide Blue Essentials network – providers who are contracted under the Blue Essential network can see participants on these plans:

- **TRS-ActiveCare Primary and TRS-ActiveCare Primary+**
  - Copays for doctor visits before meeting deductibles.
  - Primary care provider (PCP) selection and referrals to specialists are required.
  - No out-of-network coverage, except for true emergencies.

Nationwide Blue Choice PPO network plans – providers who are contracted under the Blue Choice PPO network can see participants on these plans:

- **TRS-ActiveCare HD**
  - High deductible plan which may include a health savings account (HSA) to pay for medical care.
  - Does not require PCP selection or referrals.
  - Deductibles must be met before the plan pays for diagnostic care.

- Includes out-of-network coverage. Participants have a lower cost share when using in-network providers.

- **TRS-ActiveCare 2**
  - Copays for doctor visits before meeting deductibles.
  - Does not require PCP selection or referrals.
  - Includes out-of-network coverage. Participants have a lower cost share when using in-network providers.

Identifying TRS-ActiveCare Participants
TRS-ActiveCare participants can be identified by the following on their BCBSTX ID card:

- The TRS-ActiveCare logo will be displayed on the participants' ID card.
- TRS-ActiveCare Primary and TRS-ActiveCare Primary+ plan holders will have ID cards with a three-character prefix of **T2U**.
- TRS-ActiveCare HD and TRS-ActiveCare 2 plan holders will have ID cards with a three-character prefix of **T2S** and a network ID of **BCA**.

For patients on TRS-ActiveCare Primary and TRS-ActiveCare Primary+, you must be their assigned provider to provide primary care services. Patient eligibility and benefits should be checked using Availity® or your preferred vendor before every scheduled appointment. Eligibility and benefit quotes include patients' coverage status and other important information, such as applicable copays, coinsurance and deductibles. It's strongly recommended that providers **ask to see patients' ID** card and **photo ID** to guard against medical identity theft. If services may not be covered, patients should be notified that they may be billed directly.

Prior Authorization
You can check the Prior Authorization and Predeterminations page for the list of Administrative Services Only (ASO) services and procedure codes that require prior authorization for TRS participants. Refer to How to Submit a Prior Authorization or Prenotification to learn about submission processes.

Reminders
TRS will continue to use CVS Caremark as their pharmacy benefit manager. We encourage you to attend provider training sessions related to TRS-ActiveCare benefits, prior authorization requirements and ID cards. Continue to watch News and Updates and our Blue Review newsletter for more details on TRS-ActiveCare.

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

Clinical Payment and Coding Policy Updates
The Clinical Payment and Coding policies describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is 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 or updated:

- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Effective 12/01/2020

CLINICAL RESOURCES

COPD and Spirometry
Chronic Obstructive Pulmonary Disease (COPD) is the third leading cause of death in the United States. According to the Centers for Disease Control and Prevention (CDC), nearly 12 million Americans are affected by this chronic disease and millions more do not know they have it.

Diagnosing Based on Spirometry and Symptoms

A diagnosis of COPD using Spirometry supports a treatment plan that will protect our members against worsening symptoms, exacerbations and reduce medical costs. Despite being the gold standard for the diagnosis and assessment of COPD, spirometry testing is still underutilized.

NCQA Spirometry Testing in COPD
The National Committee for Quality Assurance (NCQA) recommends spirometry testing for members 40 years and older. They also advise that newly diagnosed or newly active COPD cases receive appropriate spirometry testing to confirm a COPD diagnosis.

Educating COPD Patients
Empower your patients and establish a therapeutic dialogue so that a close relationship develops. As their provider, explain in lay terms what COPD means, share educational materials and appropriate risk assessment tools in a culturally and linguistically appropriate manner.

- COPD Foundation – How is COPD Diagnosed
- ATS Official Documents - COPD
- America Lung Association - COPD
- Centers for Disease Control and Prevention COPD

In-Home Test Kits for Diabetics; Monitor Diabetes Control

Blue Cross and Blue Shield of Texas (BCBSTX) is working with Home Access Health Corporation to provide in-home test kits for some of our fully insured individual members with diabetes. Because of the COVID-19 pandemic, many have delayed getting appropriate care. Home Access Health Corporation is sending out two different kits to members who have not received the recommended testing to close care gaps: hemoglobin A1c test kits and microalbumin urine test kits.

Eligible Members
Fully insured individual members in our Blue Advantage HMOSM and Blue Essentials HMOSM network may receive one or both kits, depending on their test history. Eligible members are:

- Between 18 and 75 years old
- Diabetic
- Have not had a hemoglobin A1c or microalbumin urine test in the recommended timeframe

Recommended Testing
The American Diabetes Association® says people living with diabetes should have the following:

- Hemoglobin A1c every three to six months depending on their diabetes treatment and level of control
- Urine microalbumin once a year to detect early signs of kidney damage

In-Home Test Kit Process
The process is quick and easy for members to follow:

- We notify members that they will receive one or both test kits and that completing the kits is voluntary.
- Home Access Health Corporation sends the appropriate test kits to eligible members.
- Members complete the test kit at home, provide the name of their primary care provider and mail the test for processing to Home Access Health Corporation. Completed tests are due to Home Access Health Corporation by Dec. 18, 2020. An addressed, postage-paid envelope is included in the kit.
- Home Access Health Corporation sends the results to the member and their primary care provider in three to four weeks.

How You Can Help
As a trusted provider, you can encourage our members to take advantage of this opportunity to learn more about their health.

- Discuss the importance of screening and healthy lifestyle choices with our member
- If our member receives a kit and calls your office with questions, discuss their screening options

- Document any test results in the member's medical record and discuss the results with our member

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

Colorectal Cancer Screening at Home

Consider screening our members who are 50 to 75 years old for colorectal cancer. Some members in Blue Essentials HMO[SM] who have not been screened may qualify for a **Fecal Immunochemical Test (FIT) Kit** at no extra charge. Blue Cross and Blue Shield of Texas (BCBSTX) is working with Home Access Health Corporation to provide **in-home** kits to encourage screening for our at-risk members. Screening with a FIT Kit may be a good option to close care gaps.

Importance of Screening

Colorectal cancer is the second leading cause of cancer deaths in the United States.[1] About one-third of adults 50 years and older have not received the recommended screening.[2]

How it Works

- We notify members that they will receive the test kit and that using it is voluntary.
- The member submits the test for processing to Home Access Health Corporation by Dec. 11, 2020.
- Home Access Health Corporation sends the results in three to four weeks to the member and their indicated primary care provider.

How You Can Help

- Discuss the importance of screening and healthy lifestyle choices with our member.
- If our member receives a FIT Kit and calls your office with questions, discuss which screening test would be the best option for them.
- Document any test results in the patient's medical record and discuss the results with our member.

Other Benefits of the FIT Kit

- No need for anesthesia or prep
- Screen members at home who may be at risk during the COVID-19 pandemic
- An annual FIT testing and colonoscopy every 10 years are the **two cornerstones** of screening for those of average risk. [3]

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

1 Basic Information About Colorectal Cancer
2 Screen for Life: National Colorectal Cancer Action Campaign
3 Colorectal Cancer Screening: Recommendations for Physicians and Patients From the U.S. Multi-Society Task Force on Colorectal Cancer

---

Childhood Immunization Rates Fall Amidst Pandemic Fears

After the pandemic declaration in March, office visits for immunizations among our members significantly dropped between March and May compared with the number of visits reported during the same period in 2019.

Parents nationwide have cancelled pediatric check-ups. Immunization levels for vaccine-preventable diseases have plummeted, according to the National Foundation for Infectious Diseases. Well-child office visits have decreased 50%[1] and doses distributed[2] through the federally funded Vaccines for Children program have dropped significantly. The World Health Organization (WHO) and UNICEF have reported[3] a decline in the number of children receiving life-saving vaccines around the world.

The Impact

"Vaccines are one of the most powerful tools in the history of public health, and more children are now being immunized than ever before," says Dr. Tedros Adhanom Ghebreyesus, WHO director-general. "But the pandemic has put those gains at risk. The avoidable suffering and death caused by children missing out on routine immunizations could be far greater than COVID-19 itself."[4]

What We Are Doing About It
Recognizing the urgency, we are using tools and pilot programs to help identify opportunities to increase member immunization rates. This includes mapping vaccination rates geographically, mobilizing our Care Vans to offer vaccination clinics where they are needed most and reaching out to members who have missed or delayed vaccines for their children. But we can't do it alone.

What Can You Do About It
As a trusted health care professional, you play a vital role in educating parents about the importance of vaccination.

- Ensure your patients are up to date on all vaccinations
- Encourage parents with children under two years old to make appointments to vaccinate their children.
- Share your pandemic safety protocol to ease their concerns and increase their comfort in visiting your office
- Discuss options for vaccinations with the parents of your patients
- Share materials[5] with parents that give solid evidence for the efficacy and safety of vaccines

Go Deeper
Read more about our vaccine initiative in the BCBSTX newsroom and learn about National Immunization Awareness Month[6].

[1] National Foundation for Infectious Diseases; #COVID-19 and Routine Vaccinations: What Parents Need To Know, April 28, 2020; https://www.nfid.org/2020/04/28/covid-19-and-routine-vaccinations-what-parents-need-to-know/
[2] Centers for Disease Control and Prevention (CDC), Morbidity and Mortality Weekly Report, May 15, 2020; Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration – United States, 2020; https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm
[3,4] WHO; WHO and UNICEF warn of a decline in vaccinations during COVID-19, July 15, 2020; https://www.who.int/news-room/detail/15-07-2020-who-and-unicef-warn-of-a-decline-in-vaccinations-during-covid-19
[5] CDC; National Immunization Awareness Month, Educational Resources for Parents and Patients; https://www.cdc.gov/vaccines/events/niam/parents/educational-resources.html
[6] CDC; National Immunization Awareness Month; https://www.cdc.gov/vaccines/events/niam/index.html

---

MEDICARE ADVANTAGE PLANS

COVID-19: FAQs for Medicare Providers
Our response to COVID-19 continues to evolve as we work to best serve our members and providers. Review FAQs regarding COVID-19 testing, treatment, telemedicine, pharmacy and more for Medicaid members.

Telehealth Visits – Medicare Advantage
Telehealth can help provide our members access to the care they need, including routine care, while helping to protect against the spread of viruses. Due to the COVID-19 Public Health Emergency, Blue Cross and Blue Shield of Texas (BCBSTX) has expanded access to telehealth at no cost-share* for our Medicare Advantage members through Dec. 31, 2020. See our FAQs for Medicare Providers for more information.

The Centers for Medicare & Medicaid Services (CMS) is allowing providers to engage in telehealth services with new and established Medicare patients. Visit the CMS website for telehealth guidance and a complete list of telehealth codes.

Telehealth Visits	CPT®/ HCPCS Codes[1]	Modifier/ Place of Service (POS)

Telehealth visits provide the same services as an in-person visit. **They use an interactive audio and video telecommunications system** that permits two-way, real-time communication,[2] including:** • HIPAA-approved telehealth platforms • Non-HIPAA-approved applications such as FaceTime and Skype Reimbursement for telehealth visits for in-network, medically necessary covered health care services are the same as in-person visits.	Common services include: • **99201-99215** (Office or other outpatient visit) • **G0438, G0439** (Medicare Annual Wellness Visit) • **G0425-G0427** (Telehealth consultations, emergency department or initial inpatient) • **G0406-G0408** (Follow-up inpatient telehealth consultations to beneficiaries in hospitals or skilled nursing facilities)	Report the same POS code as if the appointment was an in-person visit. • Include CPT telehealth **modifier 95** • You can also report **POS 02 with no modifier**

*BCBSTX Medicare (not Part D) and Medicare Supplement members can access in-network telehealth services at no cost-share for medically necessary, covered services and treatments consistent with the terms of the member's benefit plan. Services available for telehealth may vary. Providers may call the number on the member ID card with questions.
**Providers can find the latest guidance on acceptable HIPAA-compliant remote technologies issued by the U.S. Department of Health and Human Services' Office for Civil Rights in Action.

[1] Centers for Medicare and Medicaid Services (CMS) interim final rule and comment period (IFC), 136, https://www.cms.gov/files/document/covid-final-ifc.pdf
[2] CMS interim final rule and comment period (IFC), 49, https://www.cms.gov/files/document/covid-final-ifc.pdf

---

NETWORK PARTICIPATION

Share Your Medication Assisted Treatment Designation

If you offer opioid addiction or withdrawal treatment, consider making this information available to our members and other providers in our Provider Finder®. This will help others identify you when referring their patients for medication assisted treatment (MAT) care and services.

Update Your Existing Information

As of Sept. 18, 2020, you can share details on your addiction/withdrawal treatment services by using our demographic change form. Here's how:

- Go to the "Change Existing Demographic Information" section.
- Select "Other Provider Updates."
- Enter your MAT and/or OTP provider information under the "Medication Assisted Treatment" section.
- Indicate on the last question if you prefer to keep your answers private or share with our members via Provider Finder.
- Specify the "Effective Date of Change." You must enter this to submit your updates.

The update will be shared on Provider Finder which typically takes about two weeks.

New Providers

New providers can voluntarily provide their certified MAT services during the onboarding process using the Provider Onboarding form.

Opioid Treatment Designations

The Blue Cross and Blue Shield Association has defined four provider types that deliver treatment for opioid use disorders. The types are based on certification through the Substance Abuse and Mental Health Services Administration (SAMHSA):

- MAT for Opioid Use Disorders is provided at a given location
- Provider at a given location is authorized to dispense MAT for Opioid Use Disorders
- This location is a certified Opioid Treatment Program (OTP)
- Counseling for Opioid Use Disorders is provided at this location

View details about each provider type certification .We will verify MAT and OTP provider certification through the SAMHSA before posting in our Provider Finder.

Provider Finder Upgrade
In addition, as of Oct 1, you will see a significant upgrade to Provider Finder. Watch for other communications regarding these changes.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct. 1, 2020 – Part 2

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

PRIOR AUTHORIZATION INFORMATION

Verify Procedure Code Prior Authorization Requirements and Submit the Request via Availity®

Providers can electronically verify Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code-specific prior authorization requirements and submit prior authorization requests handled by Blue Cross and Blue Shield of Texas (BCBSTX) all within the Availity Provider Portal.

Checking patient eligibility and benefits is an imperative first step to confirm coverage and prior authorization requirements prior to rendering services. The Availity Eligibility and Benefits Inquiry allows you to quickly obtain prior authorization requirements by procedure code, along with contact information for the prior authorization entity. As a reminder, the procedure code inquiry option is for prior authorization determination only and is not a code-specific quote of benefits.

Step 1 – Determine code-specific prior authorization requirements via Availity:

- Complete the eligibility and benefit inquiry entry (ANSI 270) by selecting a benefit/service type and/or enter a valid CPT/HCPCS code(s) and the associated place of service. Providers may enter up to eight CPT/HCPCS codes in the inquiry.
- The eligibility and benefit inquiry response (ANSI 271) displays specific prior authorization requirements in the Pre-Authorization Info tab for the benefit/service type and/or CPT/HCPCS codes entered in the inquiry.

Note: If a benefit/service type is not selected, the place of service and at least one CPT/HCPCS code is required. If a CPT/HCPCS code is not entered, the place of service and benefit/service type is required.

Exceptions
CPT/HCPCS code inquiry for prior authorization is not yet supported for the following lines of business:

- Federal Employee Program® (FEP®)
- Blue Cross Medicare Advantage (HMO)℠ and Blue Cross Medicare Advantage (PPO)℠
- Texas Medicaid STAR, STAR Kids and CHIP

Step 2 – Submit required prior authorization requests handled by BCBSTX via Availity:

- Select the Patient Registration menu option, choose Authorizations & Referrals, then Authorizations

- Select Payer BCBSTX, then select your organization
- Select Inpatient Authorization or Outpatient Authorization
- Enter preauthorization request
- Review and submit

Important Reminders
The process of submitting benefit prior authorization requests through eviCore healthcare (eviCore) or other vendors has not changed.

For More Information
Refer to the educational Availity Eligibility and Benefits user guide, Availity Authorizations user guide and Availity Referrals user guide located under the Provider Tools section of our website. Additionally, you can visit our Provider Training page to register for upcoming online training sessions.

Have additional questions or need customized training? Email our Provider Education Consultants for assistance.

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
- 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. 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.

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.

AIM Prior Authorizations and RQI Programs

AIM Specialty Health® is administering a prior authorization review and the radiology quality initiative (RQI) program for certain services and BCBSTX members. Providers should check eligibility, benefits and prior authorization or prenotification requirements through Availity® or your preferred vendor members when ordering or scheduling the below outpatient services when performed in a health care provider’s office, the outpatient department of a hospital or a freestanding imaging center.

Services that may require prior authorization:

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

Services that may require an RQI:

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

If prior authorization or an RQI are required, providers can submit them by logging into AIM's provider portal at aimspecialtyhealth.com. If criteria are met, you will receive an approved order request number RQI. If criteria are not met, or if additional information is needed, the case will automatically be transferred for further clinical evaluation.

For more information refer to the AIM Specialty Health page on the provider website.

AIM Specialty Health (AIM) is an operating subsidiary of Anthem, Inc.
AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

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.

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 EssentialsSM, Blue PremierSM, MyBlue HealthSM, Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO) SM plans. These updates are reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Heath Provider Manual in Section F Filing Claims posted on bcbstx.com/provider under Standards and Requirements/Manuals.

ClaimsXtenTM 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 ConnectionTM (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 ClaimsXtenSM, 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

Effective Sept. 1, 2020, providers can use any in-network clinical laboratory for Blue Advantage HMO℠, Blue Essentials℠ (including TRS-ActiveCare Primary and TRS-ActiveCare Primary+ participants), Blue Premier℠ and MyBlue Health℠. There is no longer an exclusive lab for the HMO plans.

HMO physicians and professional providers located in counties on the Reimbursable Lab County List will be reimbursed on a fee-for services basis for the lab services on the Reimbursable Lab Services List if performed in the physician's or professional provider's office All other lab services must be sent to a participating lab.

Statewide in-network clinical labs for HMO members include the following as of Sept. 1, 2020:

- Quest Diagnostics, Inc - Contact Quest at 1-888-277-8772 or visit Quest's website.
- Clinical Pathology Laboratory (CPL) - Contact CPL at 1-800-595-1275 or visit CPL's website.
- LabCorp - Contact LabCorp at 1-888-LAB-CORP or visit LabCorp's website.

Refer to Provider Finder® for additional participating clinical laboratory providers.

Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

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

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

For locations or questions contact:

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

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

Medical Necessity Review of Observation Services

As a reminder, it is the policy of BCBSTX to provide coverage for observation services when it is determined to be medically necessary based on the medical criteria and guidelines as outlined in the MCG Care Guidelines. Claims for observation services are subject to post- service review, and BCBSTX may request medical records for the determination of medical necessity.

When medical records are requested, documentation should include the following information:

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

CMS Guidance Notifications

CMS Notifications for Blue Cross Medicare Advantage (PPO)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.

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.

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.

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

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

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits.

Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

bcbstx.com/provider
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