September 2020

NOTICES & ANNOUNCEMENTS

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 PPO℠ or statewide Blue Essentials℠ 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.

As a reminder, it is important to check eligibility and benefits before rendering services. This step will help you determine if prior authorization is required for a participant. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

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

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.

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.

BEHAVIORAL HEALTH

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.

Update: Behavioral Health Program Changes for HealthSelect of Texas® – Sept.1

Update: Effective 9/1/2020, **Psychological and Neuropsychological Testing** behavioral health services for **HealthSelect of Texas** and **Consumer Directed HealthSelect**SM (HealthSelect) participants will **not** require prior authorization by BCBSTX medical management. The 9/1/2020 HealthSelect prior authorization lists have been updated to reflect this change.

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

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

How Does This Affect You?
For care of Blue Essentials and Blue Premier members on or after June 1 and HealthSelect participants on or after Sept. 1:

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

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

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

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

Behavioral Health Program Changes Reminder

As of **June 1, 2020**, we are administering behavioral health benefits for Blue Essentials℠, Blue Essentials Access℠, Blue Premier℠ and Blue Premier Access℠ provider networks. Magellan Healthcare® is no longer administering behavioral health benefits for these members.

Also, behavioral health services for HealthSelect of Texas® and Consumer Directed HealthSelect℠ participants will be administered by us effective **Sept. 1, 2020**.

For more detail, refer to the April 15, 2020, article on News and Updates as well as the Behavioral Health page on our provider website. Also, watch for additional provider training sessions in the coming months.

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

CLAIMS & ELIGIBILITY

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.

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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.

Locate a Patient's ID Number Electronically

We understand that sometimes it can be challenging to obtain the Blue Cross and Blue Shield of Texas (BCBSTX) patient's identification number. To help you obtain this necessary information quickly, 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 now available for BCBSTX commercial, retail marketplace and Federal Employee Program® (FEP®) health plan members, making it easier to obtain the patient ID number for your records.

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

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

Note:

- The Patient ID Finder tool is currently unavailable for Medicare Advantage and Texas Medicaid members.
- This tool does not reflect the patient's eligibility or benefits. Refer to the General Eligibility and Benefits Expanded 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 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. 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.

Medicare Corrected Claims

To submit corrected claims for services provided to a Medicare primary member:

- File the corrected claim directly to Medicare, not Blue Cross and Blue Shield of Texas (BCBSTX).

- Follow the same process for filing corrected claims for Medicare primary members just as if filing the claim for the first time to Medicare.
- Medicare will process the corrected claim and forward that claim directly to the member's home plan for secondary processing.

Determine if the claim has been forwarded to the member's home plan by reviewing the Explanation of Medicare Benefits (EOMB). It will indicate "Crossover" or "XOVER" which tells the physician and/or facility that the claim was submitted to the member's home plan for secondary processing.

For questions on the status of a claim, call our Interactive Voice Response (IVR) phone system at 1-800-451-0287.

Medicare Crossover Claim Submissions

Blue Cross and Blue Shield Plans use the Centers for Medicare and Medicaid Services (CMS) crossover process to receive Medicare primary claims. The CMS crossover process routes Medicare Supplemental claims (Medigap and Medicare Supplemental) directly from Medicare to Blue Cross and Blue Shield of Texas (BCBSTX).

- Providers do not need to submit the claims to BCBSTX.
- Duplicate claims result when claims are submitted to both Medicare and BCBSTX.

When the Home Plan receives a Medicare Primary claim before it is crossed over, it may be incorrectly paid based on an estimated Explanation of Medicare Benefits (EOMB).

- Provider payment should be based on the actual EOMB not an estimated EOMB.
- Duplicate claims may cause incorrect member cost share calculations when estimated EOMB is used.

How do I submit a claim when Medicare is primary and Blue Plan is secondary?

- Submit claims to your Medicare carrier when Medicare is primary, and the Blue Plan is secondary.
- When submitting the claim, enter the correct Blue Plan name as the secondary carrier. Check the member’s ID card for additional verification.
- Include the three-character prefix located on the members ID card.

When you receive the remittance advice from Medicare, determine if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- Remark codes MA18 or N89 on the Medicare remittance indicate that the claim was crossed over. Do not resubmit that claim to BCBSTX.
- If the remittance indicates that the claim was not crossed over, submit the claim to BCBSTX with the Medicare remittance advice.
- The member ID card may include a Coordination of Benefits Agreement ID number, include that number on your claim.

Questions on the status of a claim?

- Electronically – send a HIPAA transaction 276 (claim status inquiry) to BCBSTX through Availity® or your preferred online vendor portal.
- Call our Interactive Voice Response (IVR) phone system at 1-800-451-0287.

When should I expect to receive payment?

- Claims submitted to Medicare will be crossed over to the Blue Plan after they have been processed by the Medicare intermediary.
- This process takes 14 business days to occur. Medicare releases the claim to the Blue Plan.
- Allow 30 additional business days to receive payment or instructions from the Blue Plan.

What should I do in the meantime?

- After submitting the claim to the Medicare carrier:
- Allow 30 calendar days from receipt of the Medicare Remittance advice.
- To avoid submitting a duplicate claim, check the status of the initial claim before resubmitting.

ClaimsXten™ Rule Descriptions

The ClaimsXten Rule Descriptions have been updated to reflect additions or changes to claims edits effective in 2020.

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:

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

CLINICAL RESOURCES

Change to HMO Outpatient Clinical Reference Lab Services

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.

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

2019 In-home Colorectal Cancer Screening Testing Quality Improvement Initiative

Review the analysis of the July 2019 colorectal cancer screening initiative that initially launched in 2017.
Read More

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.

COVID-19 Coverage Updates for Medicare Providers

As the COVID-19 crisis continues to evolve, Blue Cross and Blue Shield of Texas (BCBSTX) is making changes to serve our Medicare members. We are following Centers for Medicare & Medicaid Services (CMS) guidelines as appropriate. You can find updates in our COVID-19 FAQs for Medicare Providers, including on testing, treatment, telehealth and claims.

Unless otherwise noted, the FAQs refer to our members in these individual and group Medicare Advantage and Medicare Supplement plans:

- Blue Cross Group Medicare Advantage (PPO)SM
- Blue Cross Group Medicare Advantage Open Access (PPO)SM
- Blue Cross Medicare Advantage (HMO)SM
- Blue Cross Medicare Advantage (PPO)SM
- Blue Cross Medicare Advantage Dual Care (HMO SNP)SM
- Blue Cross Medicare SupplementSM
- BlueStagesSM

The FAQs include details on: **Coverage for testing, testing-related visits and treatment**
Medicare Advantage and Medicare Supplement members won't pay copays, deductibles or coinsurance for:

- Medically necessary lab tests to diagnose COVID-19 that are consistent with CDC guidance
- Testing-related visits related to COVID-19 with in-network* providers, including at a provider's office, urgent care clinic, emergency room and by telehealth
- Treatment for COVID-19 with providers or at facilities from April 1 through Aug. 31, 2020, (previously June 30, 2020). This change may be extended if needed. Members should confirm whether their benefit plan covers services received from out-of-network providers. For questions about benefits, members may call the number on their ID card.

Expanded access to telehealth at no cost-share
Medicare Advantage 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. Medicare Advantage PPO members have access to telehealth services with out-of-network providers but will be responsible for member cost-share for these services consistent with the terms of their plans. This cost-share waiver for telehealth services applies to claims beginning March 1, 2020.

Telehealth for annual health assessments
Initial and subsequent Annual Wellness Visits (G0438 and G0439) may be conducted by telehealth. Submit claims for wellness visits with Modifier 95 and Place of Service (POS) 11. BCBSTX covers one wellness visit every calendar year.

- Note: CMS has not approved Initial Preventive Physical Examinations (IPPE) (G0402) for telehealth. Members are eligible for the IPPE during their first 12 months of enrollment in Medicare.

To confirm Medicare members' coverage and benefits, you may use the Availity® Provider Portal or your preferred vendor. To verify telehealth coverage, please call Provider Services at **1-877-774-8592** for individual and **1-877-299-1008** for group members.

Resources
- CMS Current Emergencies and News Alerts
- CMS Covered Telehealth Services and Telehealth Codes

**Blue Cross Group Medicare Supplement and Blue Cross Medicare Supplement members do not have network restrictions unless otherwise noted in their plan terms.*

Blue Cross Medicare AdvantageSM Prior Authorization Updates Effective Sept. 1, 2020

On Sept. 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) will update its list of Blue Cross Medicare Advantage Prior Authorization Procedure Codes to comply with the American Medical Association (AMA). These changes are the result of new, replaced or removed codes implemented by the AMA.

What's New: Providers will need to utilize the new list of procedure codes on the Prior Authorization & Predetermination page when determining if a service requires prior authorization **Sept. 1, 2020,** and after. Scroll to and open the Blue Cross Medicare Advantage PPOSM and Blue Cross Medicare Advantage HMOSM section. You can view the Blue Cross Medicare Advantage Prior Authorization Requirement List, Blue Cross Medicare Advantage Procedure Code List and Blue Cross Medicare Advantage Procedure Code List Change Summary. You can also use Availity® or your preferred vendor for prior authorization requirements.

Check Eligibility and Benefits: Prior to rendering services, providers should use Availity or your preferred vendor to check eligibility and benefits to confirm membership, check coverage, determine if you are in-network for the member's policy and determine whether prior authorization is required. Availity allows prior authorization determination by procedure code and providers can submit requests on Availity using the Authorization & Referral tool. Refer to the BCBSTX Eligibility and Benefits page for more information on Availity. Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

More Information: Check the AMA website for more information on CPT codes. If you have questions, contact your Network Management Office location.

PHARMACY

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

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

PRIOR AUTHORIZATION INFORMATION

AIM Prior Authorization Expansion Training

As previously announced, effective **Sept. 1, 2020,** AIM Specialty Health® (AIM) will be administering prior authorization and post-review support for some members for the following outpatient services:

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

You will be able to identify the impacted members by the three-character prefixes T2U and T2S on the member's ID card.

Get Ready!
If you do not already have an AIM log on, **go to the *AIM ProviderPortal*℠ to sign up** before Sept. 1.
An overview training will be provided jointly by BCBSTX and AIM staff beginning at the end of July. In addition, based on services that you may provide, AIM will provide specific training by category. It will allow you and your staff to get familiar with the following AIM processes:

- Create and submit prior authorization request, update an existing one, and retrieve your order summary
- Check the status of your requests
- Get tips and shortcuts to navigate the system

Watch for training invitations by email and posted on our Educational Webinar/Workshop Sessions page.

Next Steps
As of **Aug. 17, 2020**, providers will be able to contact AIM for prior authorization of services scheduled **on or after Sept. 1, 2020**. Providers are strongly encouraged to verify prior authorization has been obtained before scheduling and performing services using Availity® or your preferred vendor Submitting medical records to AIM is not necessary, unless requested by AIM.

For more information
Please check the BCBSTX News and Updates and Blue Review newsletter for ongoing updates. Make sure we have a current email on file to get the training invitations. If you have any questions, please contact your local Network Representative.

Procedure Code Updates for Prior Authorization

On Sept. 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) will update its list of Current Procedural Terminology (CPT®) codes to comply with changes from the American Medical Association (AMA). These changes are the result of new, replaced or removed codes implemented by the AMA

What Should You Do

Providers will need to utilize the new list of procedure codes under on the Prior Authorization & Predetermination page when determining if a service requires prior authorization Sept. 1, 2020, and after. You can also use Availity® or your preferred vendor for prior authorization requirements. Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

Plans Affected

The following plans are affected by these changes:

- Blue Choice PPO℠
- Blue Essentials℠ and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- Blue Advantage℠ and Blue Advantage HMO℠ Plus
- MyBlue Health℠

Check Eligibility and Benefits: Before rendering services, providers should check eligibility and benefits through Availity® or your preferred vendor to confirm membership, check coverage, determine if you are in-network for the member's policy and determine whether prior authorization is required. Availity allows prior authorization determination by procedure code. Locate **How to Submit Prior Authorizations** on the Prior Authorizations and Predeterminations page to determine how to submit requests when it is determined if BCBSTX Medical Management, eviCore Healthcare® or AIM Specialty Health® handles prior authorization or prenotification for your services or procedure codes.

More Information: Check the AMA website for more information on CPT code changes. If you have questions, contact your Network Management Office location.

STANDARDS & REQUIREMENTS

Update: Physician Efficiency, Appropriateness, and Quality (PEAQ) Program

Driving quality of care: Learn about recent updates since our January introduction of BCBSTX's PEAQ program that will evaluate physician efficiency, appropriateness, and quality in a transparent and multidimensional way. We've made updates to the methodology for the PEAQ Program to include news about appropriateness, vendor selection and related measures. We plan to release program results to physicians in 2021 through Availity. Physicians can register for Availity at availity.com.

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 on bcbstx.com/provider. In addition, providers can submit needed prior authorizations managed by BCBSTX via Availity Authorizations & Referrals.

Prior authorizations/referrals may be required for any services provided by someone other than the member's primary care physician/provider (PCP) (i.e., specialist, ambulatory surgery centers, ancillary, etc.). A prior authorization/referral is also needed for an initial stay in a facility and any additional days or services added on.

Prior authorizations are required to allow for medical necessity review. If a member does not obtain a prior authorization/referral for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced. Retrospective reviews for medical necessity will not be performed for any HMO plans except in limited special circumstances.

A prior authorization/referral does not guarantee payment. All payments are subject to determination of a member's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations and other provisions of the policy at the time services are rendered.

If a prior authorization/referral request is received from an out-of-network (OON) provider and the member does not have an OON benefit, BCBSTX will contact the ordering provider to discuss network options. However, if a member has an OON benefit, OON benefits will apply, which could result in a higher cost sharing.

Reminder: Utilization Management Review

The Medical Management team, which includes physicians and nurses, evaluate hospital admissions (anticipated or unanticipated) and continued stays, as well as outpatient services. The team utilizes a variety of resources, including MCG criteria and BCBSTX medical policy to inform benefit determinations regarding the level of care, transition of care and the management of home care needs.

Medical management does not make determinations about whether services are medically appropriate, only if the services meet the definition of medically necessary under the terms of the applicable benefit plan. If a service does not meet the definition of medically necessary, initially the case is referred to a medical director for a review of the medical necessity determination. Board certified physicians are available to review referred cases, make medical necessity determinations and resolve appeals.

See the provider manual for guidance on provider requirements when requesting services. The final determination about what treatment or services should be received is between the patient and their health care provider.

Enrollee Notification Form Required for Out-of-Network Care for Blue Choice PPO℠ and Blue Advantage HMO℠ (for Blue Advantage Plus)

Prior to referring a Blue Choice PPO or Blue Advantage HMO (for Blue Advantage Plus point-of- service benefit plan) member to an out-of-network provider for non-emergency services – if such services are also available through an in- network provider – the referring participating network provider must complete the appropriate Out-of-Network Care – Enrollee Notification forms for Regulated Business (used when "TDI is on the member's ID Card) or Non-Regulated Business (No "TDI on member's ID card). Locate them under Forms on the provider website.

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

It is essential that Blue Choice PPO and Blue Advantage Plus enrollees fully understand the financial impact of an out-of-network referral to a health care provider that does not participate in their BCBSTX provider network. They have out-of-network benefits and may choose to use out-of- network providers, however they will be responsible for an increased cost-share under their out-of-network benefits.

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

AIM 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 Copy for Blue Cross Medicare Advantage℠

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

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

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

Annual Health Assessment Coding*

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

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

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

Billing and Documentation Information and Requirements

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

ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and HCPCS codes are periodically added to or deleted from the ClaimsXten code auditing tool software on a quarterly basis and are not considered changes to the software version.

BCBSTX will normally load this additional data to the BCBSTX claim processing system within 60 to 90 days after receipt from the vendor and will confirm the effective date via the News and Updates section of the BCBSTX provider website. Advance notification of updates to the ClaimsXten software version also will be posted on the BCBSTX provider website.

To help determine how coding combinations on a claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to our website at bcbstx.com/provider for additional information on gaining access to C3.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the C3 page under the Education and Reference then Provider Tools or Claims and Eligibility then Claims Filing Tips in the Bundling section on the BCBSTX website. Additional information may also be included in upcoming issues of *Blue Review*.

Cotiviti Code-Auditing Software

In addition to ClaimsXten℠, BCBSTX uses Cotiviti code-auditing software. This software further enhances the auditing of professional and outpatient facility claims for correct coding according to the Healthcare Common Procedure Coding System (HCPSC), Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services guidelines. Providers may use the Claim Research Tool (CRT), which is available on the Availity Provider Portal to research specific claim edits.

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

Technical and Professional Components

Modifiers 26 and TC: Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only.

Note: When a health care provider performs both the technical and professional service for a lab or radiological procedure, he/she must submit the total service, not each service individually.

Contracted Providers Must File Claims

As a reminder, health care providers must file claims for any covered services rendered to a patient enrolled in a BCBSTX health plan. You may collect the full amounts of any deductible, coinsurance or copayment due and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your provider contract with BCBSTX.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA (Health Insurance Portability and Accountability Act of 1996) to add a requirement that if a patient self pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

Hospitals, and Routine Services and Supplies

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

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

Clinical Resources

BCBSTX Lab Guidelines

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for Blue Essentials℠, Blue Premier℠, Blue Advantage HMO℠ and MyBlue Health℠ members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Choice PPO℠ members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

Quest Diagnostics offers:

- Online scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto QuestDiagnostics.com/patient or call 888-277- 8772.
- Convenient patient access to more than 195 patient service locations.
- 24/7 access to electronic lab orders, results and other office solutions through Care360® labs and meds.

For more information about Quest Diagnostics lab testing solutions or to establish an account, contact your Quest Diagnostics Physician Representative or call 866-MY-QUEST (866-697-8378).

For health care providers located in the HMO Reimbursable Lab counties, only the lab services/tests indicated on the Reimbursable Lab Services list will be reimbursed on a fee-for-service basis if performed in the physician and professional provider's office for Blue Essentials members. All other lab services must be sent to Quest. You can access the county listing and the Reimbursable Lab Services list in the General Reimbursement Information section located under the Standards and Requirements tab.

**Note: Health care providers who are contracted/affiliated with a capitated IPA/medical group and health care providers who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.*

Blue Cross Medicare Advantage (PPO)℠ 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 SM Provider Manual (Section B) and Blue Essentials, Blue Advantage HMO, Blue Premier, MyBlue Health Provider Manual (Section B) available in the General Reference Information section of our provider website.

After-hours or weekend care is reimbursable, within limitations, for services provided by an individual physician or other health care professional who is required to provide office-based services outside of regular posted office hours to treat a patient's urgent illness or condition.

BCBSTX does not reimburse facility-based or non-office-based providers for CPT Codes 99053, 99056 and 99060. These codes will be considered inclusive of the primary procedure.

Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX provider website on the 1st or 15th day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted.

To view active and pending medical policies go to bcbstx.com/provider and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to active and pending medical policies.

Draft Medical Policy Review

To streamline the medical policy review process, you can view draft medical policies on the BCBSTX provider website and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

View draft medical policies. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

Rights and Responsibilities Notification

Thank you for choosing to be a participating practitioner with BCBSTX. Please review the information below for the latest information that could affect your practice.

Your Rights

As a participating practitioner of our network, you have the right to review information submitted to support your credentialing application and receive the status of your credentialing (or recredentialing) application, upon request.

Providers have the responsibility to work directly with the reporting entity(ies) to correct erroneous information and/or conflicting information within 30 calendar days. All corrections must be submitted in writing to our Enterprise Credentialing Department, your assigned Network Management Consultant or a Medical Director to avoid future delays in processing your information for consideration in BCBSTX networks.

Mail: 1001 E. Lookout Drive Richardson,
Texas 75082
Fax: 972-766-2137
Email: CredentialingCommittee@bcbstx.com

Note: Credentialing decisions will not be made until the applicant has responded or if the response has exceeded the 30 calendar days allocated.

Applicants who only see patients in an office setting and do not have hospital admitting privileges at a network hospital may attest to having coverage for hospital admissions by submitting a signed Hospital Coverage letter. You can find a copy of this letter by visiting the Forms section under Education and Reference on the BCBSTX provider website.

Care Management Programs: Case Management and Disease Management
BCBSTX Case Management (CM) and Disease Management (DM) staff work with enrolled members to increase their knowledge about their condition and help them better manage crisis events when they occur. CM and DM staff support the member and practitioner relationship, and aid communication between them. Members are encouraged to discuss issues and questions with their practitioner, develop a "shared decision making" partnership with their practitioner and take an active role in managing their own health.

Member compliance with physician treatment plans is monitored, including keeping appointments, compliance with medications and completing ordered tests. Program interventions are designed to coordinate with the activities of a member's treating practitioners, specifically their primary care physician and/or appropriate specialist.

As a practitioner, you may refer a member for these care management programs at any time by calling the number on the back of the member's identification (ID) card. A clinician will collaborate with you to provide our members with available resources and additional support.

Member Rights and Responsibilities
As a BCBSTX practitioner, it is important that you are aware of our members' Rights and Responsibilities. Our health plan members can find their Rights and Responsibilities in their benefit booklet or on our website.

Member Rights and Responsibilities include:

- A right to receive information about BCBSTX, our services, our providers and facilities, and member rights and responsibilities.
- A right to be treated with respect and recognition of the member's dignity and right to privacy.
- A right to participate with providers in making decisions about the member's health care.
- A right to have a candid discussion of appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about BCBSTX or the care we provide.
- A right to make recommendations regarding our members' Rights and Responsibilities policy.
- A responsibility to provide, to the extent possible, information that BCBSTX and the provider and facility need to provide care.
- A responsibility to follow the plans and instructions for care that the member has agreed to with their provider.
- A responsibility to understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

Utilization Management Decisions
BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. Utilization Management (UM) determinations are made by licensed clinical personnel based on the:

- benefits policy (coverage) of a member's health plan,
- evidence-based medical policies and medical necessity criteria, and the
- medical necessity of care and service.

All UM decisions are based on appropriateness of care and service, and existence of coverage. BCBSTX prohibits decisions based on financial incentives, nor does BCBSTX specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The criteria used for UM determinations are available upon request. Please call the Customer Service or Health Advocate number on the back of the member's ID card.

Pharmacy Benefits
As a participating practitioner, you are given a list of drugs that are reviewed and updated throughout the year.

For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for the drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines.

For more information regarding our Pharmacy programs, visit the Pharmacy Program section on the BCBSTX provider website. For Federal Employee Program (FEP) members, information can be found at fepblue.org/pharmacy. We encourage you to check the website regularly and watch for updates in this newsletter.

You can find the following information on our website:

- Formulary lists, including restrictions and preferences
- How to use our pharmacy procedures
- An explanation of limits or quotas
- How you can provide information to support an exception request
- The process for generic drug substitutions, therapeutic interchange and step-therapy protocols

BCBSTX distributes the Roles and Responsibilities Notification to our practitioners annually to keep you informed about important topics that impact you and your practice.

Contact Us
View our quick directory of contacts for BCBSTX.

Update Your Information
Do you need to update your location, phone number or other important details on file with BCBSTX? Do we have the most current email address for you and your staff? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local BCBSTX Network Management Representative to have up to 10 of your office email addresses added.

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

Checking eligibility, benefit information and/or if a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's

eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

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

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

Aerial and Medecision® are trademarks of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity or Medecision. The vendors are solely responsible for the products or services

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

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

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

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