



JULY 6

NOTICES & ANNOUNCEMENTS

Update to the BCBSTX Predetermination Request Form

Blue Cross and Blue Shield of Texas (BCBSTX) providers can submit requests for predeterminations through [iExchange](#)[®] (preferred method), or by submitting the [Predetermination Request Form - Medical Surgical](#). An updated predetermination form has been posted to the BCBSTX provider website, which includes changes to the Member Data and Documentation sections. These changes will enable the collection of important information, such as drug names and dosing information. In addition, the form's procedure code fields will capture units.

If you cannot submit your predetermination electronically through iExchange, you should begin utilizing the updated predetermination form immediately. The form is located on the [provider website](#) under [Education and Reference/Forms](#). As of Oct. 1, 2018, if you use the paper form, you must submit your predeterminations using the new form (indicates 729617.0318 on the bottom of form), otherwise, your predetermination request will be rejected and you will be required to resubmit it using the new form.

If you submit your predetermination requests electronically using [iExchange](#), please add the following information in the **Additional Notes** section of the iExchange predetermination form:

- Drug Name
- Dose/Frequency/Duration
- Units

For assistance on submitting predeterminations electronically through iExchange, refer to the Tip Sheets on the [BCBSTX iExchange page](#).

If you have any further questions, please contact your [Network Management Representative](#).

Insurers Required by CMS to Conduct ACA Risk Adjustment Program Audit

In 2018, the Centers for Medicare and Medicaid Services (CMS) will conduct another Initial Validation Audit (IVA) to validate the data used when assessing the payment transfers for the Affordable Care Act's (ACA) Risk Adjustment (RA) program. The provider's role is essential to the success of the IVA.

Therefore, if any of your patients are selected to be included in the IVA, Blue Cross and Blue Shield of Texas (BCBSTX) is asking for your cooperation and commitment to fulfilling the requirements of the IVA. The IVA is expected to begin in June of 2018 and BCBSTX will be working to retrieve the requested medical records that we must submit to our IVA auditor. Our IVA auditor requires medical records to validate the sampled member's risk score calculation which is based on the diagnosis codes submitted on a member's claims, as well as through supplemental diagnosis submissions based on medical record

review. As BCBSTX providers, you may be asked to provide medical records to validate all of the diagnosis codes used in the ACA RA risk score calculation. It is of utmost importance that you respond to these requests in a timely manner.

The IVA will be performed on a sample of members enrolled in ACA-compliant individual and small group plans, both on and off-exchange. Our IVA auditor will validate medical claims of the sampled members from the previous calendar year. For example, this IVA will be conducted in 2018 but will review claims with dates of service in 2017. Please be aware some of these claims may have been paid in 2018 and are likely to be included in the IVA sample.

We understand that this is a very busy time; however, to comply with CMS' requirements, we appreciate your full support and cooperation as you receive requests from BCBSTX and deliver the requested medical record(s) in a timely manner.

If you have any questions, please contact your [Network Management Representative](#) or email the IVA team at BCBSTX directly at IVA_Records_Texas@bcbstx.com.

Provider Finder® Update

Blue Cross and Blue Shield of Texas (BCBSTX) has made additional updates to the Provider Finder tool, which is accessible via a link on our [BCBSTX website](#). The updated Provider Finder improves search results so that all users can more easily locate in-network physicians, specialists, and other health care providers.

It's important to note changes in the way you use the tool to review your own information and the way to use the tool to help direct our members to other in-network providers.

Below is a step-by-step guide to help you navigate the updated Provider Finder.

- Go to bcbstx.com
- Select "Find a Doctor or Hospital"
- Select "Search as Guest" under "Not a Member Yet?"
- On the next page, selecting the "Search All Providers" link allows you to bypass member prompts. (Please encourage members to choose "Search In-Network Providers". This will lead them through a series of prompts to help focus results.)

To check your own information for accuracy, enter your name and your location. Then in the search results, select your name to view your record, which will include the BCBSTX group and retail networks with which you are contracted.*

To search for other providers who are in-network for a member:

- You can enter a provider's name and location, or
- You can enter the location then indicate the provider type and specialty.*

* Note: If you are looking for an in-network provider for BCBSTX Medicare/Medicaid members, view the "Helpful Links" and then select the member's Medicare/Medicaid network.

Help us continue to help our members find you. If you find discrepancies when checking your own information on the Provider Finder, it's important to submit a request to make the necessary changes. Visit the [Update Your Information page](#) for more information.

If you have any further questions, please contact your [Network Management Representative](#).

Annual Rights and Responsibilities Notification

Thank you for choosing to be a participating practitioner with Blue Cross and Blue Shield of Texas (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

Please 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.

Multiple Procedure Payment Reduction Effective July 1, 2018, for Certain Diagnostic Cardiovascular and Ophthalmology Procedures

Effective July 1, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) will implement a multiple procedure payment reduction (MPPR) to the technical component (TC) modifier of certain diagnostic cardiovascular and ophthalmology procedures billed by physicians and providers on a CMS-1500 claim form.

MPPR applies to the following plans:

- Blue Advantage HMOSM and Blue Advantage PlusSM HMO
- Blue Choice PPOSM
- Blue EssentialsSM and Blue Essentials AccessSM
- Blue PremierSM and Blue Premier AccessSM
- PAR Plan

The MPPRs for multiple diagnostic cardiovascular or ophthalmology services will be applied when more than one of the services is billed for the same patient on the same day. It will apply to modifier TC-only services and to the technical component portion of global services. The MPPRs do not apply to professional component (modifier 26) services. A list of cardiovascular and ophthalmology services subject to MPPRs is included in this notice.

BCBSTX provides general reimbursement information policies, fee schedule request forms and fee schedule information on the [BCBSTX provider website](#). To view this information, visit the “[General Reimbursement Information](#)” section under the Standards and Requirements tab. Under the All Product News section, MPPR changes and updates will be posted under “Multiple Procedure Payment Reductions.”

Cardiovascular Services

For cardiovascular services, full payment is applied to the technical component service with the highest allowable under the BCBSTX fee schedule. Payment is made at 75% of the technical component allowable for the identified subsequent services when performed by the same provider for the same patient on the same day.

The following is an example of how the MPPR applies to cardiovascular services:

Sample Cardiovascular Payment Reduction

Modifier	Code #1 Allowed	Code #2 Allowed	Total Allowed prior to 7/1/18	Total Allowed 7/1/18 or after	Payment Calculation
26	\$77.00	\$65.00	\$142.00	\$142.00	no reduction
TC	\$427.00	\$148.00	\$575.00	\$538.00	$\$427.00 + (.75 \times \$148.00)$
Global	\$504.00	\$213.00	\$717.00	\$680.00	$\$504.00 + \$65.00 + (.75 \times \$148.00)$

Provider Webinars Scheduled for 2018

Do you have new staff? Or just need some refreshers? Blue Cross and Blue Shield of Texas (BCBSTX) has posted complimentary educational webinar sessions on the BCBSTX provider website. These online training sessions give you the flexibility to attend live sessions. Provider billers, utilization areas and

administrative departments will benefit from these webinars. New sessions for 2018 have been added to the [Educational Webinar/Workshop sessions](#) for the following topics:

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

Please visit the [Provider Training](#) page on the [BCBSTX provider website](#) throughout the year to view what topics are available and sign up for training sessions.

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FOCUS ON BEHAVIORAL HEALTH

Depression Is on the Rise and Linked with Other Chronic Conditions



The number of people diagnosed with major depression has increased significantly in the U.S. A new report finds that people diagnosed with major depression are almost 30 percent less healthy on average, translating to a loss of almost 10 years of healthy life. Read this [Making the Health Care System Work](#)™ article to review eye-opening findings from the report.

PREAUTHORIZATION INFORMATION

New eviCore® Email Notification for Utilization Management Decisions

On Sept. 15, 2018, eviCore healthcare (eviCore) will begin notifying providers by email for all preauthorization cases that are **initiated through the [eviCore web portal](#)**.

A few notes on this coming change:

- The email functionality is fully compliant with the Health Insurance Portability and Accountability Act (HIPAA). No protected health information is shared in the email. This is only a notification that a determination has been made on a specific case, or a case is still in process, with instructions to log in to the [eviCore](#) web portal for details.
- The email notification will only apply to cases that are initiated through the eviCore web portal. For cases initiated by phone and/or fax to eviCore, the provider will continue to receive faxed notifications from eviCore.
- This notification will only be sent to health care providers and their authorized contacts who have registered with a valid email address on the [eviCore](#) web portal. Patients will continue to receive mailed letters from eviCore.
- For any email rejections (e.g., user email mailbox is full, etc.), the provider notification will be resent by fax.
- Current options to request a faxed copy of the authorization through eviCore will remain in place.

Please contact eviCore at 855-252-1117 if you need additional information. Below is an example of the email notification providers may receive.

Subject: eviCore healthcare E-Notification: Case # 123456789 has been Updated

There has been an update issued for Case ID # [Enter Case Number] requested by NPI [Enter NPI Number]. To retrieve this information, please click on the link provided below to log in to the Web Portal and use the NPI and Case ID option to search for Case ID # [Enter Case Number] and NPI [Enter NPI Number].

As part of our initiative to speed up communications and eliminate waste, there will not be a separate fax sent to you for this approval unless you request it.

Login to the eviCore Portal: <https://www.evicore.com/pages/providerlogin.aspx>

If your case is pending additional information, you can visit www.evicore.com to upload clinical information through the authorization lookup feature.

Please do not reply to this email, as replies will be sent to a non-monitored email box. If you have any questions after viewing the case information online, please don't hesitate to contact us at 1-855-252-1117.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized 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 an independent specialty medical benefits management company that provides utilization management services for BCBSTX. eviCore is wholly responsible for its own products and services. BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by eviCore.

ERS Prior Authorization Requirement Update – 491 Outpatient Procedures Removed

Blue Cross and Blue Shield of Texas (BCBSTX) has been closely monitoring the Prior Authorization requirements to ensure proper protocols are in place. After receiving feedback from the provider community, BCBSTX has reviewed the Employee Retirement System of Texas' (ERS) HealthSelectSM of Texas and Consumer Directed HealthSelectSM prior authorization requirements which resulted in the removal of 491 outpatient procedures retroactively effective Sept. 1, 2017.

Providers should refer to the "[ERS Outpatient Procedures No Longer Requiring Prior Authorization](#)" list under [Preauthorizations/Notifications/Referral Requirements](#) on the [provider website](#) for a list of the codes being removed.

BCBSTX will be reviewing applicable claims that denied for lack of Prior Authorization and claims that include any of the 491 outpatient procedures that no longer require Prior Authorization and they will be adjusted as appropriate for payment. Additionally, BCBSTX will review any appeals and grievances to determine if an appeal or grievance is no longer appropriate.

For a list of all the prior authorization and referral requirements for ERS participants, refer to [Preauthorizations/Notifications/Referral Requirements](#) on the provider website.

If you have any questions, please contact your [Network Management Representative](#).

CLINICAL RESOURCES

Preventive Services Reminder: Zero Copay for Blue Cross Medicare AdvantageSM

Are your patients up-to-date on preventive services benefits? Blue Cross and Blue Shield of Texas (BCBSTX) would like to remind you that there are no copays for preventive services for Blue Cross Medicare Advantage (PPO)SM or Blue Cross Medicare Advantage (HMO)SM. 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.

For a detailed list of the services with zero copay, access: [Are You Up-To-Date on Your 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.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized 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.

**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.*

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The Keys to Unlocking a Great Discharge Summary

Physicians and other practitioners need to know details about the care a patient receives during an inpatient hospital stay. The hospital discharge summary is an invaluable source for this information. Discharge summaries may improve patient outcomes by providing for continuity and coordination of care, and a safe transition to other care settings and providers.

Mayo Clinic Study

In 2015, the Mayo Clinic conducted a study developed by a research group consisting of hospitalists and Primary Care Providers (PCPs). The study identified the top five elements of a discharge summary that PCPs perceived as being the most important.

1. Medication list with changes - 94%
2. List of diagnosis/problems - 89%

3. Treatment provided - 87%
4. Pending or completed lab and imaging results - 76%
5. Ongoing care recommendations - 75%

In the discussion of the results, the study found that the hospital discharge summary serves as the main conduit for communication between inpatient and outpatient care teams. The study also found that PCPs continue to identify deficits in hospital discharge summary content and availability. The findings suggest that a hospital's initial efforts should include ensuring availability of a complete summary at the posthospital follow-up visit. Improved outcomes during and after this critical transition of care will be a welcomed outcome by both patients and their care providers.

BCBSTX Provider Satisfaction Survey

The Blue Cross and Blue Shield of Texas (BCBSTX) Provider Satisfaction Survey includes questions about PCPs' satisfaction with hospital discharge summaries. Results in 2017 declined compared to 2016 demonstrating opportunities for improvement in timeliness and content.

BCBSTX Provider Satisfaction Survey – Hospital Discharge Summary Feedback

Survey Questions	2015 (Goal 85%)	2016 (Goal 90%)	2017 (Goal 90%)
When your patients are admitted to a hospital, are you sent summary information after the discharge?	72%	80%	72%
When you receive hospital discharge information, does it reach your office within a timely manner?	80%	84%	83%
When you receive hospital discharge information, does it contain adequate information about medications at discharge?	88%	89%	87%
Overall satisfaction with continuity of care	76%	80%	74%

Communications between a hospital and PCP are critical to providing a smooth and long-lasting transition of the patient to the next level of care. Continuity and coordination of care may avoid miscommunication or delays in care that may lead to poor outcomes.

BCBSTX applauds practitioners who have adopted a structured approach to discharge summaries and strongly encourages those who have not to consider adopting this practice.

Source:

Multiple Practical Facts and Ideas to Improve Family Medicine Care. J Am Board Fam Med Nov. 1, 2017, 30:687-690. [Information Transfer and the Hospital Discharge Summary: National Primary Care Provider Perspectives of Challenges and Opportunities.](#)

High-dose Influenza Vaccine Guidelines

Getting the flu vaccine is the best way to prevent the spread of the flu. Therefore, we encourage our members and communities to invest in their health and get vaccinated. We also want to ensure members are receiving the appropriate vaccine for their age according to the [Centers for Disease Control and Prevention \(CDC\)](#) and the [Advisory Committee on Immunization Practices \(ACIP\)](#).

We are here to help you give your patients and our members the best care possible. As a reminder, the flu vaccines called “High-dose influenza” are only approved by the FDA for those 65 and older. These included Fluzone High-dose and FLUAD for the 2017-2018 flu season. New products can become available each year. During flu season, please refer to the [Table of Approved Vaccines](#) on the CDC’s website for the most recent updates.

When a flu vaccine is administered to members outside of the approved age range, your patients are not receiving the most effective or appropriate care, and their health care dollars are not being used in the

most economical way. Please be aware of correct vaccine administration, as well as accurate coding when filing your claims.

Details on our complete, approved [immunization schedule](#) can be found on the BCBSTX provider website under Standards & Requirements, Clinical Payment and Coding Policies. “Preventive Services Policy CPCP006.”

Cancer Prevention: The Added Value in Adolescent Immunizations

Human Papillomavirus (HPV) is a very common virus. The Centers for Disease Control and Prevention (CDC) estimates that about 79 million people are currently infected with HPV in the U.S. and about 14 million people in the U.S. get a new HPV infection every year¹. More than 40 percent of people become infected during their lifetimes with certain “higher risk” types of HPV that are associated with cervical, vaginal, vulvar, anal, throat and penile cancers².

Recommended Vaccine Doses

Vaccination is a safe and effective way to prevent infection from these higher risk virus types. The CDC, American Cancer Society, American Academy of Pediatrics and others recommend that children ages 11 to 12, and less than 15 years of age, get two doses of HPV vaccine – rather than the previously recommended three doses – to protect against cancers caused by HPV³. The second dose should be given 6 to 12 months after the first dose³. Research demonstrates an advantage to vaccinating at this age since there is a stronger immune response against HPV infection compared to older teenagers and young adults.

[Healthy People 2020](#) is a national health initiative that has a set a goal for 80 percent of all U.S. adolescents to receive tetanus-diphtheria-acellular pertussis (Tdap) booster, one dose of meningococcal (MCV4) vaccine and complete the HPV vaccination series beginning by age 13⁴.

Better adherence to the schedule of recommended vaccines by clinicians and a two-dose vaccination sequence for those beginning HPV vaccination prior to age 15 (as opposed to a three-dose sequence) have improved HPV vaccination rates in recent years.

Strategies to Improve HPV Vaccination Rates

To further improve HPV vaccination rates, consider these five research and expert-based strategies:

1. **Provide a strong recommendation for all vaccines.**⁵ Parents trust their providers’ recommendations. A confident recommendation from their child’s provider is a proven strategy to increase both a parent’s knowledge about HPV and their consent to vaccinate. In fact, when providers don’t recommend HPV vaccination as often and consistently as other adolescent vaccines, parents may think HPV vaccination is unnecessary.
2. **Keep the primary message focused on cancer prevention.** Educate parents about the diseases that can be prevented by adolescent vaccines and talk about HPV vaccination in terms of cancer prevention. Research shows that parents are more likely to vaccinate against HPV infection when providers focus on the HPV vaccine’s cancer-prevention benefits⁶.
3. **Administer vaccines together.**⁵ To increase vaccination rates, experts recommend that providers administer the HPV vaccine at the same time they give other adolescent vaccines.⁵ For 11 and 12-year old patients, it is common to administer Tdap, HPV and Meningococcal vaccines together.



4. **Use all opportunities to immunize.**⁵ Avoid missed opportunities to administer the HPV vaccine. Research shows that providers tend to underestimate the challenges associated with adolescent vaccine compliance⁷. Since adolescents may be more likely to seek medical care for focused complaints, review a patient's immunization status during all office visits. Do not limit immunizations to well-child examinations or immunization-only appointments.⁵
5. **Use decisions support and appointment reminders tools.**⁵ Schedule next-dose appointments before patients and their parents leave the office. Appointment reminder tools that alert parents to an upcoming appointment (or to follow-up on a missed appointment), and providers' use of electronic medical record decision support prompts can increase immunization compliance rates.

These practice strategies will help ensure children receive all recommended vaccines on time. For additional information, please go to cdc.gov/vaccines.

Sources:

¹CDC. [Basic Information about HPV and Cancer](#). Accessed Jan. 5, 2018.

²Chesson HW, Dunne EF, Hariri S, Markowitz LE. The estimated lifetime probability of acquiring human papillomavirus in the United States. *Sexually Transmitted Diseases*. 2014; 41(11): 660-664.

³CDC. [Human Papillomavirus \(HPV\) ACIP Vaccine Recommendations](#). Accessed Dec. 20, 2017.

⁴Healthy People.gov. [Immunizations and Infectious Diseases](#). Accessed Nov. 27, 2017.

⁵Bernstein HH, Bocchini JA, AAP Committee on infectious diseases. Practical approaches to optimize adolescent immunization. *Pediatric*. 2017; 139(3): e20164187.

⁶Malo TL, Gilkey MB, Hall ME, Shah PD, Brewer NT. Messages to motivate human papillomavirus vaccination: national studies of parents and physicians. *Cancer Epidemiol Biomarkers Prev*. 2016; 25(10): 1383-1391.

⁷Perkins RB, Clark JA, Apte G, et al. [Missed Opportunities for HPV Vaccination in Adolescent Girls: A Qualitative Study](#). *Pediatrics*. 2014; 134(3).

CLAIMS & ELIGIBILITY




Updates to Clinical Payment and Coding Policies

Blue Cross and Blue Shield of Texas (BCBSTX) has implemented clinical payment and coding policies based on criteria developed by specialized professional societies, national guidelines (e.g., MCG™) and the Centers for Medicare & Medicaid Services (CMS) Provider Reimbursement Manual. Additional sources are used and can be provided upon request. The clinical payment and coding guidelines are not intended to provide billing or coding advice, but to serve as a reference for facilities and providers.

The following policies are being implemented or have been updated and will be effective **Sept. 1, 2018**:

- [Chiropractic Services](#) 
- [Observation Services Tool for Applying MCG Care Guidelines](#) 

The following policies have been updated and changes were effective **June 1, 2018**:

- [Applied Behavior Analysis for Autism Spectrum Disorders](#) 
- [Evaluation and Management of Emergency Department Coding](#) 
- [Neonatal Intensive Care Unit \(NICU\) Level of Care Authorization and Reimbursement Policy](#) 

The following policy has been updated and changes were effective **June 28, 2018**:

- [Preventive Services Policy](#) 

Refer to [Clinical Payment and Coding Policies](#) under Standards and Requirements on the [provider website](#) for details on the policies being implemented or updated.

If you have any questions or if you need additional information, please contact your BCBSTX [Network Management Representative](#).

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Coding Opportunities Available Using CERA On Availity®

Maintaining current and comprehensive diagnosis information for Blue Cross and Blue Shield of Texas (BCBSTX) members is imperative. BCBSTX utilizes multiple sources of data to identify conditions that a member had in the past, or may currently have, which have not been documented as a diagnosis code on a claim during the current calendar year. In turn, BCBSTX often reaches out to providers to close these potential coding opportunities.

BCBSTX is working to make it easier for you to serve members with on and off marketplace health plans that are subject to quality and risk adjustment. Providers can now electronically respond to potential coding gaps and determine treatment opportunities with the **Claim Encounter Reconciliation Application (CERA)** through the Availity Portal.

This new, easy-to-navigate feature helps improve quality of care and risk adjustment by:

- Providing a more efficient alternative to mailing or faxing medical records
- Reducing delays associated with paper submissions
- Lessening in-person visits to retrieve medical records

Mailing and faxing medical records remain options for providers when responding to requests for quality and risk adjustment purposes. Providers who are not Availity users will continue to receive these requests by mail, fax or in-person visits. If you are not a registered Availity user, you can complete the guided online registration process at Availity.com – at no charge.

LEARN MORE ABOUT CERA

- Check out this [Getting Started Guide for CERA](#) and our CERA Tip Sheet for quick reference and navigational assistance
- With an Availity login, you may view the [CERA – Training Demo](#) to understand the setup process and get started working with the tool
- With an Availity login, you may view this on-demand webinar: [Claim Encounter Reconciliation Application \(CERA\) Recording](#) for additional learning

If you have any questions, contact Availity Client Services at 800-282-4548.

Availity users gain access to many useful tools and resources as well as new payer-provider business solutions. For example, with Availity providers can complete a wide range of electronic transactions for BCBSTX patients, such as verifying patient eligibility and benefits, checking claim status, processing a prior authorization, as well as using CERA to evaluate treatment opportunities for quality and risk adjustment purposes.

Currently, the electronic medical record request and submission process through CERA is only available for quality and risk adjustment submissions, and are not available for medical record requests resulting from utilization review activities or the claims adjudication process. We anticipate offering additional capabilities throughout 2018.

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Modifier 25 and Modifier 59 Frequently Asked Questions (FAQ)

A Modifier 25 and 59 FAQ can be found under [Claims Filing Tips - Submitting Claims](#) in the [Claims and Eligibility](#) section of the [BCBSTX website](#). The FAQ defines modifiers 25 and 59, provides an effective date for the recent modifier validation in our coding software, and provides information and direction if a provider receives a denial resulting from the modifier review. If you have any questions, please contact your [Network Management Representative](#).

Blue Essentials AccessSM Benefit Plan

Blue Cross and Blue Shield of Texas (BCBSTX) introduced a new benefit plan option, **Blue Essentials Access**, that went into effect on Jan. 1, 2017. This is a reminder to providers that Blue Essentials Access is an “open access” plan that does not require BCBSTX members to select a primary care provider (PCP) or obtain a referral for specialist services when the member utilizes in-network Blue Essentials providers. All other HMO plan benefits remain the same.

Additional information regarding **Blue Essentials Access** can be found in the *Blue EssentialsSM, Blue Advantage HMOSM and Blue PremierSM Physicians, Professional Providers, Facility and Ancillary Providers - Provider Manual* on our [provider website](#) under the “Standards and Requirements” section.

Below is a copy of a sample ID Card for Blue Essentials Access for your reference.

The diagram shows a sample ID card for Blue Cross Blue Shield of Texas. Callouts on the left explain specific features:

- ALPHA PREFIX**: Points to the 'ABC' in the subscriber name.
- TDI INDICATES MEMBER IS FULLY INSURED**: Points to the 'TDI' label on the card.
- NETWORK ID**: Points to the 'HMO' label on the card.
- INDICATES OPEN ACCESS PLAN NO PCP OR REFERRALS NEEDED WHEN USING BLUE ESSENTIALS IN-NETWORK PROVIDERS**: Points to the 'Blue Essentials Access Open Access' label on the card.

The ID card itself contains the following information:

	BlueCross BlueShield of Texas An independent licensee of the Blue Cross and Blue Shield Association	HMO
Subscriber Name: ABC SAMPLE		
Identification Number: ABC 123456789		
Group Number:	123456	OV/Specialist \$30/\$60
Coverage Date:	04/01/17	Urgent care \$75
Member Effective:	04/01/17	Emergency Room \$250
		RX Generic Copay \$15
		RX Brand Copay \$40/\$75
		RxBIN: 011552
		RxPCN: BCTX

At the bottom right of the card, there is a briefcase icon and an 'Rx' symbol.

If you have any further questions, please contact your BCBSTX [Network Management Representative](#).

PHARMACY

Select Specialty Medications Transitioning to Accredo[®] Specialty Pharmacy

Beginning June 1, 2018, Accredo – a full-service specialty pharmacy – became Blue Cross and Blue Shield of Texas' (BCBSTX) preferred in-network provider of **select specialty medications covered under the medical benefit** for administration to BCBSTX members. Since June 1, 2018, AllianceRx Walgreens Prime was removed from the BCBSTX medical specialty network. AllianceRx Walgreens Prime will continue to be a preferred provider of specialty medications covered under the pharmacy benefit, which are typically FDA-approved for self-administration.

To help ensure a seamless transition, affected patients with active prescriptions (eligible prescriptions with remaining refills) are being systematically transferred from AllianceRx Walgreens Prime to Accredo. Affected patients with recent medical specialty prescription history at AllianceRx Walgreens Prime will be contacted by Accredo through awareness letters and outreach phone calls. The phone call will confirm appointments and shipping information for the next refill, as well as help setting up ongoing care and support services. **Providers with patients affected by this change will be notified via fax.**

Please Note: Specialty medication coverage is based on a member's benefit. This change does not affect patients whose specialty medication may be covered under their pharmacy benefit. This change also does not affect patients with Medicare Part D or Medicaid coverage. Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits, including any prior authorization or predetermination approval that may be required.

Getting Started with Accredo

For patients without valid prescriptions, providers can submit new prescriptions to Accredo. First, visit accredo.com, then select **Prescribers** and then **Referral Forms**. You can choose referral forms by product or therapy name, or by the first letter of the specialty condition. You can also call 866-759-1557. Prior authorization information should be included with each prescription.

Patient Care and Support Services

Accredo offers personalized care and support services, including:

- Comprehensive access to specialty drug products, and clinician-verified dosage and safety recommendations
- 24/7 access to a clinician team, plus flexible and convenient delivery to an address of your patient's choice with included supplies
- Care coordination to minimize drug-related adverse episodes or gaps in care
- Assistance with medical insurance benefits, prior authorization and financial assistance coordination
- Specialty trained clinicians at Accredo's Therapeutic Resource CentersSM who are skilled in targeted therapy management programs that improve adherence, support the provider/patient relationship and care plan, review therapy progress, and maintain open communication with the provider and patient

If you have any questions, please call the number on the back of your patient's ID card.

Accredo is an independent specialty pharmacy provider working with BCBSTX. The relationship between BCBSTX and specialty pharmacies is that of independent contractors.

New AllianceRx Walgreens Prime E-Prescribing Changes

As previously announced, the Blue Cross and Blue Shield of Texas (BCBSTX), pharmacy benefit manager (PBM), Prime Therapeutics LLC (Prime), and Walgreens' combined specialty and home delivery pharmacy services company was formed in 2017. Headquartered in Orlando, FL, the company's full brand name, AllianceRx Walgreens Prime, has officially launched to consumers as of March 31, 2018.

There are changes to the submission of electronic prescriptions as a result of this brand change.

A summary of those changes is listed below for your reference. Please take this opportunity to update any pharmacy information that may be stored in your patient records, as well as your e-prescribing contacts. The electronic prescription submissions you may be using currently may be returned as 'unable to fill'. **Please note:** Updated specialty referral and mail order prescription fax forms, if not submitting electronic prescriptions, will be available on our [provider website](#) soon.

While pharmacy communications, packaging, and informational materials have been updated with the new brand, the contact information, pharmacy hours of operation and prior authorization processes

remain the same.

Specialty Pharmacy Services

As of Jan. 1, 2018, the specialty pharmacy started operating under the name AllianceRx Walgreens Prime. Previous names for the specialty pharmacy were Prime Specialty by AllianceRx Walgreens Prime and Prime Therapeutics Specialty Pharmacy (Prime Specialty Pharmacy).

There are changes to the way you will need to e-prescribe:

- AllianceRx Walgreens Prime has specialty pharmacies located in key regions across the United States. While some restrictions may apply, providers can usually submit the prescription to the location closest to the patient.
- Note: Cystic fibrosis specialty prescription referrals may be sent to any of the locations listed below as well as the dedicated cystic fibrosis pharmacy.
- If you are uncertain where to send a prescription, please call AllianceRx Walgreens Prime at 877-627-6337.

Specialty Pharmacy Address	E-prescribing Pharmacy Name
Beaverton, OR 9775 SW Gemini Drive, Suite 1 Beaverton, OR 97008	AllianceRx WALGREENS PRIME-SPEC-OR
Canton, MI 41460 Haggerty Circle South Canton, MI 48188	AllianceRx WALGREENS PRIME-SPEC-MI
Frisco, TX 10530 John W. Elliott Drive, Suite 100 Frisco, TX 75033	AllianceRx WALGREENS PRIME-SPEC-TX
Pittsburgh, PA 130 Enterprise Drive Pittsburgh, PA 15275	AllianceRx WALGREENS PRIME-SPEC-PA
Orlando, FL 2354 Commerce Park Drive, #100 Orlando, FL 32819	AllianceRx WALGREENS PRIME-SPEC-FL
Cystic fibrosis pharmacy 10530 John W. Elliott Drive, Suite 200 Frisco, TX 75033	AllianceRx WALGREENS PRIME-SPEC-CFS

Home Delivery Services

Home delivery pharmacy services have been operating under the name of AllianceRx Walgreens Prime as of March 31, 2018. This pharmacy fills covered 90-day supply home delivery prescriptions. Previous names were PrimeMail by Walgreens Mail Service, Walgreens Mail Service and PrimeMail.

There are changes to the way you will need to e-prescribe:

- ALLIANCERX WALGREENS PRIME-MAIL-AZ

Members with recent prescription history were notified of the specialty and/or home delivery pharmacy name changes. If your patients have questions about their pharmacy benefits, please advise them to contact the number on their member ID card. Members may also visit bcbstx.com and log in to Blue Access for MembersSM for a variety of online resources.

Blue Cross and Blue Shield of Texas (BCBSTX) contracts with Prime Therapeutics to provide pharmacy benefit management and related other services. In addition, contracting pharmacies are contracted

through Prime Therapeutics. The relationship between BCBSTX and contracting pharmacies is that of independent contractors.

NETWORK PARTICIPATION

BCBSTX Using Centralized Verification Organization Aperture® for Credentialing Notifications

Beginning in April 2018, Blue Cross and Blue Shield of Texas (BCBSTX) will be utilizing the services of a Centralized Verification Organization (CVO). All new and currently contracted professional and facility providers with BCBSTX will begin to receive notifications from Aperture Credentialing, LLC, the CVO that BCBSTX will be using. These notifications are regarding initial credentialing events and information about the new common recredentialing date that will be assigned from Aperture.

Facility Providers ONLY: Facilities can submit their credentialing application through the Availity™ provider portal. An Availity portal demonstration is available for facility providers on how to use the [Provider Credentialing Tool](#).

If you have questions, please contact your [Network Management Representative](#).

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Aperture is a trademark of Aperture Credentialing, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. "Aperture" provides administrative services to BCBSTX. If you have any questions about the products or services offered by such vendor, you should contact the vendor directly.

Keep Your Information Updated to Receive Quick and Accurate Payments

To provide the best service to you and your patients, it's very important that all the information BCBSTX has about your practice is current and accurate. Be sure to let us know about any changes to your practice address, email or physician rosters. **Keeping us informed of any changes to your information helps us pay your claims more quickly and accurately.** It also makes it easier for your patients to get current and correct information on [Provider Finder](#)®. Please update your information by completing the [Demographic Change form](#). Note: Changes may take up to 30 business days to complete. Please consider the impact of your change(s) and the timeliness of your submissions.

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 physicians, professional providers, and facility and ancillary providers. It includes a collection of articles to assist provider offices in servicing BCBSTX patients. For the latest updates, visit the [News and Updates area](#) of the BCBSTX provider website.

Topics:

- Authorizations and Referrals
- Benefits and Eligibility
- Claims
- Clinical Resources
- CMS Guidance Notifications
- Education & Reference
- Electronic Options
- eviCore™

- Pharmacy
 - Provider General Information
 - Rights and Responsibility
-

Authorizations and Referrals

Importance of Obtaining a Preauthorization/Referral

A preauthorization/referral is required for certain types of care and services. Although Blue Cross and Blue Shield of Texas (BCBSTX) participating physicians, professional providers and facility and ancillary providers are required to obtain preauthorizations/referrals, it is also the responsibility of the member/subscriber to confirm that this action has been taken for services that require a preauthorization/referral.

To determine if a service requires a referral or preauthorization, refer to the [Preauthorizations/Notifications/Referral Requirements Lists](#) under Clinical Resources on [bcbstx.com](#).

Preauthorizations/referrals must be obtained 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 preauthorization/referral is also needed for an initial stay in a facility and any additional days or services added on.

Preauthorizations are required to allow for medical necessity review. If a member/subscriber does not obtain a preauthorization/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 preauthorization/referral does not guarantee payment. All payments are subject to determination of the member/subscriber'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.

BCBSTX has implemented fax notifications of benefit preauthorization and predeterminations to the requesting provider. This enhancement provides real-time information and eliminates the need for providers to check the status of preauthorization or predetermination requests while waiting on the mailed notification letters. The faxed notification will be in addition to the notification letter sent via mail to the address we have on file.

Notifications are faxed to the number either on file, or listed on the utilization management or clinical request. You can also check the status of your submitted request via iExchange®. As a reminder, because we are sending confidential protected health information (PHI) to your fax machine, it should be in a secure location that is not accessible to those who do not have the authority to review member/patient PHI.

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

If you need any additional information on the preauthorization process or do not wish to receive faxed notifications, please contact your [BCBSTX Network Management Representative](#).

Checking eligibility, benefit information and/or if a service has been preauthorized 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.

iExchange is a trademark of Meddecision, 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 third-party vendors such as Meddecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

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 PPOSM and Blue Advantage HMOSM (for Blue Advantage Plus)

Prior to referring a Blue Choice PPO or Blue Advantage HMO (for Blue Advantage Plus point-of-service benefit plan) member to an out-of-network provider for non-emergency services – if such services are also available through an in-network provider – the referring participating network provider must complete the appropriate Out-of-Network Care – Enrollee Notification form below.

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

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

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

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

AIM RQI Reminder

Note: Be sure to review the [Preauthorizations/Notifications/Referral Requirements Lists](#) under Clinical Resources on the BCBSTX website for changes effective Jan. 1, 2018, to some self-insured Blue Choice PPOSM plan requirements for Advanced Radiology Imaging.

Physicians, professional providers, and facility and ancillary providers must contact AIM Specialty Health (AIM) first to obtain a Radiology Quality Initiative (RQI) for most Blue Choice PPOSM members. Refer to the [Preauthorizations/Notifications/Referral Requirements Lists](#) for applicable members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's, professional provider's or facility or ancillary provider's office, a professional provider's office, the outpatient department of a hospital or a freestanding imaging center:

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

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

Notes:

- Facilities cannot obtain a RQI from AIM on behalf of the ordering physician, professional provider, facility or ancillary provider.
- The RQI program does not apply to Medicare enrollees with Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.

AIM Specialty Health (AIM) is an operating subsidiary of Anthem, Inc.

Are Utilization Management Decisions Financially Influenced?

Blue Cross and Blue Shield of Texas (BCBSTX) is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

BCBSTX does not specifically reward practitioners or clinicians for issuing denials of coverage, nor is there compensation based on the number or frequency of telephone calls or other contacts that occur with health care providers, members or subscribers. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)SM

What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO network sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow 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.

What does the BCBS MA PPO network-sharing mean to me?

If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX) and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

If you are not a contracted BCBS MA PPO provider with BCBSTX and you provide services for any BCBS MA PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a BCBS MA PPO member when their Blue Cross and Blue Shield Member ID card has the following logo:



The "MA" in the suitcase indicates a member who is covered under the BCBS MA PPO network sharing program. BCBS MA PPO members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID card.

Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?

If you are a contracted BCBS MA PPO provider with BCBSTX, you should provide the same access to care for BCBS MA members from other BCBS Plans as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans, but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local BCBS MA PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

How do I verify benefits and eligibility?

Call BlueCard® Eligibility at 800-676-BLUE (800-676-2583) and provide the BCBS MA PPO member's alpha prefix located on the member's ID card. You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:

- Log in to the [Availity Provider Portal](#) or your preferred vendor
- Enter required data elements
- Submit your request

Where do I submit the claim?

You should submit the claim to BCBSTX under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.

What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?

If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO network sharing?

When you provide covered services to other BCBS MA PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the BCBS MA PPO claim, BCBSTX will send you the payment. However, these services will be paid under the BCBS MA member's out-of-network benefits unless for urgent or emergency care.

What is the BCBS MA PPO member cost sharing level and co-payments?

A BCBS MA PPO member cost sharing level and co-payment is based on the BCBS MA PPO member's health plan. You may collect the co-payment amounts from the BCBS MA PPO member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800- 676-BLUE (800-676-2583).

May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?

No, you may not balance bill the BCBS MA PPO member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

Who do I contact if I have a question about BCBS MA PPO network sharing?

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

Claims

HMO Plans – PCP Selection and Referral Requirements

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

- Blue Advantage HMOSM
- Blue Advantage PlusSM
- Blue EssentialsSM
- Blue Essentials AccessSM
- Blue PremierSM
- Blue Premier AccessSM

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

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

The table below defines when a PCP selection and referrals to specialists (except OB-GYN) are required and when they are not required. (Note: Members can self-refer to in-network OB/GYNs – no referrals are required.) If an in-network physician, professional provider, ambulatory surgery center, hospital or other facility is not available in the member's applicable provider network, preauthorization is required for services by an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility, through either iExchange[®] or by calling the preauthorization number on the back of the member ID card.

Additional services for all HMO plans may require preauthorization. A complete list of services that require preauthorization or a referral for in and out of network benefits is available on the BCBSTX provider website under [Clinical Resources/Preauthorization/Notification/Referral Requirements](#).

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

*Prior to referring a Blue Advantage Plus member to an out-of-network provider for non-emergency services, please refer to Section D Referral Notification Program, of the Blue Essentials, Blue Advantage HMO and Blue Premier provider manual for more detail including when to utilize the Out-of-Network Enrollee Notification forms for [Regulated Business](#) and [Non-Regulated Business](#).

Sample HMO [ID cards](#) and other benefit plan ID cards are available on the BCBSTX provider website.

Reminders:

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

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits 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 questions, contact the number on the member's ID card.

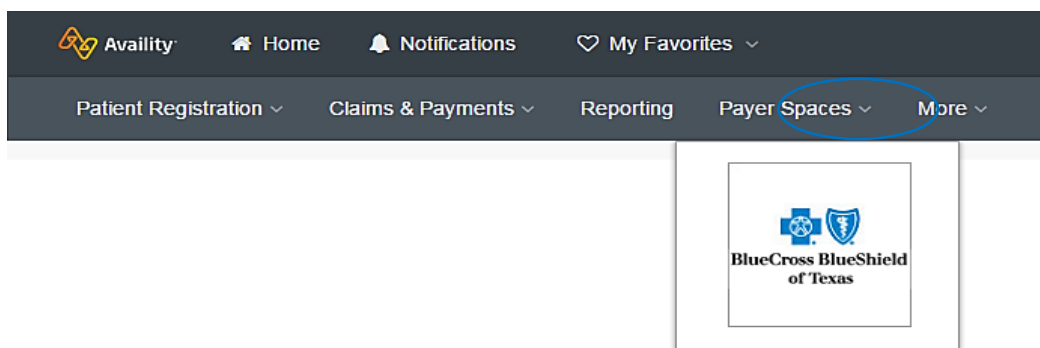
iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Find BCBSTX Resources in Availity® Payer Spaces

Have you recently been searching in the [Availity Provider Portal](#) to locate a specific Blue Cross and Blue Shield of Texas (BCBSTX) tool or enrollment option? Some of our electronic resources offered through Availity have moved to the BCBSTX-branded Payer Spaces section in Availity.

The **BCBSTX Payer Spaces** section contains payer-specific in-house applications, resources and links to the BCBSTX provider website for quick access to pertinent information. You can also view the latest Availity news and announcements for various payer-specific articles, newsletters and reference documents.

Providers may access **BCBSTX Payer Spaces** by selecting the Payer Spaces drop-down option from the Availity navigation menu.



The following online tools and resources are now available via the **Resource tab** within the BCBSTX Payer Spaces section:

- Electronic Fund Transfer online enrollment
- Electronic Remittance Advice online enrollment
- iExchange® online benefit preauthorization registration
- National Drug Code Units Calculator
- Electronic Refund Management (eRM) tool
- And more ...

Note: The Claim Research Tool (BCBS) remains available in the **Claims & Payments** tab on the Availity navigation menu.

To learn more about BCBSTX's electronic offerings, visit the [Provider Tools](#) page in the [Education & Reference Center](#) on the BCBSTX [provider website](#). For assistance or customized training, contact a BCBSTX Provider Education Consultant at PECS@bcbstx.com.

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EFT and ERA Information Available Online

Refer to the Blue Cross and Blue Shield of Texas (BCBSTX) Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) page on BCBSTX's provider website for electronic transactions that may increase administrative efficiencies for your office, while also making it easier for you to conduct business with BCBSTX.

The [EFT/ERA](#) page includes resources to help you learn more about EFT and ERA such as EFT and ERA Online Enrollment Tip Sheets, EFT and ERA 835 Companion Guides and other pertinent information.

Providers are encouraged to enroll for EFT and ERA through the [Availity® Provider Portal](#), which also allows users to make any necessary set-up changes online. Once you are enrolled for ERA, providers and billing services have access to the [Availity Remittance Viewer](#). This tool allows users to search, view, save and print remittance information, even if the ERA is delivered to a vendor and/or clearinghouse other than Availity. To register for Availity, simply go to availity.com and sign up today. There is no cost to register to become an Availity user.

Visit the [EFT/ERA](#) page in the [Claims and Eligibility](#) section of our [provider website](#) for additional information on electronic options. For assistance with EFT and ERA enrollment through Availity, or to learn more about how to use the remittance viewer tool, contact a BCBSTX Provider Education Consultant at ECommerceHotline@bcbsil.com or 800-746-4614.

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Billing and Documentation Information and Requirements

Blue Cross and Blue Shield of Texas (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, Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM plans effective Sept. 15, 2017, as reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual in Section F Filing Claims posted on bcbstx.com/provider under [Standards and Requirements/Manuals](#). Below are the updates to be posted:

Billing & Documentation Information & Requirements Permissible Billing

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

Pass-through Billing

Pass-through billing occurs when the ordering physician, professional provider, facility, or ancillary provider requests and bills for a service, but the service is not performed by the ordering physician, professional provider, facility, or ancillary provider.

The performing physician, professional provider, facility, or ancillary provider is required to bill for the services they render unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

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

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

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

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

Under Arrangement Billing

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

All Inclusive Billing

Any testing performed on patients treated by a physician, professional provider, facility, or ancillary provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services.

The Physician, professional provider, facility, or ancillary provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to BCBSTX.

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

Other Requirements and Monitoring CLIA Certification Requirement

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

Review of Codes

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

Limitations and Conditions

Reimbursement is subject to:

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

Obligation to notify BCBSTX of Certain Changes

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

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

Assignment

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

Benefit Categories Contained in IVR Phone System

Below is a list of common benefit categories contained within the Blue Cross and Blue Shield of Texas (BCBSTX) Interactive Voice Response (IVR) phone system.

The IVR quotes the same level of eligibility and benefit information that a Customer Advocate provides. Our Customer Advocates are available for more complex benefit quotes.

As a reminder, this information is continually reviewed and may vary across different BCBSTX networks, products and/or group policies. The current contained benefit category lists are shown below.

Contained Benefit Categories	
<ul style="list-style-type: none"> • Allergy Colonoscopy Consultations Coordinated Home Care • Electrocardiogram (EKG) Extended Care Facility Hospital • Inhalation Therapy Laboratory Mammogram Office Services Office Visit Pap Smear Physical Exam Preventive Care • Private Duty Nursing Ultrasound • X-ray • 23-hour Observation Air Ambulance Anesthesia Assistant Surgeon CAT Scan Dialysis • Ground Ambulance Hospice • Medical Supplies MRI • Pathology PET Scan Prosthetics • Prostate-specific Antigen (PSA) Sterilization 	

FEP IVR Contained Benefit Categories	
Accidental Injury	Maternity
Allergy	Office Visit
Chiropractic Services	Outpatient Physical, Occupational and Speech Therapy
Diagnostic – Lab, X-ray, Outpatient Diagnostic	Vision
Inpatient Benefits – Inpatient Hospital, Inpatient Surgery	

Note: The above listings are not applicable to Blue Cross Medicare Advantage (PPO)SM or Blue Cross Medicare Advantage (HMO)SM government program member policies. For eligibility and benefits for these government programs via phone, refer to the number on the member’s BCBSTX identification card. As a reminder, checking eligibility and benefits electronically through Availity® or your preferred web vendor is the quickest way to access BCBSTX member information. To learn more about online solutions, see the [Provider Tools section of the BCBSTX provider website](#).

Checking eligibility, benefit information and/or if a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member’s ID card.

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Clinical Payment and Coding Policies Now Online

BCBSTX is now publishing [Clinical Payment and Coding Policies](#) on our website. These payment and coding policies describe BCBSTX’s application of payment rules and methodologies for Current Procedural Terminology (CPT®), HCPCS and ICD-10 coding as applied to claims submitted for covered

services. This information is offered as a helpful general resource regarding BCBSTX payment policies and is not intended to address all reimbursement related issues. New policies have been posted and existing policies will be added over time. We regularly adjust clinical payment and coding policy positions as part of our ongoing policy review processes. Check [this newsletter](#) and the [News and Updates section on our website](#) for newly adapted or revised policies.

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Update to After-hours and Weekend Care Codes Payment Policy

Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its payment policy regarding after-hours and weekend care codes.

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.

Effective Jan. 1, 2017, BCBSTX will no longer 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. Please contact your [BCBSTX Network Management Representative](#) if you have any questions or if you need additional information.

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

Blue Cross and Blue Shield of Texas (BCBSTX) will normally load this additional data to the BCBSTX claim processing system within 60 to 90 days after receipt from the software 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 (i.e., change from ClaimsXten version 4.1 to 4.4) 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](#) or [Claims Filing Tips](#) under [Claims and Eligibility](#) on the [BCBSTX website](#). Additional information may also be included in upcoming issues of [Blue Review](#).

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Checks of eligibility and/or benefit information are 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.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third-party vendor that is solely responsible for its products and services. CPT copyright

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Additional Code-Auditing Software

Blue Cross and Blue Shield of Texas (BCBSTX) implemented additional code-auditing software, Verscend ConVergence Point™ BCBSTX implemented this code-auditing software in June 2017*.

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 Inquiry Resolution Tool, which is available on the Availity Provider Portal to research specific claim edits.

*The above notice does not apply to government program claims.

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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 physician or professional provider and facility or ancillary 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.

Surgical Procedures Performed in the Physician's Office

When performing surgical procedures in a non-facility setting, the physician and professional provider reimbursement covers the services, equipment and some of the supplies needed to perform the surgical procedure when a member/subscriber receives these services in the physician's or professional provider's office.

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in a physician's or professional provider's office. 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 Blue Cross and Blue Shield of Texas' (BCBSTX) code-auditing software. Refer to the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3.

Please note the physician's and professional provider's reimbursement includes surgical equipment that maybe owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied since the global physician's or professional provider's reimbursement includes staff and equipment.

Improvements to the Medical Records Process for BlueCard® Claims

Blue Cross and Blue Shield of Texas (BCBSTX) is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.

As always, we request that you submit your medical records to BCBSTX if needed for claims processing. Requests for medical records from other Blues Plans before rendering services, as part of the preauthorization process, should be submitted directly to the requesting Plan.

Contracted Providers Must File Claims

As a reminder, physicians, facilities, professional providers and ancillary providers must file claims for any covered services rendered to a patient enrolled in a Blue Cross and Blue Shield of Texas (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.

Billing for Non-Covered Services

As a reminder, contracted physicians, professional providers, facility and ancillary providers may collect payment from members/subscribers for copayments, co-insurance and deductible amounts. The physician, professional provider, facility or ancillary provider may not charge the member/subscriber more than the patient share shown on their provider claim summary (PCS) or electronic remittance advice (ERA).

If Blue Cross and Blue Shield of Texas (BCBSTX) determines that a proposed service is not a covered service, the physician, professional provider, facility or ancillary provider must inform the member/subscriber in writing in advance. This will allow the physician, professional, facility or ancillary provider to bill the member/subscriber for the non-covered service rendered.

In no event, shall a contracted physician, professional provider, facility or ancillary provider collect payment from the subscriber for identified hospital acquired conditions and/or serious reportable events.

Avoidance of Delay in Claims Pending COB Information

Blue Cross and Blue Shield of Texas (BCBSTX) receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our physicians, professional providers, facility and ancillary providers is a possible delay, or even denial of services, pending receipt of the required information from the member/subscriber.

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

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

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

Hospitals, and Routine Services and Supplies

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

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

Clinical Resources

BCBSTX Lab Guidelines

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for Blue EssentialsSM, Blue Premier and Blue Advantage HMOSM members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) Blue Choice PPOSM subscribers. 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](https://www.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 physicians, professional providers or facility and ancillary 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's, 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: Physicians, professional providers or facility and ancillary providers who are contracted/affiliated with a capitated IPA/medical group and physicians, professional providers or facility or ancillary providers who are not part of a capitated IPA/medical group but who provide services to a member/subscriber whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.*

Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

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

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

For locations or questions contact:

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

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

Medical Necessity Review of Observation Services

As a reminder, it is the policy of Blue Cross and Blue Shield of Texas (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 [Milliman 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:

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

Coordination of Care Between Medical and Behavioral Health Providers

Blue Cross and Blue Shield of Texas (BCBSTX) continually strives to promote coordination of member care between medical and behavioral health providers. We understand that communication between providers and their patients regarding the treatment and coordination of care can pose challenges. Here are few resources available to you through BCBSTX:

The Coordination of Care Form Available Online

To provide assistance when coordinating care, BCBSTX has created a [Coordination of Care form](#) that is available online. This new form may help in communicating patient information, such as:

- To provide member treatment information to another treating provider
- To request member treatment information from another treating provider. It is important to note that a written release to share clinical information with members' medical providers must be obtained prior to the use of this form. BCBSTX recommends obtaining a written release prior to the onset of treatment.

If you are requesting member treatment information from another provider, it is recommended that the Patient Information and Referring Provider sections of the form be completed to expedite the care coordination process for the receiving provider.

If You Need Help Finding Behavioral Health Providers for Your Patients

Call the number on the back of members' BCBSTX ID cards to receive assistance in finding outpatient providers or behavioral health facilities.

Behavioral Health or Medical Case Management Services

If you believe a patient has complex health needs and could benefit from additional support and resources from a clinician, you can make a referral to one of the BCBSTX Case Management programs by calling the number on the back of the member's BCBSTX ID card. Case Management can also provide you and the member with information about additional resources provided by their insurance plan.

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.

Education & Reference

Provider Manual Update

Blue Cross and Blue Shield of Texas (BCBSTX) makes periodic updates and clarifications related to operational changes and regulatory mandates to the provider manual, as well as the processes, policies and procedures that you comply with as a network provider. It is important that you stay up-to-date, so we share these changes in our monthly [Blue Review newsletter](#), in the [News and Updates](#) and/or the [Standards & Requirements/Disclosures](#) sections of the [BCBSTX provider website](#). These changes may

also be communicated via mail. We encourage you to review both resources as you provide care to your patients. As a provider, it is your responsibility to review and comply with these changes.

Electronic Options

Multiple Online Enrollment Options Available in Availity®

Blue Cross and Blue Shield of Texas (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.

Online Enrollment for EFT and ERA

BCBSTX contracted providers can enroll online for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA), and make any necessary set-up changes in Availity. The online enrollment process can be completed in near real-time.

Providers will receive a confirmation letter acknowledging the enrollment effective date and related information. Once enrolled for ERA, providers and billing services also gain access to the Availity Remittance Viewer. This online tool permits users to search, view, save and print remittance information, even if the ERA is delivered to a different clearinghouse or vendor.

Single Sign-On Access

Benefit Preauthorization Via iExchange®

Once you are registered as an Availity user, you may enroll through the Availity Provider Portal for iExchange. This tool supports online submission and electronic approval of benefits for inpatient admissions, as well as select outpatient and clinical pharmacy services. iExchange also offers you an alternative to calling to request the status of most benefit preauthorization requests. Additionally, iExchange accepts electronic medical record documentation for predetermination of benefits requests. As a reminder, always check eligibility and benefits first to find out if benefit preauthorization is required for a member.

Please note that for behavioral health services, you should continue to use the current fax and telephone benefit preauthorization methods.

Electronic Refund Management (eRM)

Registered Availity users can also gain access to eRM, an online tool that helps simplify the overpayment reconciliation process. You will receive electronic notification of overpayments with the option to deduct from a future payment or pay by check. eRM also gives access to the Claim Inquiry Resolution (CIR) tool. CIR offers online assistance that helps save your staff time by reducing the number of calls and specific written inquiries on finalized claims.

Please note that the eRM and CIR tools are not available for government programs claims.

Learn More

To learn more about these and other electronic tools and resources, visit the [Provider Tools section](#) of our website. Also, see the [Provider Training](#) page for dates, times and registration for online training sessions on a variety of topics.

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

Register with Availity

Visit availity.com to complete the online application today. If you need registration assistance, contact Availity Client Services at 800-AVAILITY (800-282-4548).

*Checking eligibility, benefit information and/or the fact that a service has been preauthorized 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. *This excludes atypical providers who have not acquired a National Provider Identifier (NPI).*

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Online Portal Applications Help Expedite Administrative Workflows

Does your office or organization ever ask: "Is this patient eligible for Blue Cross and Blue Shield Texas (BCBSTX) benefits? Does this service require preauthorization? or How did my claim process?" If so, these questions and so many more can be answered in a matter of seconds with a few key strokes using an online portal application, such as Availity®.

Electronic options deliver real-time resolutions, avoiding disapproved services and optimizing your payment. You can confirm patient coverage, preauthorize services and post payments with a few simple clicks.

Not only can you conduct Health Insurance Portability and Accountability Act-compliant transactions online, using Availity you can also:

- Submit pre- and post-exam transactions
- Conduct pre-service requests
- Complete post-service reconciliations
- Update provider demographics
- Enroll for electronic remittance and fund transfers

If you have not registered and would like to learn more about Availity, and our online referral and preauthorization tool iExchange®, register for a [Back to Basics: Availity 101 webinars](#).

Additionally, for more advanced training of online tools, email a Provider Education Consultant at PECS@bcbstx.com.

Corrected Claim Request Change

As a reminder, corrected claim requests for previously adjudicated claims must be submitted as electronic replacement claims, or on the appropriate professional (CMS-1500) or institutional (UB-04) paper claim, and Claim Review form.

Electronic Submission

Electronic replacement claims should be submitted with the appropriate claim frequency code. Frequency code 7 will result in Blue Cross and Blue Shield of Texas (BCBSTX) adjudicating the original claim number (sometimes referred to as a Document Control Number, or DCN) with the corrections. The replacement claim will be issued a new BCBSTX claim number and subsequently deny based on the re-adjudication of the original claim.

Note: Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSTX claim number will not be adjudicated. See below for additional information on claim frequency codes and guidelines to assist you with when and how to use them for making corrections to electronic claims submitted to BCBSTX.

Claim Frequency Codes			
Code	Description	Filing Guidelines	Action
5 Late Charge(s)	Use to submit additional charges for the same date(s) of service as a previous claim.	File electronically, as usual. Include only the additional late charges that were not included on the original claim.	BCBSTX will add the late charges to the previously processed claim.
7 Replacement of Prior Claim	Use to replace an entire claim (all but identity information).	File electronically, as usual. File the claim in its entirety, including all services for which you are requesting reconsideration.	BCBSTX will replace the original claim with corrections and the replacement claim will be denied. Refer to the original claim for adjudication.
8 Void/Cancel of Prior Claim	Use to eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."	File electronically, as usual. Include all charges that were on the original claim.	BCBSTX will void the original claim from records, based on request.

Paper Submission

More than 98 percent of the claims BCBSTX receives from providers are submitted electronically. BCBSTX encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer web vendors available to providers. If you are a registered Availity® Provider Portal user, you have access to submit direct data entry replacement claims electronically, at no additional cost.

As of July 11, 2016, any changes to a claim that are specified only on the Claim Review form (or via a letter) will be returned with a notice advising resubmission on the appropriate CMS-1500 or UB-04 paper claim form. Paper claim submitters are required to indicate "corrected claim" on the paper claim form and the accompanying Claim Review form.



eviCore Preauthorization Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) contracts with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to administer preauthorization requirements for certain specialized services and products for BCBSTX members.

To determine which specialized clinical services and the effective dates of those services which require preauthorization/prior authorization through eviCore, refer to the [Preauthorization/Referral/Notification Requirements](#) found on the BCBSTX provider web site.

Be sure to review the [Preauthorization/Referral/Notification Requirements Lists](#) carefully as the services and effective dates vary by product as well as whether the member's group is self-insured or fully insured (identified by TDI on ID card).

For a detailed list of the services that require authorization through eviCore, refer to the [eviCore implementation site](#). Services performed without authorization may be denied for payment and you may not seek reimbursement from members/subscribers.

eviCore authorizations can be obtained using one of the following methods:

- Use the [eviCore healthcare web portal](#), which is available 24/7. After a one-time registration, you can initiate a case, check status, review guidelines, view authorizations and eligibility, and more. The web portal is the quickest, most efficient way to obtain information.
- Call eviCore at 855-252-1117 toll-free between 6 a.m. - 6 p.m. CT, Monday through Friday, and 9 a.m. - noon CT, Saturday, Sunday and legal holidays.

For all other services that require a referral and/or authorization as noted on the Preauthorization/Referral Requirements Lists or the Prior Authorization/Referral List for ERS, continue to use iExchange®. iExchange is accessible to all physicians, professional providers and facilities. [Learn more about iExchange or set up a new account on BCBSTX's provider website.](#)

Watch for additional information and training opportunities for eviCore in [future editions of this newsletter](#), on the [BCBSTX provider website](#) or on the [eviCore implementation site](#).

If you have any questions, please contact your [BCBSTX Network Management Representative](#).

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if a member requires benefit preauthorization or prior authorization. For additional information, such as definitions and links to helpful resources, refer to the [Eligibility and Benefits section](#) on BCBSTX's provider website.

Checking eligibility, benefit information and/or if a service has been preauthorized or 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.

iExchange is a trademark 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 third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Pharmacy

Pharmacy Benefit Tips

For Blue Cross and Blue Shield of Texas (BCBSTX) members with prescription drug benefits administered by Prime Therapeutics®, BCBSTX employs many industry-standard management strategies to ensure appropriate utilization of prescription drugs. These strategies can include drug list management, benefit design modeling, specialty pharmacy benefits, clinical programs, among others. BCBSTX providers can assist in this effort by:

1. Prescribing drugs listed on the drug list

BCBSTX drug lists are provided as a guide to help in the selection of cost-effective drug therapy. Every major drug class is covered, although many of the drug lists cover most generics and fewer brand name drugs. The lists also provide members with criteria for how drugs are selected, coverage considerations and dispensing limits. While these drug lists are a tool to help members maximize their prescription drug benefits, the final decision about what medications should be prescribed is between the health care provider and the patient.

BCBSTX drug lists are regularly updated and can be found on the [Pharmacy Program](#) page on the [BCBSTX provider website](#).

Note: For members with Medicare Part D or Medicaid coverage, the drug lists can be found on the plan's website:

- Blue Cross MedicareRx (PDP)SM: getbluetx.com/pdp/druglist
- Blue Cross Medicare AdvantageSM: getbluetx.com/mapd/druglist
- Blue Cross Medicare Advantage Dual Care (HMO SNP)SM: getbluetx.com/dsnp/druglist
- Texas STAR: bcbstx.com/star/prescription-drugs/drug-coverage
- Texas CHIP: bcbstx.com/chip/prescription-drugs/drug-coverage
- Texas STAR KIDS: bcbstx.com/starkids/plan-details/drug-coverage.html

2. Reminding patients of covered preventive medications

Many BCBSTX health plans include coverage at no cost to the member for certain prescription drugs, women's contraceptive products and over-the-counter medicines used for preventive care services.*

- [ACA \\$0 Preventive Drug List](#)
- [Women's Contraceptive Coverage List](#)

3. Submitting necessary prior authorization requests

For some medications, the member's plan may require certain criteria to be met before prescription drug coverage may be approved. You will need to complete the necessary prior authorization request and submit it to BCBSTX. More information about these requirements can be found on the [Pharmacy Program](#) page on the [BCBSTX provider website](#).

4. Assisting members with drug list exceptions

If the medication you wish to prescribe is not on your patient's drug list or the preventive care lists, a drug list exception can be requested. You can call the customer service number on the member's ID card to start the process, or [complete the online form](#).

Visit the [Pharmacy Program](#) page for more information.

**Not available for all plans. Members should call the customer service number on their ID card to help determine what benefits may be available, including any requirements, limitations or exclusions that apply. Please refer to the member's certificate of coverage and prescription drug list as there may be coverage for additional products beyond these lists.*

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.

Dispensing QVT (Quantity Versus Time) Limits

To help minimize health risks and to improve the quality of pharmaceutical care, dispensing QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer's package insert. For current Drug List Dispensing Limits, visit [Pharmacy Program/Dispensing Limits](#) on the BCBSTX provider website.

Prescription Drug Lists

Throughout the year, the Blue Cross and Blue Shield of Texas (BCBSTX) Clinical Pharmacy department frequently reviews the prescription drug lists. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

For current drug updates, visit [Pharmacy Program/Prescription Drug List and Prescribing Guidelines](#) on the BCBSTX provider website.

Provider General Information

Fee Schedule Updates

Reimbursement changes and updates for Blue Choice PPO, Blue Essentials (Independent Provider Network only), Blue Advantage HMO and Blue Premier practitioners will be posted under Standards and Requirements/General Reimbursement Information/Reimbursement Schedules and Related Information/Professional Schedules section on the Blue Cross and Blue Shield of Texas (BCBSTX) provider website at bcbstx.com/provider.

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the [General Reimbursement Information section on the BCBSTX provider website](#). The CPT/HCPCS Drug/Injectable codes Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC fee schedule will be updated monthly.

Employees Retirement System of Texas (ERS)

Effective Sept. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) was awarded the six- year contract for the Employees Retirement System of Texas (ERS) account, effective Sept. 1, 2017.

ERS participants covered under HealthSelectSM of Texas and Consumer Directed HealthSelectSM benefit plans will access care through the Blue EssentialsSM provider network in all 254 counties in Texas.

ERS participants plan options:

- HealthSelect of Texas In-Area (Texas)
- Participants must select a primary care physician (PCP) participating in the Blue Essentials provider network and referrals are required to see Blue Essential providers for in network benefits.
- Consumer Directed HealthSelect In-Area (Texas)
- Consumer Directed HealthSelect participants have open access to providers in the Blue Essentials provider network for their in-network benefits. This plan does not require PCP selection and does not require referrals.

ERS participants can be identified through their BCBSTX ID card:

- The plan names HealthSelect of Texas and Consumer Directed HealthSelect will be printed directly on the ID card.
- ERS Participants will have a unique Blue Essentials network ID labeled HME.

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit quotes include participant verification, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It's strongly recommended that providers ask to see the participant's ID card for current information and photo ID to guard against medical identity theft. When services may not be covered, participants should be notified that they may be billed directly.

For a list of services that require prior authorization for ERS participants through BCBSTX or eviCore, refer to the [ERS HealthSelect of Texas Prior Authorization/Notification/Referral Requirements List](#) or [ERS Consumer Directed Health Select Prior Authorization/Notification/Referral Requirements List](#) on the [Clinical Resources](#) page of BCBSTX's provider website.

Continue to watch for additional information regarding ERS in future editions of the Blue Review newsletter and on our website at bcbstx.com/provider.

If you have any questions or if you need additional information, please contact your [BCBSTX Network Management Representative](#).

Provider Training

BCBSTX is proud to offer complimentary educational webinar sessions. These online training sessions give you the flexibility to attend live sessions. Provider billers, utilization areas and administrative departments will benefit from these webinars. Please visit [Educational Webinar/Workshop Sessions](#) on the bcbstx.com/provider website to view what is available and sign up for training sessions.

After-hours Access Is Required

Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians/providers, Specialty care physicians, professional providers, and facility and ancillary providers provide urgent care, and emergency care or 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 PPOSM Physician, Professional Provider and Facility and Ancillary Provider Manual (Section B) and Blue, Blue Premier Physician, Professional Provider, Facility and Ancillary Provider Manual (Section B) available in the Education & Reference section of our provider website. Click on the “Manual” link (note, a password is required).

Medical Record Requests: Include Our Letter as Your Cover Sheet

When you receive a letter from Blue Cross and Blue Shield of Texas (BCBSTX) requesting additional information, such as medical records or certificates of medical necessity, please utilize the letter as a cover sheet when sending the requested information to us.

This letter contains a barcode in the upper right corner to help ensure that the information you send is matched directly to the appropriate file and/or claim. Do not submit a Claim Review form in addition to the letter, as this could delay the review process. Thank you for your cooperation!

Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the Blue Cross and Blue Shield of Texas (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 Blue Cross and Blue Shield of Texas (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

Blue Choice PPOSM Subscribers/Blue Advantage HMOSM Member Rights and Responsibilities
As a provider for Blue Cross and Blue Shield of Texas (BCBSTX), you are obligated to be aware of subscribers'/members' rights and informed of subscribers' responsibilities. Our health plan subscribers/members may refer to their benefit booklet for a listing of their rights and responsibilities, which are also included below; you can also access these documents on our website at bcbstx.com.

RIGHTS		RESPONSIBILITIES	
Subscriber(s)/Member(s)		Subscriber(s)/Member(s)	
You have the right to:		You have the responsibility to:	
<p>Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities.</p> <p>Make recommendations regarding the organization's subscribers' rights and responsibilities policy.</p>	<p>Provide, to the extent possible, information that your health benefit plan and practitioner/provider needs to provide care.</p>		
<p>Participate with practitioners in making decisions about your health care.</p>	<p>Follow the plans and instructions for care you have agreed to with your practitioner.</p>		
<p>Be treated with respect and recognition of your dignity and your right to privacy.</p> <p>A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. Voice complaints or appeals about the organization or the care it provides.</p>	<p>Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the highest degree possible.</p>		

Member Rights – You Have the Right to:

- Receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policy.
- Participate with practitioners in making decisions about your health care.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.

Member Rights – You Have the Responsibility to:

Meet all eligibility requirements of your employer and the Health Maintenance Organization (HMO).

- Identify yourself as an HMO member by presenting your ID card and pay the copayment at the time of service for network benefits.
- Establish a physician/patient relationship with your primary care physician/provider (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency or services are performed by your HMO participating OB/Gyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, to care for you. Including changes in your family status, address and phone numbers within 31 days of the change.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Notify your primary care physician/provider or HMO plan within 48 hours or as soon as reasonably possible after receiving emergency care services.

- Communicate complete and accurate medical information to health care providers.
- Call in advance to schedule appointments with your network provider and notify them prior to canceling or rescheduling appointments.
- Read your coverage documents for information about benefits, limitations, and exclusions.
- Ask questions and follow instructions and guidelines given by your provider to achieve and maintain good health.
- Understand your health problems and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

Contact Us

View our [quick directory of contacts](#) for BCBSTX.

Update Your Information

Do you need to update your location, phone number, email or other important details on file with BCBSTX? 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.

bcbstx.com/provider

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