BLUE REVIEW℠

For Providers

MAY 2024

REGULATORY & REQUIREMENTS

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

Note: When "Commercial plans" is referenced, it includes:

- Blue Choice PPO® and Blue High Performance Network® (BlueHPN®)
- Blue Advantage HMO℠
- Blue Advantage Plus℠
- Blue Essentials℠ (including TRS-ActiveCare Primary and TRS-ActiveCare Primary+ participants) and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- MyBlue Health℠

Topics:

REGULATORY AND REQUIREMENTS CORNER

Annual Notice of Provider and Member Rights and Responsibilities

As a participating provider in Blue Cross and Blue Shield of Texas (BCBSTX) provider networks, you have certain rights and responsibilities noted below that may affect your practice. Your patients also have rights and responsibilities.

Provider rights include:

Your Credentialing Rights

If you are applying or reapplying to participate in our networks, you have the right to:

- Review information submitted to support your credentialing application
- Update incorrect and/or conflicting information
- Receive the status of your credentialing or recredentialing application upon request

To learn more about these rights: Visit the Credentialing page on our Provider website.

Provider responsibilities include:

Case Management Programs

You can help our members maintain or improve their health by encouraging them to participate in relevant case management programs. These may include:

- Condition management programs to support members with specific conditions like asthma or diabetes
- Complex case management services for members facing multiple or complicated medical or behavioral health conditions
- Programs to help members transition home after a hospital stay or navigate the health care system
- Wellness and prevention programs for members of all ages

Members can access applicable services for complex and condition case management by:

- Asking to enroll, or having their caregiver ask to enroll
- Referral from a primary care physician, practitioner, hospital, or other discharge planner
- Referral through utilization management programs

To refer members to any case management programs: Call the number on the member's BCBSTX ID card. Our clinicians will collaborate with you to provide our members with available resources and additional support.

Utilization Management Decisions

It is BCBSTX's policy that licensed clinical personnel make all utilization management decisions according to the benefit coverage of a member's health plan, evidence-based medical policies and medical necessity criteria. Decisions are based on appropriateness of care and service and existence of coverage.

BCBSTX prohibits decisions based on financial incentives. We do not reward practitioners or clinicians for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

To obtain the criteria used for utilization management decisions: Call the number on the member's BCBSTX ID card. You can also refer to BCBSTX's medical policies, which are available for review online. Learn more about Utilization Management on our provider website.

Blue Cross and Blue Shield Federal Employee Program® (FEP®) members: In addition to the details provided above, visit FEP for more information about our FEP members. Call 1-800-441-9188 for questions regarding FEP prior authorizations. For FEP expedited appeals only, the fax number is 972-766-9776.

Member Rights and Responsibilities
Also, as a participating provider we are informing you of members' rights and responsibilities summarized below. Additional information can be found in members' benefit booklets and on our member website.

Member rights include the right to:

- Receive information about Blue Cross and Blue Shield of Texas (BCBSTX), our services, participating providers and facilities, and member rights and responsibilities
- Be treated with respect and dignity with recognition of their right to privacy
- Participate with providers in making decisions about their health care
- Have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Voice complaints or appeals about BCBSTX or the services we provide
- Make recommendations regarding our members' rights and responsibilities policy

Member responsibilities include a responsibility to:

- Provide, to the extent possible, information that BCBSTX and the provider and facility need to provide care
- Follow the plans and instructions for care that the member has agreed to with their provider
- Understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible

Blue Cross and Blue Shield Federal Employee Program® (FEP®) members: In addition to the details provided above, visit fepblue.org for more information about our FEP members.

To learn more about member rights and responsibilities you may refer to:

- Blue Choice PPO℠ and Blue High Performance Network® (Blue HPN®) Provider Manual
- Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠
- Members' benefit booklet
- Member website, which includes HIPAA NOTICE OF PRIVACY PRACTICE

Texas Medicaid members: In addition to the details provided above, our Medicaid members have an expanded list of rights and responsibilities that can be found here and also in the STAR and CHIP provider manuals (Chapter 13) and STAR Kids provider manual (Chapter 18).

Contracted Providers Must File Claims

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

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

directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

After-Hours Access Is Required

BCBSTX requires that primary care and specialty care health care providers provide urgent, and emergency coverage for care 24 hours a day, seven days a week. Providers must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

Acceptable after-hours access mechanisms may include:

- an answering service that offers to call or page the physician/provider or on-call physician/provider,
- a recorded message that directs the patient to call the answering service and the phone number is provided, or
- a recorded message that directs the patient to call or page the physician/provider or on-call physician/provider and the phone number is provided.

For more detail, refer to the provider manuals (Section B).

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

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

Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX provider website on the 1st or 15th day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted. To streamline the medical policy review process, you can view draft medical policies 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. To view medical policies, go to Medical Policies. After reviewing and agreeing to the disclaimer, you will then have access to active and pending medical policies.

Refer to the Recommended Clinical Review Option page for information on submitting a request for review of your services prior to rendering the service. In addition, other policies and information regarding payment can be found on the Clinical Payment and Coding Policies page.

The BCBSTX Medical Policies are for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own clinical judgment based on each individual patient’s health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Some benefit plans administered by BCBSTX, such as some self-funded employer plans or governmental plans, may not utilize BCBSTX Medical Policies. Members should contact the customer service number on their member ID card for more specific coverage information.

Prior Authorization Exemptions

Under Texas House Bill 3459 (HB3459), providers may qualify for an exemption from submitting prior authorization requests for specific health care service(s) for all fully insured (TDI is indicated on the ID card) and certain Administrative Services Only (ASO) groups. Be sure to review our Prior Authorization Exemption page on our provider website for more information.

BENEFITS & ELIGIBILITY

No articles this month. Refer to the Claims & Eligibility section or the Provider Manuals section on our provider website.

CLAIMS

ClaimsXten™ Quarterly Updates

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

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

To help determine how coding combinations on a claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software.

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

Cotiviti Code-Auditing Software

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

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

CLINICAL RESOURCES

BCBSTX HEDIS® Tip Sheets

We created quality improvement and behavioral health tip sheets to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code appropriately. These measures from the National Committee for Quality Assurance (NCQA) help ensure our members receive appropriate care.

The tip sheets include measurement requirements, medical record best practices and billing codes. Compliance with HEDIS measures reduces the need for you to send medical records later for review. Review tip sheets below:

- Quality Improvement HEDIS Tip Sheets

For tipsheets that include procedure codes, refer to the Resources tab in Availity Essentials.

BCBSTX Lab Guidelines

Providers can use any in-network clinical laboratory for commercial and retail plans. Statewide in-network clinical labs for PPO and HMO members include the following:

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

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

EDUCATION & REFERENCE

No articles this month. Refer to the Education & Reference section on our provider website.

ELECTRONIC OPTIONS

Provider Self-Service Tools via Availity®

BCBSTX offers many electronic options through Availity Essentials with single sign-on access. Providers can use these self-service tools through Availity at no cost, securely and conveniently. Refer to Provider Tools, Electronic Commerce Services and Provider Self Service Tools via Availity Essentials on our provider website for additional information on the following services and tools:

- Authorizations & Referrals
- Availity Attachments – submit recommended clinical review requests
- Claim Status Tool – includes Claim Reconsideration Request
- Electronic Clinical Claim Appeal Requests
- Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA)
- Electronic Quality and Risk Adjustment Medical Record Requests
- Electronic Refund Management(eRM)
- Eligibility and Benefits (including viewing member ID cards)
- Fee Schedule Tool
- Medical Record Status Viewer
- Message This Payer Option
- Patient ID Finder
- Provider Data Management
- Remittance Viewer

Refer to Manage Our Organization in Availity Essentials to learn how to add or edit providers to your Availity profile. For assistance or customized training, contact a BCBSTX Provider Education Consultant at PECS@tx.com.

MEDICARE ADVANTAGE

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:

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

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.

CMS Notifications for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠

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. They 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.

Medicare Advantage Prior Authorization Requests through eviCore®

BCBSTX contracts with eviCore (eviCore), an independent specialty medical benefits management, for select specialty utilization management services for Medicare Advantage members.

After you check Availity®, or your preferred vendor, and determine the service requires prior authorization through eviCore, submit prior authorization requests through eviCore's provider portal. Using the eviCore provider portal to submit requests for prior authorization allows you to view and print information, review clinical to determine what is needed, and schedule consultations for questions.

To begin managing eviCore authorizations, go to eviCore.com and register. Training sessions are available through the eviCore training center. For provider portal help, portal.support@evicore.com or call 1-800-646-0418 and select option 2.

PHARMACY

Refer to the Pharmacy Program section on our provider website.

UTILIZATION MANAGEMENT

Importance of Obtaining a Prior Authorization/Referral

A prior authorization/referral is required for certain types of care and services. Prior authorizations may be managed by BCBSTX Medical Management or a vendor such as Carelon℠, eviCore healthcare® or Magellan Health®. Although BCBSTX participating health care providers are required to obtain prior authorizations/referrals, it is also the responsibility of the member to confirm that this action has been taken for services that require a prior authorization/referral.

To determine if a service requires a referral or prior authorization and who to contact, it is imperative that providers check eligibility, benefits and prior authorization requirements through Availity® or your preferred vendor and also reference the Utilization Management page on our provider website. Providers can submit prior authorizations managed by BCBSTX via Availity Authorizations & Referrals or find links to the Carelon and eviCore sites for services they manage on Availity.

Prior authorizations/referrals may be required for any services provided by someone other than a member's primary care physician/provider (PCP) (i.e., specialist, ambulatory surgery centers, ancillary, etc.).

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

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

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

Note: Per House Bill 3459, we will periodically review providers for prior authorization exemptions for particular health care services applicable to Fully Insured and certain administrative services only (ASO) plans. Refer to the prior authorization exemption webpage for more information.

Carelon Prior Authorizations and RQI Programs

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

Services that may require prior authorization:

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

Services that may require an RQI:

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

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

For more information refer to the Carelon page on our provider website.

CONTACT US

View our directory of contacts for BCBSTX.

UPDATE YOUR INFORMATION

Remember, per the Consolidated Appropriations Act, you must verify your demographic information every 90 days. Refer to the Verify and Update Your Information page for more details on using Provider Data Management via Availity or our online Demographic Change Form. You can also use the Demographic Change Form to include up to 10 of your office emails addresses to receive the *Blue Review* newsletter by email.

Checking eligibility, benefit information and/or if a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you

Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through BCBSTX.

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

CPT copyright 2023 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

ClaimsXten and Clear Claim Connection are trademarks of Change Healthcare, an independent company providing coding software to BCBSTX. Change Healthcare is solely responsible for the software and all the contents.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

HEDIS is a registered trademark of NCQA. Use of this resource is subject to NCQA's copyright, found here. The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for quality improvement purposes.

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.

BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

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.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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