Blue Review / TEXAS

June 1, 2016

Why MACRA is a Big Step Forward for Fee-for-Value Heath Care

As celebrated as the Medicare Access & CHIP Reauthorization Act (MACRA) was, its true impact will be felt in the long term, Dr. Stephen Ondra writes. The law is a clear signal that fee-for-service – for decades the primary way business was done in health care – will one day soon be the exception, not the norm. Dr. Ondra is senior vice president and Enterprise chief medical officer of our health insurance Plans in Illinois, Montana, New Mexico, Oklahoma and Texas.

New CDC Guidelines for Prescribing Opioids for Chronic Pain

Part 1 of a 3-Part Series: Determining When to Initiate or Continue Opioids for Chronic Pain

This article is a direct summarization of the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain[1].

In March 2016, the Centers for Disease Control and Prevention (CDC) issued new recommendations for prescribing opioid medications for chronic pain, excluding reasons for cancer, palliative and end-of-life care. These recommendations were in response to an increased need for provider education, due to a nationwide epidemic of opioid overdose and opioid use disorder.

The CDC has developed 12 recommendations, grouped into three areas of consideration:

1. Determining when to initiate or continue opioids for chronic pain
2. Opioid selection, dosage, duration, follow up and discontinuation
3. Assessing risk and addressing harms of opioid use

Determining When to Initiate or Continue Opioids for Chronic Pain

1. The CDC recommends non-pharmacologic and non-opioid pharmacologic therapy as the preferred treatment for chronic pain. In terms of pain relief and function, health care clinicians should weigh the benefits versus the risk when using opioid therapy. If a clinician decides to use opioid therapy, non-pharmacologic and non-opioid pharmacologic therapy should also be incorporated, when possible.

    - **Non-pharmacologic therapies can include:** physical therapy, weight loss for knee osteoarthritis, psychological therapies such as CBT and exercise therapy
    - **Non-opioid pharmacologic therapy can include:** acetaminophen, NSAIDs, and certain antidepressant and anticonvulsant medications
    - **Comprehensive pain management may include:** a coordination of different specialties including primary care, mental health, physical therapy and social work

2. Clinicians should establish realistic goals for pain relief and function with the patient before starting opioid therapy. Prior to starting therapy, patients should be engaged in conversation about how their opioid therapy may be discontinued (i.e., an exit strategy) if the benefits do not outweigh the risks. Opioid therapy should only be continued if there are clinically meaningful improvements in pain and function that outweigh any risks to patient safety.

- Patients should understand that while opioid therapy can reduce pain short term, there is no solid evidence that opioids will continue to improve pain and function with long-term use.
- Clinicians may not want to prescribe opioids for longer than 30 days to ensure that the patient's pain is reassessed at intervals.
- Measuring improvements in function can include emotional, social and physical dimensions.

3. Clinicians should also ensure that patients are aware of all serious adverse side effects of opioid use, as well as the more common side effects of opioids and how to alleviate them. Additionally, the clinician should review with patients the responsibilities of managing opioid therapy and include them in the final decision of whether or not to start, or continue, opioid therapy.

    - Serious adverse side effects of opioids can potentially include fatal respiratory depression and/or opioid use disorder that can be life-long and cause major distress.
    - **Common side effects of opioids can include:** constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence and withdrawal symptoms when stopping opioid therapy.
    - Given the risks, clinicians should review the risks and possible diminished benefits of continued opioid therapy with patients on a periodic basis, at least once every three months.

Stay tuned for next month's *Blue Review* for a review on opioid selection, dosage, duration, follow up and discontinuation.

[1]Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain-United States, 2016. MMWR Recomm Rep 2016; 65:1-49. DOI: dx.doi.org/10.15585/mmwr.rr6501e1.

Provider Services Changes Coming

Effective July 11, 2016, duplicate copies of paper PCSs will no longer be provided by Blue Cross and Blue Shield of Texas. Additionally, corrected claim requests will no longer be accepted via phone or through the Claim Inquiry Resolution feature of our Electronic Refund Management tool. Rather, electronic corrected claims must be submitted as electronic replacement claims, and corrected paper claims must be submitted to our claims mailing address.

Join us for a webinar to learn more about these changes, as well as electronic alternatives to better assist you. To register now, select your preferred date and time from the list below:

June 1, 2016 – 2 to 3:30 p.m.
June 8, 2016 – 2 to 3:30 p.m.
June 21, 2016 – 10 to 11:30 a.m.
June 28, 2016 – 10 to 11:30 a.m.

Learn About the Benefits of the BCBSTX BlueEdge℠ Product Portfolio

Blue Cross and Blue Shield of Texas (BCBSTX) offers the BlueEdge product portfolio for our employer groups and subscribers who are looking for consumer-driven health plans. The BlueEdge product portfolio includes the Health Care Account (HCA) and the Health Savings

Account (HSA) products. Both products provide preventative care covered at 100 percent even before the deductible is met. There are no deductibles or office visit copayments for the following preventative/wellness services:

- Physicals
- Routine lab and X-ray
- Diagnostic tests
- Mammograms
- Well child care and immunizations

To ensure the accurate and quick processing of BlueEdge member claims:

- Ask the member to show his or her BlueEdge ID card; this card will list "BlueEdge" in the lower right corner of the ID card.
- Call the toll-free Provider Customer Service number to check benefits and eligibility
- Submit all claims to BCBSTX

With BlueEdge, providers do not need to collect deductible amounts from the member at the time of service. Providers will be reimbursed for claims submitted from the member's account until the account is depleted. If the member has a remaining balance, BCBSTX will notify you of any patient responsibility through the distribution of the Provider Claims Summer (PCS). Following the receipt of the PCS, you may bill the member directly for any deductible and coinsurance amount owed.

BCBSA Report Highlights Dramatic Increase in Specialty Drug Spending

Spending on medications used to treat chronic health conditions such as cancer and hepatitis C rose 26 percent across most Blue Cross and Blue Shield (BCBS) companies* from 2013 to 2014 – similar to a national spending rate that is expected to quadruple within four years, according to a new Blue Cross and Blue Shield Association (BCBSA) Health of America report.

Most of the $18.4 billion that BCBS Plans spent on these medications in 2014 was driven by rising drug prices and physician treatment expenses. Specialty drugs get their name because they require special monitoring and administration to patients with serious or chronic conditions such as cancer, hepatitis C, hemophilia, multiple sclerosis and more.

Our Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma and Texas have also seen a rise in specialty drug spending. Although specialty drugs represent less than 1 percent of all prescription drug spending, they are 50 times more expensive than traditional prescription medications. Nevertheless, specialty drugs, when taken as prescribed, play an important role in members' health by providing both improved health outcomes and sustainable long-term cost reductions (i.e., ER visits, transplants, hospital stays, etc.) for our members and customers. Yet, as these high-cost treatment advances emerge, there is an increased need to manage rising drug cost trend in this specialty market.

A couple examples of our management efforts include specialty drug channel management and value-based contracting through:

- Managing specialty drugs comprehensively, including those covered under the medical benefit. Specialty drugs that require a health care professional to administer, or supervise, are often covered under the medical benefit rather than the pharmacy benefit. Managing these drugs includes monitoring whether the specialty drug is being administered in the most

appropriate site of care, such as the physician's office or member's home, to help better serve the member and reduce unnecessary spending.
- Contracting with select accredited specialty pharmacies. These pharmacies can integrate coordination of coverage between the member, physician and health plan; offer education to the member and provide members with 24-hour access to a health care professional for any medication questions.

Find more information on our strategy for managing specialty drugs on the HCSC Pulse website.

**Does not include members who receive coverage through Medicare or Medicaid programs.*

NOTICES AND ANNOUNCEMENTS

Remittance Viewer Webinars

The remittance viewer offers providers and billing services a convenient way to retrieve, view, save or print claim detail information and help reconcile claim data provided by Blue Cross and Blue Shield of Texas (BCBSTX) in the 835 Electronic Remittance Advice (ERA).

To gain access to the remittance viewer, you must be a registered Availity™ user, enrolled to receive the Availity ERA. Online enrollment for ERA may be completed via the Availity Web portal. For additional details, view the Remittance Viewer Frequently Asked Questions and the Remittance Viewer Tip Sheet.

Online training sessions have been scheduled to provide an introduction to the remittance viewer. Participants will learn how to gain or grant access, conduct a search, view general and payer-specific information, and save or print results. In addition, a question and answer time will be available.

Select a date and time from the list below to register now:

June 15 – 11 a.m. to 12 p.m.
July 6 – 11 a.m. to 12 p.m.
July 13 – 11 a.m. to 12 p.m.
July 20 – 11 a.m. to 12 p.m.
July 27 – 11 a.m. to 12 p.m.

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

IN EVERY ISSUE

HMO Plans – Importance of Obtaining a Referral and/or Preauthorization and Admitting to a Participating Facility as a Network Provider

HMO Blue Texas℠, Blue Advantage HMO℠ and **Blue Premier℠** members require a referral from their PCP before receiving services from a specialty care physician or professional provider

(except for OBGYNs). The referral must be initiated by the member's PCP, and must be made to a participating physician or professional provider in the same provider network.

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 iExchange or call the preauthorization number 1-855-462-1785.

Reminders:

- The **HMO Blue Texas, Blue Advantage HMO and Blue Premier** physician, professional provider, facility or ancillary provider is required to admit the patient to a participating facility, except in emergencies.
- **Additional services may also require preauthorization**. A complete list of services that require preauthorization for **HMO Blue Texas** and **Blue Advantage HMO,** and for **Blue Premier** and **Blue Premier Access℠**, is available on the BCBSTX Provider website. Under the 'Standards and Requirements' tab, click on General Reimbursements (password is 'manual') and scroll down to the 'Preauthorization/Notification/Referral Requirements Lists'.
- **Blue Advantage Plus℠ HMO Point of Service (POS)** is a benefit plan that allows those members to use out-of-network providers. However, it is essential that those members understand the financial impact of receiving services from an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility. Prior to referring a Blue Advantage Plus enrollee to an out of network provider for non-emergency services, please refer to Section D Referral Notification Program, of the **HMO Blue Texas, Blue Advantage HMO** and **Blue Premier Provider Manual** for more detail including when to utilize the Out-of-Network Enrollee Notification Form

Importance of Obtaining Preauthorization for Initial Stay and Add-on Days

Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or professional provider obtains preauthorization for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

If an insured person does not obtain preauthorization for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

Preauthorization does not guarantee payment. All payments are subject to determination of the insured person'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.

Implantable Device Versus Medical Supply/Material

We have received a number of questions from providers about billing for implants. To help address the topic, we have provided a reminder about the National Uniform Billing Committee definition of an implant.

National Uniform Billing Committee (NUBC) definition of an implant:

- Revenue Code 274 – Prosthetic/orthotic devices
- Revenue Code 275 – Pacemaker
- Revenue Code 278 – Other Implants

An implantable device is that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Also included is an object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.

Examples of other implants reported under revenue code 278 include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds (not an all-inclusive list).

Supplies that are not implantable should be submitted as supply charges. In conjunction, a device is not a “material or supply furnished incident to a service.” Items used as routine supplies should not be submitted as an implant.

Guide wires, catheters and clips that are used during surgery but do not remain in the body are used the same way as an instrument and are not “implanted” should not be submitted as an implant.

Additional reference and definition of implantable devices, supplies and material can be located in the UB04 Editor and the website of the implantable device’s manufacturer.

Managing Your Patients' Questions on Their Individual Plans

In previous issues, Blue Cross and Blue Shield of Texas (BCBSTX) announced changes that would be made to our individual plans starting in January 2016.The content offered in this alert was created to help providers who are getting questions from patients regarding changes to their plans.

Recap of Options Offered During the 2016 Open Enrollment Period

Jan. 31 marked the end of the third annual enrollment period through the Health Insurance Marketplace. BCBSTX remained committed to providing all Texans with sustainable health plan options that meet the varying needs of the state's population and contribute to the state's overall health. BCBSTX offers health insurance in all 254 counties in Texas and is the only health insurance provider offering individuals access to health insurance through the Federal Health Insurance marketplace in 58 of those counties.

2016 Individual Network Options

Individual members are those who buy their own insurance that is not provided by an employer or through a government program (Medicare, Medicaid or CHIP). The following options were offered to individual members:

- BCBSTX offered its **Blue Advantage (BAV) HMO**[SM] again to individual members both on and off the Health Insurance Marketplace.
- BCBSTX offered the new **Blue Advantage Plus**[SM] **HMO** plan with added Point of Service (POS) benefits to individual members both on and off the Health Insurance Marketplace. This new HMO utilizes the Blue Advantage HMO network of doctors and hospitals while still having out-of-network benefits.
- BCBSTX also offered **Blue Cross Blue Shield Premier 101**[SM], a multi-state plan that utilizes the Blue Advantage HMO network and has the same preauthorization requirements as Blue Advantage HMO. **Blue Cross Blue Shield Premier 101** is only available to Individual members on the Health Insurance Marketplace.

Please Note: Multi-state plans are designed to increase consumer options on the exchanges. They are only available in the Individual market segment, through the public exchange. Multi-state plans are bound by the same ACA regulations as other qualified health plans, i.e., essential health benefits, out-of-pocket maximum regulations, etc.

Small Business Health Options Program (SHOP) Options

BCBSTX will continue to offer the **Blue Choice PPO to small group members on the Small Business Health Options Program (SHOP)**. Small Group members will also still have access to our **Blue Advantage HMO product**. As a reminder, the terms of your BCBSTX agreements apply to plans offered on and off the SHOP. The terms of the agreement also require providers to offer their services to a BCBSTX member, regardless of where they purchased their coverage.

Identifying Your Patients' BCBSTX Insurance Plan
To identify your patient's BCBSTX plan, please view our sample ID cards at: bcbstx.com/provider. Plan specific alpha prefixes are assigned to every Blue Cross Blue Shield (BCBS) plan and start with **X, Y, Z or Q.** The first two positions indicate the BCBS Plan to which the member/subscriber belongs, while the third position identifies the product in which the member/subscriber is enrolled. **Note:** ZG identifies the Texas Plan.

- To identify a patient who has the BAV HMO plan look for the alpha prefix or Texas alpha prefix which will start with “ZG*”" on the member ID card. The first two positions indicate the Plan to which the member/subscriber belongs while the third position identifies the product in which the member/subscriber is enrolled.
- To identify a patient who has the BAV Plus, look for alpha prefix "ZGN" on the member ID card.
- To identify a patient who has the 'Blue Cross Blue Shield Premier 101' multi-state plan (not specific to Texas), look for alpha prefix "VAL" on the member ID card.

Resources to Provide to your Patient's with Questions
If you have patients that are seeking assistance with their transition of care, we encourage you and your patients to contact BCBSTX with your questions through the phone numbers below. Our member advocates will work closely with your patients to ensure they have someone to speak with directly regarding their transition of care plan.

- Member Customer Service: 888-697-0683
- Pre-Authorization: 855-462-1785
- Behavioral Health: 800-729-2422

BCBSTX provides a wide range of services and online tools to help renewing members make informed health decisions:

- **Provider Finder®:** Members can select the best network provider for their needs based on location, as well as view industry-respected third party quality indicators, costs and patient-submitted reviews on an easy-to-navigate website.
- **Blue Access for Members℠:** Members can access information on their policy, including status of claims, alerts, temporary ID cards and more. This also includes Blue Access Mobile℠, which allows members to find a doctor, hospital or urgent care facility in addition to benefit information.
- **24/7 Nurseline:** Members can speak with registered nurses about health concerns, common health information and tips and advice on where to go to receive necessary care.

You can also contact your local network management representative with any questions you may have.

BCBSTX Provider Relations Office Locations	Telephone Number	Fax Number
Austin	512-349-4847	512-349-4853
Corpus Christi	361-878-1623	361-852-0624

Dallas, East Texas	972-766-8900 / 800-749-0966	972-766-2231
El Paso	915-496-6600, press 2	915-496-6611 915-469-6614
Houston, Beaumont	713-663-1149	713-663-1227
Lubbock, Amarillo	806-783-4610	806-783-4666
Midland, Abilene, San Angelo	432-620-1406	432-620-1428
San Antonio	361-878-1623	361-852-0624

BCBSTX Announced New Health Insurance Options for Individuals and Small Businesses Individual Network Options

In previous issues, Blue Cross and Blue Shield of Texas (BCBSTX) announced its 2016 offerings for individual and small group health insurance coverage. Texas residents were able to choose coverage options for their needs Nov. 1, 2015 – Jan. 1, 2016.

BCBSTX again offered its **Blue Advantage (BAV) HMO℠** to individual members both on and off the Health Insurance Marketplace. Individual members are anyone who buys their own insurance that is not provided by an employer or through a government program (Medicare, Medicaid or CHIP).

In addition, BCBSTX offered their new **Blue Advantage Plus℠ HMO** plan that has added Point of Service (POS) benefits to individual members both on and off the Health Insurance Marketplace. This new HMO utilizes the Blue Advantage HMO network of doctors and hospitals while still having out-of-network benefits. The BAV and BAV Plus plans will be offered in all 254 counties across the state.

BCBSTX transitioned individual members who had Blue Choice PPO℠ in 2014 and 2015 to the BAV Plus plan if they did not select a different plan during open enrollment, which opened on Nov. 1.

Many of our BCBSTX members were NOT be impacted by this change, including:

- Patients covered by large and small employer groups
- Patients with individual coverage who have grandfathered plans *(Grandfathered plans are plans that existed on March 23, 2010, when the Affordable Care Act became law.)*
- Patients covered by Medicare and Medicaid.

BCBSTX has always been dedicated to helping our members access quality care at the right time, resulting in the best possible outcomes. Managed care, like an HMO, makes health care simple. In each of the offered plans, members selected a primary care physician (PCP) to best coordinate their health care. We worked with impacted members and their providers to minimize the impact of this change to their ongoing care. However, BCBSTX did not provide extended authorizations for the Texas PPO on/off exchange past Dec. 31, 2015.

If you're still receiving inquiries from your impacted patients, we encourage you and your patients to contact BCBSTX with your questions through the phone numbers below. Our member advocates will work closely with these individuals to address their needs.

Member Customer Service: 888-697-0683
Pre-authorization: 855-462-1785
Behavioral Health: 800-729-2422

Please see below for specific product names that will be offered to individual members on and off the Health Insurance Marketplace in Texas:

- Blue Advantage (BAV) HMO *(Offered on the Health Insurance Marketplace in Texas and on the SHOP)*
- Blue Advantage Plus HMO Point of Service (POS) *(Offered on the Health Insurance Marketplace in Texas)*

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

Effective Jan. 1, an out-of-network care form is required to be completed by the referring network physician for enrollees of **Blue Choice PPO℠** and **Blue Advantage HMO℠ (for *Blue Advantage Plus* point-of-service benefit plan only)**, prior to referring or directing an enrollee to an out-of-network physician, professional provider, hospital, ambulatory surgery center or other facility, for non-emergency services, if such services are available through an in-network provider.

It is essential that **Blue Choice PPO and Blue Advantage Plus** enrollees fully understand the financial impact of an out-of-network referral to a physician, professional provider, hospital, ambulatory surgery center or other facility that does not participate in their BCBSTX provider network. 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.

Prior to referring or directing a **Blue Choice PPO or Blue Advantage Plus** enrollee to an out-of-network provider for non-emergency services, referring network physicians must complete this form if such services are also available through an in-network provider. The referring network physician must provide a copy of the completed form to the enrollee and retain a copy in his or her medical record files.

Use of this form is subject to periodic audit to determine compliance with this administrative requirement outlined in the provider manuals.

Claims with More Than One Unit Count for Drug Test Codes

BCBSTX periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our member's/subscriber's benefit plan and meet BCBSTX's guidelines. Some providers are submitting claims with more than one-unit count for drug test codes (80300, 80301, 80303, 80320-80328 and 80345-80377) which should be a single date of service.

Effective Jan. 1, 2016, the following range of codes will allow only one unit on a single date of service: 80300, 80301, 80303, 80320-80328 and 80345-80377. Services should be provided in the most cost effective manner and in the least costly setting required for the appropriate treatment of the member/subscriber.

Beginning Feb. 1, Two Additional Drug Codes to Allow Only One Unit for Single Date of Service

BCBSTX periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our member's/subscriber's benefit plan and meet BCBSTX's guidelines. Some providers are submitting claims with more than one-unit count for drug test codes 80337 and 80338, which should be a single date of service.

Effective **Feb. 1, 2016**, the following two codes will allow only one unit on a single date of service: 80337 and 80338. Services should be provided in the most cost-effective manner and in the least costly setting required for the appropriate treatment of the member.

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.

BCBSTX Implements Changes in Maximum Allowable Fee Schedule

BCBSTX implemented changes in the maximum allowable fee schedule used for Blue Choice PPO℠, HMO Blue Texas℠, Blue Advantage HMO℠ (Independent Provider Network and The Limited Network only), and ParPlan which was effective Nov. 1, 2015.

The changes to the maximum allowable fee schedules used for the Blue Cross Medicare Advantage PPO℠ and Blue Cross Medicare Advantage HMO℠ were effective Jan. 1, 2016.

- The methodology used to develop the maximum allowable fee schedule for Blue Choice PPO, HMO Blue Texas and Blue Advantage HMO will be based on 2015 CMS values posted on the CMS website as of Jan. 16, 2015, for those services for which the BCBSTX reimbursement is based on CMS values.
- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.
- Blue Choice PPO, HMO Blue Texas, Blue Advantage HMO and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility).
- The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year.
- The NDC Fee Schedule will continue to be updated monthly.

BCBSTX provides general reimbursement information policies, request forms for allowable fees and fee schedule information. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. If you would like to request a sample of maximum allowable fees or if you have any other questions, please contact your Network Management office.

Reimbursement changes will be posted under "Reimbursement Changes and Updates" in the Reimbursement Schedules section on the BCBSTX provider website. 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.

Blue Choice PPO℠ Subscriber(s) / Blue Advantage HMO℠ Member Rights and Responsibilities

As a provider for 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:**
• Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities. • Make recommendations regarding the organization's subscribers' rights and responsibilities policy.	• Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.
• Participate with practitioners in making decisions about your health care.	• Follow the plans and instructions for care you have agreed to with your practitioner.
• Be treated with respect and recognition of your dignity and your right to privacy. • 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.	• Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

HMO Blue Texas Member Rights & Responsibilities

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.
- 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.

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 (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OBGyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, in order 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 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.

Fee Schedule Updates

Reimbursement changes and updates for Blue Choice PPO, HMO Blue Texas (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 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 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.

After-hours Access Is Required

BCBSTX requires that primary care physicians, 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. They 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 or on-call physician;
- 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 or on-call physician and the phone number is provided.

For more detail, please refer to the provider manuals for **Blue Choice PPO℠ Physician, Professional Provider and Facility and Ancillary Provider Manual** (Section B) and **HMO Blue Texas℠ / Blue Advantage HMO℠ / 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).

BCBS Medicare Advantage PPO Network Sharing

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 as long as 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 Blue Shield Member ID card has the following logo:

MA | PPO
MEDICARE ADVANTAGE

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 Portal, the Availity Revenue Cycle Management 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.

Medical Record Requests: Include Our Letter as Your Cover Sheet

When you receive a letter from 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!

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 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 the physician's or professional provider's office. To help determine how coding combinations on a particular 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 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 may be 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 based on the fact that the global physician reimbursement includes staff and equipment.

AIM RQI Reminder

Physicians, professional providers and facility and ancillary providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPO℠ subscribers 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 a RQI. If criteria are not met, or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM's ***Provider****Portal*℠ uses the term "Order" rather than "RQI."

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

Notes*:*

1. *Facilities cannot obtain a RQI from AIM on behalf of the ordering physician, professional provider, facility or ancillary provider.*
2. *The RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.*

Quest Diagnostics, Inc., Is the Exclusive HMO and Preferred Statewide PPO Clinical Reference Lab Provider

Quest Diagnostics, Inc., is the **exclusive** outpatient clinical reference laboratory provider for HMO Blue Texas℠ members and Blue Advantage HMO℠ subscribers,* and the **preferred statewide** outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO℠ 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:

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

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

For physicians, professional providers or facility and ancillary providers located in the HMO capitated 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 or facility or ancillary provider's office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician's, professional provider's or facility or ancillary provider's offices will not be reimbursed. 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.*

Improvements to the Medical Records Process for BlueCard® Claims

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 will 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.

Pass-through Billing

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

The performing physician, professional provider or facility and ancillary provider should bill for these services 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 or facility and ancillary provider is performed at the place of service of the ordering provider and is billed by the ordering physician or professional provider.
- The service is provided by an employee of a physician, professional provider or facility and ancillary provider (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 this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used *ONLY* if they assist at surgery.)

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

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 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 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.

Medical Policy Disclosure

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

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

Draft Medical Policy Review

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

To view draft medical policies go to our provider website 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 view any draft medical policies, if available.

No Additional Medical Records Needed

Physicians, professional providers or facility or ancillary provider who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) from AIM Specialty Health need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

Predetermination does not guarantee payment. All payments are subject to determination of the insured person'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.

Importance of Obtaining a Preauthorization/Referral

A preauthorization/referral is required for certain types of care and services. Although 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.

Preauthorizations/referrals must be obtained for any services provided by someone other than the member's primary care physician (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.

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.

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.

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.

Avoidance of Delay in Claims Pending COB Information

BCBSTX receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our 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.

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).

In the event that 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.

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.

Access the 2015 Standard Drug List Dispensing Limits and 2015 Generics Plus Drug List Dispensing Limits documents online.

Prescription Drug Lists

Throughout the year, the BCBSTX Clinical Pharmacy Department team 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 the 2015 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html and click on the Rx List/Prescribing Guides offering in the left-side navigation list.

Are Utilization Management Decisions Financially Influenced?

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.

Contact Us

View our quick directory of contacts at BCBSTX.

Update Your Contact Information

Accurate provider directories are an important part of providing BCBSTX members/subscribers with the information they need to manage their health. If any of your information has changed, please update your contact information.

Disclaimer

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