

BLUE REVIEWSM

A newsletter for physician, professional, facility, ancillary and Medicaid providers

Oct. 5, 2016

Claims & Eligibility

Flucelvax Quadrivalent Billing Update

The American Medical Association released CPT® code 90674 (Influenza virus vaccine, quadrivalent [ccIIIV4], derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage), which best describes Flucelvax Quadrivalent – a new flu vaccine for the 2016-2017 flu season. This code will be effective Jan. 1, 2017. Until the effective date, Blue Cross and Blue Shield of Texas (BCBSTX) feels Flucelvax Quadrivalent is appropriately billed with CPT code 90749.

Announcing Changes that will Affect Claims Submissions for Medicare Advantage Plans Effective Jan. 1, 2017

Beginning Jan. 1, 2017, changes will affect claims submissions for our Medicare Advantage plans, including the Payer ID.

Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM will have changes that affect claims submissions for our Medicare Advantage plans. These changes will assist in streamlining claims processing and improve efficiencies of claims routing to our primary claims adjudicator.

Changes include:

- **New Payer ID for Blue Cross Medicare Advantage Plans**

The Payer ID for the Blue Cross Medicare Advantage plans will change to **66006** for claims submitted on and after **Jan. 1, 2017**. Providers who are not registered with Availity® and Passport/NEBO ([ecare online](#)) should contact their clearinghouse to confirm the new Payer ID for this plan – as other clearinghouses may assign their own unique number.

Blue Cross Medicare Advantage member ID card will contain the following applicable Texas member ID number alpha prefixes:

PPO	HMO
ZGD	ZGJ

The new **payer ID 66006**, should be used for submission of electronic claims for any Medicare Advantage members from the states referenced above. **You will no longer use the commercial payer IDs for claims for Medicare Advantage members from those states with member ID number prefixes listed above.** Claims for members with those ID number prefixes that are not submitted to payer ID 66006, on or after January 1, 2017, will be rejected and the reason for the rejection will be included.

- **Daily Payment Cycle**

- Payment cycles will be changing from weekly to daily. Blue Cross Medicare Advantage will make daily payments.

- **Paper Claim Mailbox Address for Non-delegated Providers** (no changes for RPO/EPIC/VOP providers)
 - Paper claim mailbox address and fax number for non-delegated providers will change to:

Blue Cross Medicare Advantage
P.O. Box 3686
Scranton, PA 18505
Fax Number: 855-674-9192

- **New Processes**
 - A new format for Electronic Funds Transfer and paper checks is expected; details will be shared in future communications.
 - A new process will be implemented for claims overpayment recovery. All letters, remittance advisers, vouchers, lockbox and provider manual details will be updated in future communications.
- **Electronic Remittance Advice (835 ERA)**
 - 835 ERA files will be distributed to the address associated with the billing provider's Tax ID, rather than being distributed to multiple locations.

Blue Cross and Blue Shield of Texas (BCBSTX) will be providing additional information regarding these changes in the coming months on our [provider website](#) and in the **Blue Review** provider newsletter.

Eligibility and Benefit Quotes

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

If you have any questions or if you need additional information, please contact your BCBSTX [network management representative](#).

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

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 HIPAA-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 one of the [Back to Basics: Availity 101 webinars](#) being held weekly through December.

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

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Clinical Resources

2017 Updates to the Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM Preauthorization Lists

Blue Cross and Blue Shield of Texas (BCBSTX) has updated the list of procedures requiring preauthorization for our [Blue Cross Medicare Advantage \(PPO\)](#) and [Blue Cross Medicare Advantage \(HMO\)](#) plans. Both updated preauthorization lists will be **effective Jan. 1, 2017**. If you are not participating in the Blue Cross Medicare Advantage (PPO) network or Blue Cross Medicare Advantage (HMO) network, disregard the information pertaining to that plan.

BCBSTX will require notification of inpatient admission for post stabilization care within one business day following treatment of an emergency medical condition. Failure to timely notify BCBSTX and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post-stabilization care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX.

Additionally, when a Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO) member arrives at the facility for an elective admission, providers should notify the BCBSTX Utilization Management Department in order to assist in patient care coordination.

The updated preauthorization lists are linked above. They are also located on Standards & Requirements tab/[General Reimbursement Information](#) area.

As a reminder, iExchange® – our automated referral and preauthorization tool – is available 24 hours a day, seven days a week (with the exception of every third Sunday of the month when the system is unavailable from 11 a.m. to 3 p.m. CT). iExchange is accessible to physicians, professional providers and facilities contracted with BCBSTX. For more information or to set up a new account, complete and submit the [iExchange online enrollment form](#).

If you have any questions or if you need additional information, please contact your BCBSTX [network management representative](#)

Notification for Inpatient Admission for Post-stabilization Care Required Within One Business Day for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM Members

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will require notification of inpatient admission for post-stabilization care within one business day following the treatment of an emergency medical condition. This requirement applies to Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO) plans.

Post-stabilization notification of inpatient admissions allows BCBSTX to evaluate the appropriateness of the setting of care and other criteria for coverage purposes. It aids in early identification of members who may benefit from specialty programs available from BCBSTX, such as Case Management, Care Coordination and Early Intervention (CEI), or Longitudinal Care Management (LCM).

Notification also allows BCBSTX to assist the member with discharge planning. **Failure to timely notify**

BCBSTX and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post-stabilization care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX. You can submit a notification for post stabilization care services through our secure provider portal via [iExchange®](#), or by phone, using the number on the member's ID card. Timely post stabilization notification of inpatient admission does not guarantee payment.

In the event of a claim denial that includes emergency care services, the provider can rebill the claim for the emergency services (including stabilization services), as well as post-stabilization care services for which BCBSTX may be financially responsible for possible re-adjudication by BCBSTX.

Update to Blue Advantage HMOSM and Blue Advantage PlusSM HMO Preauthorization/Referral List – Preauthorization Required for Specific Outpatient Surgeries

Effective Jan.1, 2017, there will be a requirement for a preauthorization for a designated list of surgical CPT codes if performed in an **outpatient hospital setting** for members enrolled in **Blue Advantage HMO or Blue Advantage Plus HMO**. Preauthorization for these services is processed through Medical Management Review, by calling the number on back of the member's ID card.

The updated **Blue Advantage HMO and Blue Advantage Plus HMO Preauthorization/Referral Requirements List** reflecting the applicable CPT codes is located in the [General Reimbursement Information](#) section of the Standards and Requirements tab on our website.

At Blue Cross and Blue Shield of Texas (BCBSTX), we use preauthorization requirements to:

- help make sure that the service or drug being requested is medically necessary and appropriate,
- follow up-to-date medical recommendations,
- make sure the most economical treatment is being used and not duplicated
- ensure the service is actually helping.

This is one of many things we are doing to make the health care system work better – focusing on improving health care delivery, as well as finding solutions to aid in reducing unnecessary health care costs for everyone. We want our members to receive the best health outcomes for all of the dollars spent on their care.

As noted on the preauthorization requirements list, you can use iExchange®, our automated referral and preauthorization tool for other applicable services. iExchange is available to physicians, professional providers and facilities that are contracted with BCBSTX, and is available 24 hours a day, seven days a week (with the exception of every third Sunday of the month when the system is unavailable from 11 a.m. to 3 p.m. CT). For more information or to set up a new account, complete and submit the [iExchange online enrollment form](#).

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

If you have any questions or if you need additional information, please contact your BCBSTX [network management representative](#).

New Preauthorization Requirement for Applied Behavior Analysis for Blue Choice PPOSM Members

Effective Jan. 1, 2017, there will be a preauthorization requirement for Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder for **Blue Choice PPO** members. Preauthorization for these services is processed through a Behavioral Health Medical Management review, by calling the number on the back of the member's ID card.

The updated **Blue Choice PPO Preauthorization Requirements list** is located under [Standards & Requirements/General Reimbursement Information](#) in the General Reimbursements page of our website.

At BCBSTX, we use preauthorization requirements to help make sure that the service or drug being requested is medically necessary and appropriate, follows up-to-date medical recommendations, is the most economical treatment, is not being duplicated and is actually helping.

This is one of many things we are doing to make the health care system work better – focusing on improving health care delivery, as well as finding solutions to aid in reducing unnecessary health care costs for everyone. We want our members to receive the best health outcomes for all of the dollars spent on their care.

Reminders:

- The member must have an Autism Spectrum Disorder diagnosis from a qualified diagnostician.
- The ABA service provider must have the credentials necessary to conduct ABA services.
- An initial functional assessment, including a treatment plan that identifies any deficient skills and the appropriate interventions, must be completed.
- After the first authorization for ABA services, additional authorizations may require concurrent review to ensure the member continues to meet the medical necessity guidelines.
- iExchange® is not available for ABA preauthorization or behavioral health at this time, therefore please call the number on the back of the member's ID card for ABA preauthorization requests.

We will be providing additional information about ABA in the coming months on our provider website and in later issues of *Blue Review*. Be on the lookout for:

- **Preauthorization forms:** Diagnostic Physician/Specialist Evaluation, Provider Credentials Verification, Assessment Information and Initial Treatment Plan

Eligibility and Benefit Quotes

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

If you have any questions or if you need additional information, please contact your BCBSTX [network management representative](#).

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:

1. 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 in order to expedite the care coordination process for the receiving provider.

2. 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.

3. 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.

2015 Continuity and Coordination of Care Report Results, and Recommended Interventions

Continuity and coordination of care is important to the care of members. Therefore, it is important that the Primary Care Physician (PCP) be kept informed of a member's condition and any treatment provided by specialist providers (SCP), ancillaries or other health care providers.

Blue Cross and Blue Shield Texas (BCBSTX) monitors the continuity and coordination of care between PCP and specialist providers across the health care network, at least annually. From 2014 Physician Office Review evaluations, opportunities were identified to improve communication between PCP and specialist consultations. The BCBSTX 2015 Provider Satisfaction Survey was modified to include questions related to continuity and coordination of care in order to better analyze strengths and opportunities.

Specific questions were added to the following areas:

- Referral to an ophthalmologist or optometrist for patients requiring a diabetic eye exam and receiving results
- Timely discharge summary data for patients who have been hospitalized is provided to practitioners and includes medication administration instructions

The audits from the Physician Office Review Program had high scores related to continuity and coordination of care. One consideration from the evaluation is that offices were randomly selected without knowledge of patients that required continuity and coordination services from other providers. This resulted in very small denominator of records to assess for continuity and coordination of care. Recommendation for future studies is that the methodology should be evaluated in order to generate a sample of members in need of continuity and coordination of care.

In the 2015 Provider Satisfaction Survey the following items scored less than the target of 85 percent:

- Receiving eye exam results from eye care professionals
- Receiving summary information after inpatient discharge
- Overall satisfaction with continuity of care

Survey Question	Goal	BCBSTX 2015 Score
33. Do ophthalmologists and optometrists inform you of their findings after seeing patients you referred for diabetes eye exams?	85%	77%
34. When your patients are admitted to a hospital, are you sent summary information after the discharge?		72%
35. When you receive hospital discharge information, does it reach your office within five business days?		80%
36. When you receive hospital discharge information, does it contain adequate information about medications at discharge?		88%
40. Overall Satisfaction with Continuity of Care		76%

The findings of this survey recognize the barriers to care that impact continuity-of-care coordination and BCBSTX's HEDIS rates. The possibilities for improvements were identified to remove barriers impacting continuity and coordination of care.

To support continuity and coordination of care, BCBSTX is recommending the following interventions:

1. Specialists should provide a report to the Primary Care Physician summarizing the member's visit, the services provided and recommended follow-up treatment or needs.
2. Hospitals provide timely discharge summary reports to primary care physicians that include a synopsis of the stay, treatment or procedures done, follow-up needs and a list of discharge medications.

Please contact Quality Improvement Programs at 800-863-9798 with questions or comments.

Pharmacy Program

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct. 1, 2016

Drug List (Formulary) Changes

Based on the availability of new prescription medications and the Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some revisions were made to the Blue Cross and Blue Shield of Texas (BCBSTX) **Standard drug list** and **Generics Plus drug list** that became effective on Oct. 1, 2016.

Brand Medications Added to the Standard and Generics Plus Drug Lists, Effective Oct. 1, 2016:

Preferred Brand¹	Drug Class/Condition Used for
Afstyla	Hemophilia

Brand Medications Added to the Standard Drug List, Effective Oct. 1, 2016:

Preferred Brand¹	Drug Class/Condition Used for
Impavido	Leishmaniasis
Velphoro	Anemia

Utilization Management Program Changes

Effective July 1, 2016, the Hetlioz Prior Authorization (PA) program changed its name to: Circadian Rhythm Disorders. All targeted medications and program criteria remained the same. Also, the Kalydeco (Cystic Fibrosis) specialty PA program officially changed its name to: Cystic Fibrosis.

Effective Oct. 1, 2016, several targeted medications were added to the current PA program for select members on standard pharmacy benefit plans.

Targeted drugs added to current pharmacy PA standard programs, effective Oct. 1, 2016:

Drug Category	Targeted Medication(s)^{1, 2}
Therapeutic Alternatives	Cardizem CD, Evzio*, Kazano, Lidocaine patch/ointment, Nesina, Oseni, Sitavig

Targeted mailings were sent to select members affected by PA program changes. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our website at bcbstx.com/provider.

¹Third party brand names are the property of their respective owners.

²These lists are not all inclusive. Other medications may be available in this drug class.

*Due to Substance Abuse Parity, some members may not need to submit a PA request for Evzio to be considered for coverage.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy 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.

Updates to the Diabetes Blood Glucose Meter Program

BCBSTX offers certain blood glucose meters to members with diabetes at no additional charge to help them manage their condition. (Note: Members are limited to one glucose meter per year.) However, effective Oct. 1, 2016, there are changes to the types of products offered, as well as how members can obtain one of these meters. Please share this updated information with your patients by directing them to [information on the program](#) on our website. Or, you can provide them the [member flier](#) (PDF).

Reminder: Pharmacy Benefit Tips

For Blue Cross and Blue Shield of Texas (BCBSTX) members with prescription drug benefits administered by Prime Therapeutics®, BCBSTX employs a number of industry-standard management strategies to ensure appropriate utilization of prescription drugs. These strategies can include formulary management, benefit design modeling, specialty pharmacy benefits, and clinical programs, among others. You can help us achieve these goals by:

1. Prescribing Drugs Listed on the Formulary

The BCBSTX formularies 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 formularies 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 formularies are regularly updated and can be found under [Pharmacy Program](#) 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: bcbstx.com/medicare/part_d_druglist.html
- Blue Cross Medicare Advantage (HMO)SM and (PPO)SM: bcbstx.com/medicare/mapd_drug_coverage.html
- Blue Cross Medicare Advantage Dual Care (HMO SNP)SM: bcbstx.com/medicare/snp_drug_coverage.html
- Texas STAR: bcbstx.com/star/prescription-drugs/drug-coverage
- Texas CHIP: bcbstx.com/chip/prescription-drugs/drug-coverage

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 (OTC) medicines used for preventive care services.*

- ACA \$0 Preventive Drug List: bcbstx.com/pdf/rx/rx-aca-prev-list-tx.pdf
- Women's Contraceptive Coverage List: bcbstx.com/pdf/rx/contraceptive-list-tx.pdf

**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.*

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 under [Pharmacy Program](#) on the BCBSTX provider website.

4. Assisting Members with Formulary Exceptions

If the medication you wish to prescribe is not on your patient's drug or the preventive care lists, a formulary 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 at: myprime.com/en/coverage-exception-form.html.

Visit the [Pharmacy Program](#) section of our website for more information.

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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.

Standards & Requirements

eviCore to Pre-certify Outpatient Molecular and Genomic Testing, and Outpatient Radiation Therapy

Blue Cross and Blue Shield of Texas (BCBSTX) has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to provide Utilization Management services for new preauthorization requirements that are outlined below.

Providers should contact **eviCore** to request preauthorization for **Blue Advantage HMOSM** and **Blue Advantage PlusSM HMO** members for services rendered on and after **Oct. 3, 2016**, for:

- Outpatient molecular and genomic testing
- Outpatient radiation therapy

You can reach [eviCore](#) toll-free at 855-252-1117. Access to eviCore healthcare's preauthorization call center is available from 7 a.m. to 7 p.m. Monday through Friday.

The **Blue Advantage HMO** and **Blue Advantage Plus HMO Preauthorization/Referral Requirements** list has been updated to include the **services listed above that require preauthorization through eviCore, for dates of service beginning Oct. 3, 2016**. The preauthorization list is located under [Standards & Requirements/General Reimbursements](#) on the [BCBSTX provider website](#). Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.

For all other services that require a referral and/or preauthorization, as noted on the Preauthorization/Referral Requirements list, you will continue to use iExchange®. iExchange is accessible to physicians, professional providers and facilities contracted with BCBSTX. For more information or to set up a new iExchange account, please visit [Getting Started with iExchange](#).

BCBSTX and eviCore will be providing additional information in the coming weeks on the provider website

and in *Blue Review*, including:

- Training opportunities and webinars
- How to register with eviCore on their website

Refer to [eviCore Preauthorization Program](#) for more information. You may also contact your [Network Management consultant](#) for more information.

Annual Medical Record Data Collection for Quality Reporting begins Feb. 1, 2017

Blue Cross and Blue Shield of Texas (BCBSTX) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS) and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS).

HEDIS is the most widely used and nationally accepted effectiveness of care measurement available and HHS requires reporting of QRS measures. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule and patient authorization for release of information is not required. Additionally, Texas state law (Chapter 108 of the Texas Health and Safety Code) requires Health Maintenance Organizations (HMO) in Texas to report HEDIS data by service area to the Department of State Health Services (DSHS) on an annual basis.

To meet these requirements, BCBSTX will be collecting medical records using internal resources and leveraging independently contracted third-party vendor, CIOX. If you receive a request for medical records, we encourage you to reply within 3 to 5 business days. Cooperation with the collection of HEDIS data or any quality improvement activities are required under providers' contractual obligation at no cost to BCBSTX or as stated within the provider's individual contract.

A BCBSTX representative or a representative from CIOX may be contacting your office or facility anytime between December 2016 to February 2017 to identify a key contact person, and to ascertain which data collection method your office or facility prefers (fax, secure email or on-site). Appointments for on-site visits will be scheduled with your staff, if applicable. You will then receive a letter outlining the information that is being requested, and the medical record request list with members' names and the identified measures that will be reviewed.

If you have any questions about medical record requests, please contact a BCBSTX representative at the phone number listed on your provider letter.

HEDIS is a registered trademark of NCQA.

CIOX is an independent third party vendor that is solely responsible for the products or services they offer. BCBSNM makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions regarding the services they offer, you should contact the vendor directly.

Announcing a New Change for Rehabilitative and Habilitative Services for Members Enrolled in QHPs under the Affordable Care Act

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will implement a change for rehabilitative and habilitative services that are essential health benefits (EHB) and billed by Physical Therapy, Speech Therapy and Occupational Therapy providers, as well as any other providers that may bill for these services. This new change applies to **Blue Advantage HMOSM**, **Blue Advantage PlusSM HMO** and **Blue Choice PPOSM** members enrolled in qualified health plans under the Affordable Care Act.

Note: This change only includes the above products; it does not apply to other BCBSTX plans.

The change impacts visit limits for rehabilitative and habilitative services and devices. Each rendered service should be billed separately since these plans provide coverage for 35 visits per calendar year each for habilitative services and for rehabilitative services. As a result of this change, only claims for habilitative services should be submitted with a **CPT modifier of SZ**. This modifier will be used to identify applicable procedures as habilitative for claims adjudication. This requirement does not impact how rehabilitative services are currently billed.

Reminders

- Habilitative services are health care services and devices that help a person keep, learn or improve skills, and assist with functioning for daily living. These services could include devices that are provided for a person to attain, maintain or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- Rehabilitative services that include devices are provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to illness, injury or a disabling condition.
- When submitting claims for habilitative services, please submit procedure codes with a **CPT** modifier of **SZ**. Refer to your applicable billing policies and procedures for more information regarding applicable rehabilitative and habilitative procedure codes.

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

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

Reminder: Medicare Marketing Guidelines for Providers – Rerun from September. No changes.

The 2017 Centers for Medicare & Medicaid Services (CMS) Annual Election Period for beneficiaries is fast approaching. For those providers who have contracted with Blue Cross and Blue Shield of Texas (BCBSTX) to provide services to our Blue Cross Medicare Advantage (HMO)SM or Blue Cross Medicare Advantage (PPO)SM members, it's important to keep in mind the rules established by CMS when marketing to potential new members.

You may not be planning specific marketing activities, but what if a patient asks for information or advice? **Remaining neutral when assisting with enrollment decisions is essential.** See below for a partial listing of additional "Dos" and "Don'ts" for contracted providers, as specified within the CMS Medicare Marketing Guidelines (MMG) for contract year 2017 (excerpted from the section on Provider-based Activities):

DO: <ul style="list-style-type: none">• Provide the names of Plans/Part D sponsors with which [you] contract and/or participate (see MMG section 70.11.2 for additional	DON'T: <ul style="list-style-type: none">• Accept Medicare enrollment applications
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<p>information on provider affiliation)</p> <ul style="list-style-type: none"> • Provide information and assistance in applying for the LIS* • Make available and/or distribute plan marketing materials in common areas • Refer [your] patients to other sources of information, such as SHIPs** plan marketing representatives, [the] State Medicaid Office, local Social Security Office, CMS' website at medicare.gov or 800-MEDICARE • Share information with patients from CMS' website, including the 'Medicare and You' Handbook or 'Medicare Options Compare' (from medicare.gov), or other documents that were written by or previously approved by CMS 	<ul style="list-style-type: none"> • Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider • Mail marketing materials on behalf of Plans/Part D Sponsors • Offer inducements (e.g., free health screenings, cash, etc.) to persuade beneficiaries to enroll in a particular plan or organization • Accept compensation directly or indirectly from the plan for enrollment activities • Distribute materials/applications within an exam room setting
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The above list provides just a sampling of important points for your convenience. For a more in-depth review of the guidelines that are applicable to providers, please refer to the [Provider Medicare Marketing Guidelines](#) excerpt.

If you have questions about these guidelines or are planning marketing activities, please refer to the [Managed Care Marketing](#) page on CMS' website.

*LIS refers to low-income subsidy

**SHIPs are Senior Health Insurance Assistance Programs

This material is provided for informational purposes only and is not the provision of legal advice. If you have any legal questions with respect to CMS rules or regulations, you should seek the advice of legal counsel.

Education & Reference

Reminder: iExchange® Now Accepts Electronic Medical Record Attachments – Rerun from September. No changes.

Blue Cross and Blue Shield Texas (BCBSTX) is pleased to announce that enhancements have been made to iExchange, our online tool that supports online benefit preauthorization requests for inpatient admissions, medical, behavioral health and clinical pharmacy services. Effective Sept. 1, 2016, iExchange now accepts electronic medical record attachments when necessary in support of benefit preauthorization requests. Electronic medical record documentation may also be submitted via iExchange for predetermination of benefit requests. With these enhancements, iExchange offers providers and facilities a secure, online alternative to faxing their patients' protected health information.

Join us for an iExchange webinar! Do you have questions? Would you like training on how to use iExchange? We welcome the opportunity to share more information about iExchange with you and your staff. Our webinars spotlight recent enhancements, as well as navigation tips and key features of the online tool. For iExchange webinar dates, times and online registration, visit [iExchange](#) on BCBSTX's provider website.

Not enrolled for iExchange? Sign up now. iExchange is accessible to independently contracted physicians, professional providers, facility and ancillary providers who are participating in the various health benefit products offered by BCBSTX. For details and to sign up online, refer to [iExchange](#) on BCBSTX's provider website.

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if benefit preauthorization is required for a particular member. For additional information,

such as definitions and links to helpful resources, refer to the [Eligibility and Benefits](#) section on BCBSTX's provider website.

Please note that 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.

Health & Wellness

New Health of America Report Links C-Section Rates to Where Members Live

The rates of babies delivered by cesarean section (C-section) varies widely by geographic location, indicating that where a mother lives has a significant impact on how she will give birth, according to the newest Health of America Report by the Blue Cross and Blue Shield Association (BCBSA). The study, Cesarean Birth Trends: Where You Live Significantly Impacts How You Give Birth, represents a comprehensive analysis of medical claims from 3 million commercially insured Blue Cross and Blue Shield members across the U.S.



BLUE CROSS BLUE SHIELD | THE HEALTH OF AMERICA

Results of the study show that in a five-year span from 2010 to 2015, certain parts of the country – primarily the West South Central divisions of the U.S. – had the highest C-section rate of 39.4 percent, while the lowest rate of 29.3 percent was found in the Mountain division. In fact, the rate of C-section deliveries was more than twice as high in some parts of the country than in others, after adjusting for factors such as age, breech birth and multiple births.

The study looked at markets that had at least 5,000 births from 2010 to 2015. Among markets served by Blue Cross and Blue Shield of Texas, those making the list of markets with high C-section rates include most major markets in Texas, including Houston, Dallas-Sherman-Denison, San Antonio, and Midland-Odessa. The south Texas market that includes McAllen, Edinburg, Mission, Brownsville and Harlingen had the third highest rate of C-section use across the nation, only trailing behind Miami, Florida and Jackson, Mississippi.

While the reasons for the variations were not included in the study, the report indicated that factors such as local and regional practice patterns and malpractice laws may play a role.

The data also pointed to a consistent decline in the national rate of C-section births, reversing a 20-year trend of increasing rates. Given the increased medical complications and extended recovery time association with C-sections, this reversal is promising. The report does not examine the cause or factors that affect the rate decrease. It notes that general awareness by women and the medical community as well

as trends toward healthy living could be contributing to the decline.

Besides the higher likelihood of complications for mothers and babies, C-section deliveries that are not medically necessary add cost to the health care system. For commercially-insured BCBS members the average cost difference between cesarean and vaginal deliveries, adjusted for risk, currently exceeds \$4,000 -- \$17,482 for C-section compared to \$13,32 for natural birth.

For more information, [see the full report](#).

Online *LifeTimes*® Newsletter Offers Healthy Tips and Insurance Basics

Blue Cross and Blue Shield of Texas's *LifeTimes* under-65 member newsletter is now [online](#)! Anyone can read articles about taking care of costly health issues like diabetes, heart disease, cancer and more. Readers can also learn more about health plan basics and benefits.

A monthly newsletter email will still be sent to our under-65 members, tailored to their benefits. To get the email, members just need to sign up on the [Blue Access for Members](#)SM portal. From the newsletter email, members will click through to the [LifeTimes website](#) to explore articles from current and past editions. The September edition is the first to be hosted online.

On the *LifeTimes* website:

- Search articles by topic or keywords
- Find health issues grouped by topic in the Health & Wellness tab:
 - Bone & Joint Health
 - Cancer
 - Diabetes
 - Heart Health
 - Lung Health
 - General Health
- Read about insurance benefits and coverage
- Visit any time, day or night, outside of the newsletter email
- Share articles on Facebook and Twitter
- *Coming soon:* All articles will be available in Spanish

Be sure to bookmark the [LifeTimes website](#) today. You can print this page to share with your patients and office staff.

BCBSTX Launches 'Taking on Asthma' SITE

As part of a five-year partnership with the American Lung Association of Texas to enhance care for children with asthma, BCBSTX has launched a "Taking on Asthma" microsite to spread the word about childhood asthma. The site shares information about our initiative, **Enhancing Care for Children with Asthma**, that aims to improve pediatric asthma care for high-risk patients through community-based interventions. The site also has information and tools for health professionals to better manage and care for children with asthma using the project's training methods. [Learn more about the Enhancing Care for Children with Asthma project and access the resources available for medical professionals.](#)

Notices & Announcements

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 [Education and Reference](#) on the [bcbstx.com/provider](#) website to view what is available and sign up for training sessions.

In Every Issue – October 2016

The following is information that BCBSTX is required to provide in all published correspondence with physicians, professional providers, and facility and ancillary providers. For the latest updates, visit the [News and Updates area](#) of the BCBSTX provider website.

Reminder: Corrected Claim Request Change, Effective July 11, 2016

As a reminder, effective July 11, 2016, 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 entirely 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™ web 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.

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

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

HMO Blue TexasSM, Blue Advantage HMOSM and Blue PremierSM 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 AccessSM**, 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 PlusSM 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.

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.

Blue Choice PPOSM Subscribers/Blue Advantage HMOSM 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:	
<ul style="list-style-type: none">• 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.		<ul style="list-style-type: none">• Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.	
<ul style="list-style-type: none">• Participate with practitioners in making decisions about your health care.		<ul style="list-style-type: none">• Follow the plans and instructions for care you have agreed to with your practitioner.	

<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.
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HMO Blue Texas Member Rights and 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 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.

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. 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 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 PPOSM Physician, Professional Provider and Facility and Ancillary Provider Manual** (Section B) and **HMO Blue TexasSM/Blue Advantage HMOSM/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) PPOSM 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:



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/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 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's or professional provider's reimbursement includes staff and equipment.

Reminder: 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.)

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 PPOSM 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 **ProviderPortal**SM 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 TexasSM members and Blue Advantage HMOSM subscribers* and the **preferred statewide** outpatient clinical reference laboratory provider for 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:

- 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 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 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.

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.

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.

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 [Standard Drug List Dispensing Limits](#) and [Generics Plus Drug List Dispensing Limits](#) documents online.

Prescription Drug Lists

Throughout the year, the 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.

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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