October 2017

NOTICES & ANNOUNCEMENTS

Fee Schedule Updates Effective Oct. 1

Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule used for Blue Choice PPO℠, Blue Essentials℠, Blue Premier℠, Blue Advantage HMO℠ and ParPlan effective Oct. 1, 2017. The changes include:

- The methodology used to develop the maximum allowable fee schedule for these plans will be based on 2017 Centers for Medicare and Medicaid Services (CMS) values as posted on their website for the services in which the BCBSTX reimbursement is based on CMS values.
- BCBSTX provides general reimbursement information policies, fee schedule request forms and fee schedule information on the General Reimbursement Information section of BCBSTX's provider website.
    - Reimbursement changes and updates will be posted under "Reimbursement Changes/Updates" in the Reimbursement Schedules section.
    - The specific effective date will be noted for each change that is posted.
- The conversion factor for certain surgical codes may vary by place of service for ambulatory surgical center and outpatient hospital.
- Blue Choice PPO, Blue Essentials, Blue Premier and Blue Advantage HMO:
    - Will consider the site of service where the service is performed.
    - The multiple procedure payment will be changing on the professional component of certain diagnostic imaging procedures. This change applies to services billed as professional component only or global for the procedures listed on the website. The highest priced procedure will be reimbursed at 100 percent of the allowable and each additional procedure – when performed during the same session on the same day – will be reimbursed at 95 percent (previously 75 percent) of the allowable.

If you would like to request a sample of maximum allowable fees or if you have any questions, please contact your Network Management office.

Integration of Prime Therapeutics® and Walgreens® Specialty Pharmacy and Mail Order Services

Blue Cross and Blue Shield of Texas' (BCBSTX) pharmacy benefit manager (PBM), Prime Therapeutics LLC (Prime), and Walgreens announced a strategic alliance in August 2016 to create a first-of-its-kind model for pharmacy benefit management that aligns a national pharmacy chain, a leading PBM and health plans, including a long-term retail pharmacy agreement. As part of this alliance, Prime and Walgreens have formed a combined company for specialty pharmacy and mail order services, headquartered in Orlando, FL.

Teams have been working to unite each organization's mail service and specialty pharmacy operations. As of mid-August 2017, all BCBSTX members whose pharmacy benefits are administrated through Prime will have been integrated into the new combined company's pharmacy systems.[1] A summary of the changes you might experience from this integration are included below.

Specialty Pharmacy Services
As of July 15, 2017, BCBSTX members were integrated into the new specialty pharmacy system. The new company is nationally accredited by Accreditation Commission for Health Care and Utilization Review Accreditation Commission. Any additional accreditation and licenses will be pursued as needed. Additionally, a vast selection of previously labeled limited distribution products will be available through Prime Therapeutics Specialty Pharmacy.

There are no changes to the way you submit a prescription. The following remains the same:

- The name used when e-prescribing: Prime Therapeutics Specialty (as of April 5, 2017)
- The fax number used to send prescriptions
- The prior authorization process; patient prior authorization approvals on file were transferred and will follow the BCBSTX process for renewals
- The number you call to reach Prime Specialty Pharmacy: 877-627-MEDS (6337)
- The hours of operation: Monday-Friday, 7 a.m. – 7 p.m. CT

For prescriptions coming to your location, you may notice changes in Prime Therapeutics' communications and packaging, including:

- The use of the Prime Specialty Pharmacy and Walgreens names/logos may both appear on the packing receipt, enclosed information sheets, stickers on the box, etc.
- Cooler/cooler packaging and the box holding the medicine may look different
- The label affixed to the front of the box may show a dispensing location other than Orlando, FL

Mail Order Services
Covered 90-day supply mail order prescriptions are being filled by "PrimeMail by Walgreens Mail Service" home delivery program as of Aug. 18, 2017.

There is a new way to submit a prescription electronically:

- For patients with expired/no remaining refill prescriptions, you will need to provide a new prescription. If submitting this prescription electronically after Aug. 18, you will need to send it to Walgreens Mail Service in Tempe, AZ, or you can fax the prescription to 800-332-9581.

Please Note: Existing PrimeMail ePrescribing or fax methods you may currently be using can continue for the immediate future, but will be returned as "unable to fill" at some point later this year. Please take this opportunity to update any pharmacy information that may be stored in your patients' records. Also, if your patient has a current prior authorization approval on file, it was transferred over to the new mail order system and will follow the standard BCBSTX process for renewals.

Members with prescription history within the last 12-18 months were notified of the specialty pharmacy and/or mail order service changes. Full integration of all mail service and specialty pharmacy services are expected to be completed by the first quarter of 2018. More information about the new combined company, including the official name, will be shared in future *Blue Review* issues and/or in the News and Updates section of the BCBSTX provider website.

If your patients have questions about their pharmacy benefits, please advise them to contact the Pharmacy Program number on their member ID card. Members may also visit bcbstx.com and log in to Blue Access for Members℠ for a variety of online resources.

[1]Members with Medicare Part D or Medicaid coverage transitioned to the new mail order services as of earlier this year.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime Therapeutics to provide pharmacy benefit management and other related services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSTX and contracting pharmacies is that of independent contractors. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Prime has entered into an agreement with Walgreens, an independently contracted pharmacy, to form a combined specialty pharmacy and mail order services company, owned by Prime and Walgreens.

BCBSTX New Employer Group Plan – Employees Retirement System of Texas (ERS) Effective Sept. 1, 2017

We are excited to announce that Blue Cross and Blue Shield of Texas (BCBSTX) was awarded the six-year contract for the Employees Retirement System of Texas (ERS) account, effective Sept. 1, 2017. ERS participants covered under HealthSelectSM of Texas and Consumer Directed HealthSelect[SM] benefit plans will access care through the Blue EssentialsSM provider network in all 254 counties in Texas.

ERS participants plan options:

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

ERS participants can be identified through their BCBSTX ID card:

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

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

For a list of services that require prior authorization for ERS participants, refer to the ERS HealthSelect of Texas Prior Authorization/Notification/Referral Requirements List or ERS Consumer Directed Health Select Prior Authorization/Notification/Referral Requirements List on the Clinical Resources page of bcbstx.com/provider.

In addition, BCBSTX has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company to provide Utilization Management services for the prior authorization requirements outlined below and indicated on the HealthSelect or Consumer Directed HealthSelect Prior Authorization/Notification/Referral Requirements lists for ERS participants:

- Molecular and genomic testing
- Radiation oncology for all outpatient and office services
- Advanced Radiology Imaging
- Sleep Studies and Sleep Durable Medical Equipment

To obtain prior authorization through eviCore you may use one of the following methods:

- The eviCore HealthCare Web Portal is available 24x7. After a one-time registration, you can initiate a case, check status, review guidelines, view authorizations/eligibility and more. The Web Portal is the quickest, most efficient way to obtain information.
- Texas Providers can call toll-free at 855-252-1117 between 6 a.m. to 6 p.m. CT Monday through Friday and 9 a.m. to noon on Saturdays, Sundays and legal holidays.

For all other services (not listed above), that require a referral and/or prior authorization, providers should refer to the telephone numbers on the participants' ID card or physicians, professional providers and facilities contracted with BCBSTX can access iExchange. Go to iExchange to learn more or set up a new account.

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

If you have any questions or if you need additional information, please contact your BCBSTX Network Management Representative.

Become a BCBSTX HealthSelect℠ of Texas provider today!

Are you currently providing or interested in providing healthcare services for Employees Retirement System of Texas (ERS) participants? ERS will utilize the Blue Essentials network to support its custom POS network for ERS HealthSelect of Texas℠ and Consumer Directed HealthSelect℠. If you are not currently an active Blue Essentials network provider, you need to apply for participation in Blue Essentials prior to September 1, 2017, as HealthSelect will access the Blue Essentials network. To ensure a seamless transition and have the optimum providers available, we are reaching out to increase awareness about this opportunity.

ERS participants in the HealthSelect Point of Service (POS) plan receive maximum benefits when care is provided or directed by an in-network Primary Care Provider. Participants have an out-of-network option available to them, but there could be a significant financial impact when utilizing out-of-network services.
Open enrollment for ERS participants will take place from June 26 through July 28, 2017. To continue providing care to your ERS participants, we hope you will consider participating in our customized HealthSelect network. Please contact your local Network Management office to obtain an agreement to be a HealthSelect provider through the Blue Essentials network.

We value your participation in our existing networks and it is our earnest hope you consider being a part of the Blue Essentials network for the benefit of your current and future ERS patients.

CLAIMS & ELIGIBILITY

National Drug Code (NDC) Billing Update for Medicare Advantage Claims

Beginning Dec. 15, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will activate edits to validate NDCs that are submitted on electronic and paper professional and institutional Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM claims. These validation edits are being implemented to align with the Centers for Medicare & Medicaid Services (CMS) encounter data submission requirements. Providers should confirm that the NDCs submitted are appropriate for services rendered and active for the date(s) of service billed.

The table below specifies which NDC-related elements must be entered if NDCs are included on electronic professional and institutional claims for Medicare Advantage members. Claims submitted containing NDCs may be rejected if any of these data elements are missing or incorrect. Rejected claims must be resubmitted with the correct data. If you use a billing service or clearinghouse, please share the above information with your vendor.

Elements Required when NDC is Present on Electronic Claims	Professional Electronic Claim (837P) Loops and Segments	Institutional Electronic Claim (837I) Loops and Segments
Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) Code	Loop 2400, SV101-1 = HC	Loop 2400, SV202-1 = HC Loop 2400, SV202-2 = [CPT/HCPCS code]

	Loop 2400, SV101-2 = [CPT/HCPCS code]	
If the CPT/HCPCS code in SV101-2 (professional claim)/ SV202-2 (institutional claim) is an unlisted procedure code or Not Otherwise Classified (NOC)" code, a description is required	Loop 2400, SV101-7	Loop 2400, SV202-7
Line Item Charge Amount	Loop 2400, SV102	Loop 2400, SV203
Unit of Measurement Code	Loop 2400, SV103 = UN	Loop 2400, SV204 = UN
Service Unit Count	Loop 2400, SV104	Loop 2400, SV205
NDC Qualifier	Loop 2410, LIN02 = N4	Loop 2410, LIN02 = N4
NDC (11-character alpha-numeric value containing no spaces, hyphens or special characters)	Loop 2410, LIN03 = NDC Number	Loop 2410, LIN03 = NDC Number
Quantity / Dosage* (Number of NDC units)	Loop 2410, CTP04	Loop 2410, CTP04
Unit of Measure (UOM = UN, ML, GR or F2)	Loop 2410, CTP05-1	Loop 2410, CTP05-1
Prescription Number (when applicable)	Loop 2410, REF01 = XZ REF02 = [prescription number]	Loop 2410, REF01 = XZ REF02 = [prescription number]

If NDCs are submitted on paper professional (CMS-1500) and institutional (UB-04) claims for Medicare Advantage members, the following NDC-related elements must be included:

Professional (CMS-1500) fields

- 24A – (shaded area) – NDC Qualifier, NDC 11-digit number, Unit of Measure Qualifier and Unit Quantity
- 24D – CPT/HCPCS code
- 24G – HCPCS unit

Institutional (UB-04) fields

- 42 – Revenue code
- 43 – Revenue Code Description, NDC Qualifier, NDC 11-digit number, Unit of Measure Qualifier and Unit Quantity
- 44 – HCPCS code
- 45 – Service/Assessment Date
- 46 – Service Units

*For assistance with calculating the number of NDC units, independently contracted BCBSTX providers may access the NDC Units Calculator Tool at no cost through our secure site – look for the National Drug Codes (NDCs): Billing Resources link on our provider website Home page at bcbstx.com/provider. The NDC Units Calculator Tool is also available via the Availity™ Web Portal.

For additional claim-related information, refer to the appropriate Provider Manual in the Standards and Requirements section of our Provider website. As always, your assigned BCBSTX Provider Network Representative is available to provide personalized assistance to you and your staff.

Notice of changes to Billing and Documentation Information and Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) is implementing changes to clarify existing policies related to billing and documentation requirements for the BlueChoice® PPO, Blue Advantage HMO℠, Blue Essential℠, Blue PremierSM, Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO)℠ plans effective 9/15/17 as reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual in Section E Filing Claims posted on bcbstx.com/provider under Standards and Requirements/ Manuals. Below are the updates to be posted:

Billing & Documentation Information & Requirements

Permissible Billing

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

Pass through Billing

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

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

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

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

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

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

Under Arrangement Billing

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

All Inclusive Billing
Any testing performed on patients treated by a physician, professional provider, facility, or ancillary provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services.
The Physician, professional provider, facility, or ancillary provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to BCBSTX.

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

Other Requirements and Monitoring

CLIA Certification Requirement

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

Review of Codes

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

Limitations and Conditions

Reimbursement is subject to:

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

Obligation to notify BCBSTX of Certain Changes

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

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

Assignment

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

New ClaimsXten™ Rules to be Implemented

Beginning on or after September 18, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will implement 4 new rules to the ClaimsXten software database. These new rules are defined as:

- **Add On Without Base Code** – This rule will identify claim lines containing a CPT/HCPCS add-on- code billed without the presence of one or more related primary service/base procedure codes. According to

American Medical Association (AMA), "add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code."

- **Global Component Billing** – This rule will identify procedure codes which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule will also identify when duplicate submissions occur for the total global procedure or its components across different providers.

- **Duplicate Component Billing** – This rule identifies when a professional or technical component of a procedure is submitted and the same global procedure was previously submitted by the same provider ID for the same member for the same date of service.

- **New Patient Code for Established Patient** – Identifies claim lines containing new patient procedure codes that are submitted for established patients. According to AMA, "A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last 3 years." As well, similar guidance is provided by Centers for Medicare Medicaid Services (CMS): According to Pub 100-04, Medicare Claims Processing Manual Ch. 12, Physicians/Non-Physicians Practitioners, Section 30.6.7, Subsection A, "Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years."

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the Education & Reference/Provider Tools/ Clear Claim Connection page on our Provider website at bcbstx.com/provider. Information also may be published in upcoming issues of the Blue Review.

Checks of eligibility and/or benefit information are not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

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

New EFT and ERA Information Available Online

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

Recent enhancements to the EFT/ERA page include resources to help you learn more about EFT and ERA. In addition to new EFT and ERA Online Enrollment Tip Sheets, the page includes links to updated EFT and ERA 835 Companion Guides and other pertinent information.

Electronic options offer health care providers a more efficient alternative to the traditional paper methods. Providers are encouraged to enroll for EFT and ERA through the Availity™ Web Portal, which also allows users to make any necessary set-up changes online. Once an organization is enrolled for ERA, providers and billing services also gain access to the Availity Remittance Viewer. This tool allows users to search, view, save and print remittance information, even if the ERA is delivered to a vendor and/or clearinghouse other than Availity.

Online EFT and ERA enrollment is available to registered Availity users. To register for Availity, simply go to availity.com and sign up today. There is no cost to register to become an Availity user.

For providers who are unable to access Availity to complete the online EFT and ERA enrollment process, paper EFT and ERA enrollment forms are available in the Education and Reference Center/Forms section on BCBSTX's provider website.

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

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

EFT and ERA Update for Non-Contracted Blue Cross Medicare Advantage Plan Providers

Effective July 24, 2017, if you are contracted with Blue Cross and Blue Shield of Texas (BCBSTX) to receive Electronic Funds Transfer (EFT) and enrolled to receive Electronic Remittance Advice (ERA) files from BCBSTX, you will also receive EFTs and ERAs for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM member claims, even if you are not participating in a Blue Cross Medicare Advantage provider network. Specifically, this information applies to claims submitted for any of the following BCBSTX government programs members:

- Blue Cross Medicare Advantage (PPO)SM (MA PPO)
- Blue Cross Medicare Advantage (HMO)SM (MA HMO)

This notice provides an update to a March 2017 announcement that specified delivery of paper checks and provider claim summaries to non-contracted government programs providers. Please continue to watch the News and Updates and *Blue Review* for additional information.

If you are not currently enrolled to receive EFT and ERA from BCBSTX, we encourage you to enroll online through the Availity™ Web Portal, which also permits users to make any necessary set-up changes online, at no cost. To learn more about EFT and ERA enrollment, visit the EFT and ERA page in the Claims and Eligibility section at bcbstx.com/provider. If you have questions or need assistance with EFT and ERA enrollment through Availity, contact a BCBSTX Provider Education Consultant at ECommerceHotline@bcbsil.com or 800-746-4614.

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

CLINICAL RESOURCES

UPDATE: Prior Authorizations and Referrals for HealthSelect of Texas Participants

iExchange® is now available for submission of prior authorizations and referrals for HealthSelect of TexasSM participants. Usage of iExchange for all submissions is highly recommended to reduce call hold times.

iExchange is a web-based application that supports the direct submission and processing of referrals and approval of select outpatient services and inpatient admissions to acute care facilities by network physicians, professional providers, and facilities within Texas. To learn more information about iExchange please visit our Provider Website.

BCBSTX will honor all Prior Authorizations and Referrals previously submitted through United Health Care for HealthSelect participants for service dates post September 1, 2017. Although not required, if you feel verification is needed, providers should call 800-344-2354.

For phone inquiries and requests, hours of operation are as follows:
Normal Hours of Operation
(Monday – Friday) 6:00 am – 6:00 pm
(Saturday – Sunday) 9:00 am – 1:00 pm

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

2018 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 January 1, 2018. 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.

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. To authorize services requiring preauthorization through eviCore, you can go to eviCore.com or call 855-252-1117.

Preauthorization/Referral Requirements Lists are attached and have been updated to include the services that require preauthorization through BCBSTX and eviCore. The updated preauthorization lists will be located on bcbstx.com/provider under Clinical Resources. For specific codes that apply, the BCBSTX Medicare Advantage CPT Preauthorization Code List can be viewed on the above link from 10/1/2017 through 12/31/2017.

As a reminder, iExchange®, our automated referral and preauthorization tool, is available 24 hours a day, seven days a week (except for every third Sunday of the month when the system will be unavailable from 11 a.m. to 3 p.m. CT) for those services requiring preauthorization through BCBSTX. 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.
Failure to timely notify BCBSTX and obtain pre-approval for listed procedures may result in denial of the claim(s) for care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX.

If you have any questions or if you need additional information, please contact your BCBSTX Network Management Representative.

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

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

Preauthorization and Referral Requirements Lists Are Changing Jan. 1, 2018

Beginning Jan. 1, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) will be changing the preauthorization requirements for Blue Choice PPOSM, Blue EssentialsSM, Blue Essentials AccessSM, Blue PremierSM and Blue Advantage HMOSM.

The changes include **three new Health Advocacy Solutions (HAS) preauthorization service options**, including Primary, Advanced and Premier. These options allow Blue Choice PPO and Blue Essentials Access self-insured groups to choose one of three preauthorization-specific service options for their group. In addition,

Blue Choice PPO fully insured members, Blue Essentials, Blue Essentials Access, Blue Premier and Blue Advantage HMO will have additional care categories that require preauthorization through BCBSTX or eviCore healthcare™ (eviCore).

Preauthorization for certain care categories that are handled through eviCore can be obtained by accessing evicore.com or calling 855-252-1117.

Check Eligibility First
As a reminder, it is important to check eligibility through Availity™ or your preferred web vendor prior to rendering services. This step will help you determine if your services require preauthorization through BCBSTX or eviCore.

Please note: Services performed without benefit preauthorization may be denied in whole or in part for payment and you may not seek any reimbursement from the member. For any service not approved for payment, BCBSTX will provide all appropriate appeal rights for review. Please note that a member penalty may also apply based on the benefit plan.

Preauthorization/Referral Requirements Lists
You can find the preauthorization/referral requirements lists that are effective Jan. 1, 2018, under Clinical Resources on the BCBSTX provider website. Additional information, such as definitions and links to helpful resources, can be found in the Eligibility and Benefits section.

iExchange® Automated Preauthorization Tool
Continue using iExchange to obtain preauthorization for the services that require authorization through BCBSTX on any of the preauthorization lists. The iExchange online tool is accessible to physicians, professional providers and facilities contracted with BCBSTX. For more information or to set up a new account, refer to the BCBSTX iExchange web page.

If you have any questions or if you need additional information on the above information, please contact your Network Management Representative.

eviCore Orientation Sessions
eviCore will be hosting education sessions in December. During these training sessions, BCBSTX will provide a brief overview of the new HAS benefit and Availity's role. Anyone wishing to attend one of the sessions must register in advance. **Sessions are free of charge and will last approximately one hour.**

Session	Date	Time
Radiation Therapy	Dec. 5, 2017	11 a.m. CT
Genomic Lab	Dec. 5, 2017	1 p.m. CT
Radiology (CT/MR/PET)	Dec. 6, 2017	1 p.m. CT
Sleep Testing	Dec. 7, 2017	10 a.m. CT
Sleep DME	Dec. 7, 2017	1 p.m. CT

How to Register
- Choose a date and time, and then go to evicore.webex.com.
- Click on the "Training Center" tab at the top of the page.
- Find the date and time of the orientation session you wish to attend by clicking the "Upcoming" tab. All orientation sessions will be named "Blue Cross and Blue Shield of Texas Provider <Program Name> Orientation Session."
- Click "Register."
- Enter the registration information.

After you have registered for the conference, you will receive an email containing:

- The toll-free phone number and pass code you will need for the audio portion of the conference
- A link to the online portion of the conference
- The conference password

Please keep the registration e-mail so you will have the link and phone number for the session. If you are unable to participate in a session during any of the times listed, you can find a copy of the presentation on the eviCore BCBSTX implementation site.

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.

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Antidepressant Medication Management Initiative

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to improving the rate at which members remain on antidepressant medications after being newly diagnosed and treated for depression.

Did You Know?
According to the American Psychological Association (APA), Major Depressive Disorder is a chronic condition that requires patients to participate actively in and adhere to treatment plans for long periods, despite the fact that side effects or requirements of treatment may be burdensome.

APA guidelines recommend antidepressants as the initial treatment for mild to moderate depression.

Our Goal and Who Is Eligible?
Our goal is to increase antidepressant medication adherence. The initiative is targeting members age 18 and older with at least one of the following:

- Principal diagnosis of major depression in an outpatient, emergency department intensive outpatient or partial hospitalization setting
- At least two visits in an outpatient, emergency department, intensive outpatient or partial hospitalization setting on different dates of service with any diagnosis of major depression
- At least one inpatient (acute or non-acute) claim

We measure adherence for both the **acute and continuation phases** as outlined in Healthcare Effectiveness Data and Information Set (HEDIS®) 2017 specifications:

- **Effective Acute Phase:** Percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective Continuation Phase:** Percentage of newly diagnosed and treated members who remained on an antidepressant for at least 180 days (6 months)
- Comprehensive analysis of the results will be conducted quarterly and annually by BCBSTX.

What You Should Do

- The physician should assess and acknowledge potential barriers to treatment adherence, including lack of motivation, side effects of treatment, and logistical, economic or cultural barriers to treatment. The physician should collaborate with the patient (and the family if possible) to minimize the impact of these potential barriers.
- Patients should be given realistic expectations during the different phases of treatment. This includes the symptom-response time and the importance of medication adherence for successful treatment.
- Misperceptions, fears and concerns about antidepressants should be addressed with the patient.
- Education should be provided about major depression, the risk of relapse, the early recognition of recurrent symptoms, and the efficacy of Cognitive Behavioral Therapy in combination with medication.
- Patients should be informed about the need to taper antidepressants rather than discontinuing them prematurely.
- Common side effects of antidepressants should be discussed with the patient. The physician should encourage the patient to identify side effects they would consider reasonable and those they would consider unreasonable.
- Physicians should explain when and how to take the medication, reminder systems, information about continuing the medication after symptoms of depression improve, strategies to incorporate medication into the daily routine and minimizing the cost of antidepressant regimens to improve adherence.

References

Practice Guideline for the Treatment of Patients with Major Depressive Disorder 3rd Edition, (2010) American Psychiatric Association
HEDIS 2017 Volume 2 Technical Specifications for Health Plans (the Healthcare Effectiveness Data and Information Set)

EDUCATION & REFERENCE

Update: Texas Severe Weather: BCBSTX Responds to Help Providers

Many Blue Cross and Blue Shield of Texas (BCBSTX) providers and members are currently being impacted by Hurricane Harvey. Members and Providers who are residents of the 60 disaster counties or those impacted by Harvey will be covered by Governor Greg Abbott's proclamation. Recovering from a natural disaster like Hurricane Harvey is never easy. Throughout the duration of the governor's proclamation, we are helping members by:

- Authorizing up to a 90-day supply of prescription medications for members
- Not requiring pre-authorization or referrals (members' benefit coverage will apply)
- Allowing claims for an HMO member to receive services out-of-network if necessary, without a referral
- Extending claim filing deadlines for providers
- Working with members to extend premium payment deadlines
- Authorizing payment for necessary medical equipment, supplies, and services regardless of the date on which the service, equipment, or supplies were most recently provided

How to Check Eligibility

Checking eligibility, benefits and accessing patient clinical summaries electronically through AvailityTM or your preferred web vendor is the quickest way to access BCBSTX member information. To learn more about online solutions, see the Provider Tools section on the BCBSTX Provider website. Additionally, we are providing a list of important phone numbers you can use to verify eligibility and benefits if you do not have internet access:

Blue Advantage HMO℠:
Provider Customer Service - 800-451-0287
Utilization Management - 855-896-2701

Blue Essentials℠:

Provider Customer Service - 877-299-2377
Utilization Management - 855-896-2701

PPO (Blue Choice℠ and Home BlueCard members):
Provider Customer Service - 800-451-0287
Utilization Management - 800-441-9188

Medicare Advantage HMO & PPO:
Provider Customer Service - 877-774-8592
Utilization Management - 877-774-8592

Blue Premier℠
Provider Customer Service - 800-676-2583
Utilization Management - 800-441-9188

STAR Kids - 1-877-784-6802
CHIP and STAR - 1-877-560-8055

Note: Adoption Assistance and Permanency Care Assistance (AAPCA) eligibility and benefits should be verified using the STAR and STAR Kids information above.

Medicaid Personal Care attendants see additional information for Electronic Visit Verification (EVV) below.

National BlueCard access (Host Blue Card members): 800-676-BLUE (2583)

Claims and Provider Reimbursement Payments
Be sure to include your NPI on all claims to ensure accurate and timely claim processing. Please remind your office staff to bill BCBSTX directly for all services rendered to patients with BCBSTX coverage. We will then compensate you based on each specific patient's (member) benefits. Your Provider Claims Register will indicate any patient responsibility for payment, and you may bill your patient for that amount. If you are providing care outside of your home office location, please continue to use the address to your permanent location. If you have online access, please use the Availity® provider portal at www.Availity.com which provides access to member's real-time eligibility & benefits and claims status information, as well as offers batch or web claim submissions.

Your provider reimbursement payments will continue to be processed as claims are submitted. If you are receiving a paper check payment, service should resume in accordance with the United States Postal schedule. If you need a payment prior to that time or have any other payment related inquiries, please call customer service.

Need Prior/Preauthorization/Extension/Clinical Care
BCBSTX's prior authorization unit has extended hours from 8 a.m. to 8 p.m. until further notice.
BCBSTX will review requests as per our normal business operation and manage issues on a case by case basis to ensure that our members have access to the necessary care they need during this time. However, if your patients don't have their ID card, they should call member services or print a temporary card from Blue Access for Members℠.

Note: Medicare Advantage patients should call member services if they don't have their ID card.
Magellan can be reached at 800-729-2422.

Note: Magellan is providing free, confidential counseling services and other resources, such as referrals to local non-profit organizations, shelters and additional community-based support. Onsite counseling services are available for a small fee. The toll-free number to access free, confidential counseling services is 1-800-327-7451.

eviCore can be reached at 855-252-1117 or by visiting eviCore.com.

Quest Diagnostics, Inc. - For locations or questions, contact Quest at 888-277-8772 or visit Quest's website at: QuestDiagnostics.com/patient.
Clinical Pathology Laboratory (CPL) – For locations or questions, contact CPL at 800-595-1275 or visit CPL's website at: cpllabs.com.

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

Provider Service Hours
For phone inquiries and requests:
(Monday – Friday) 6 a.m. – 6 p.m.
(Saturday – Sunday) 9 a.m. – 6 p.m.

Pharmacy Provider
Pharmacy customer service will remain open for 24 hours. In addition, our customer advocates are providing customized assistance to members in the impacted ZIP codes.

Helpful Tips to Relay to Your Patients

- For emergencies, your patients should call 911 or go directly to the nearest hospital.
- For non-emergencies, your patients should call member services to find a doctor or health care professional in their network.
- Your patients should bring their BCBSTX member ID card when they get care.
- However, if your patients don't have their ID card, they should call member services or print a temporary card from Blue Access for Members. Note:Medicare Advantage patients should call member services if they don't have their ID card.
- If your members have questions, please direct them to bcbstx.com for updates.

Medicaid Provider Information
Electronic Visit Verification (EVV) for Personal Care attendants:

- Providers that are unable to call in and/or call out because of Hurricane Harvey will need to complete visit maintenance for those visits using Reason Code 130; Disaster or Emergency to document service delivery in the EVV system.
- Reason Code 130 is used when an attendant or assigned staff is unable to provide all or part of the scheduled services due to a disaster (e.g. Flood, tornado, ice storm, fire, etc.) or other emergency (e.g., EMS must be called). Reason Code 130 is a preferred reason code.
- Free text is required in the comment field; the provider must document the nature of the disaster or emergency and the actual time service delivery begins and/or ends in the comment field. For example: Hurricane Harvey. Time in: 8:30 am - Time out: 11:30 am.
- EVV Providers: If phone service is interrupted or unavailable during service delivery, attendants should document:
    - Service start and end times
    - Small Alternative Device (SAD) values

This documentation is necessary to ensure service visits can be verified in the EVV system once phone service is restored.

Pharmacy for Medicaid Members
BCBSTX is implementing a dynamic PA (dPA) for their Medicaid members for refill too soon rejections at the pharmacy. The dynamic PA will be in place for 7 days, implemented as of 8/24, and allow a 30-day refill of the members' medications. In addition, our PBM will provide a report for medications filled through the dPA process to ensure the refills were appropriate.

Continue to check the BCBSTX provider website and the *Blue Review* in the coming weeks, for additional information from BCBSTX.

Update: Special Severe Weather Message for Providers in the HealthSelectSM Network

Recovering from a natural disaster like Hurricane Harvey is never easy. Blue Cross and Blue Shield of Texas (BCBSTX) is here to help network providers as well as participants.

For phone inquiries and requests, hours of operation are normal:
(Monday – Friday) 6 a.m. – 6 p.m.
(Saturday – Sunday) 9 a.m. – 1 p.m. Provider Customer Service: (800) 451-0287

Utilization Management: (800) 354-2354

To Check Eligibility:
The quickest way to access HealthSelect participant information like eligibility, benefits and patient clinical summaries is online through Availity® or your preferred web vendor. To learn more about online solutions, see the Provider Tools section on the BCBSTX Provider website.

Provider Customer Service and Utilization Management are available from 8 a.m. – 8 p.m. until further notice.

Provider Customer Service: (800) 451-0287
Utilization Management: (800) 441-9188

To verify HealthSelect plan participants' eligibility and benefits if you don't have internet access:

Provider Customer Service: (877) 299-2377
Utilization Management: (855) 896-2701

Claims and Provider Reimbursement Payments

- Include your National Provider Identifier on all claims to ensure accurate and timely claim processing
- Bill BCBSTX directly for all services rendered to patients with BCBSTX coverage. We will then compensate you based on each specific patient's (participant) benefits. Your Provider Claims Register will indicate any patient responsibility for payment, and you may bill your patient for that amount. If you are providing care outside of your home office location, please continue to use the address of your permanent location.
- Use the Availity provider portal at www.Availity.com if you have online access. This portal provides access to participant's real-time eligibility & benefits and claims status information, as well as offers batch or web claim submissions.
- A claims system edit will be implemented based on participant zip codes associated with the 60 impacted counties specified in the declaration areas until further notice. This means claims will suspend for the specific edit, enabling claims examiners to review claims for services rendered to impacted participants to determine if any of the exceptions apply.

Note: Your provider reimbursement payments will continue to be processed as claims are submitted. If you are receiving a paper check payment, service should resume in accordance with the United States Postal schedule. If you need a payment prior to that time or have any other payment related inquiries, please call customer service.

Referrals / Prior-Authorization / Extensions / Clinical Care

- The BCBSTX prior authorization unit has extended hours from 8am – 8pm until further notice.
- BCBSTX will review requests as we normally do and manage issues on a case by case basis. This will ensure that our participants have access to timely care that's needed during this time. If your patients don't have their ID card, they should call participant services or print a temporary card from Blue Access for Members℠.

Note: Medicare Advantage patients should call participant services if they don't have their ID card.

- **Magellan** can be reached at (800) 729-2422.
- **eviCore** can be reached at (855) 252-1117 or online at eviCore.com.
- **Quest Diagnostics, Inc.** can be reached at (888) 277-8772 or online at QuestDiagnostics.com/patient
- **Clinical Pathology Laboratory (CPL)** can be reached at (800) 595-1275 or online at cpllabs.com

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

IF APPLICABLE OFFER SERVICE REMINDER for Virtual Visit – Promotions (Reminder if participant has immediate need they should seek emergency care.)

- MDLIVE is offering free virtual medical consultations through 9/16/2017. MDLIVE will connect you with a board-certified doctor 24/7 in your state for free. To access your free visit, call MDLIVE at (888) 959-9516 use promo code HARVEY.

Helpful Tips to Relay to Your Patients

- For emergencies, your patients should call 911 or go directly to the nearest hospital.
- For non-emergencies, your patients should call participant services. A PHA can help find a doctor or health care professional in their network.
- Your patients should bring their BCBSTX participant ID card when they get care.
- If your patients don't have their ID card, they can print a temporary card from Blue Access for Members or call participant services to have a PHA send the ID card information over the phone. Participants can also download their ID card from the BCBSTX App on a smart phone. Text BCBSTX APP to 33633 to download the app.

HealthSelect providers and participants of the 60 disaster counties or those impacted by Harvey will be covered by Governor Greg Abbott's proclamation.

To help all HealthSelect participants for the duration of the governor's proclamation, we are:

- Authorizing up to a 90-day supply of prescription medications for participants
- Not requiring prior-authorization or referrals (participants' benefit coverage will apply)
- Allowing claims for a plan participant to receive services out-of-network if necessary, without a referral
- Extending claim filing deadlines for providers
- Working with participants to extend premium payment deadlines
- Authorizing payment for necessary medical equipment, supplies, and services regardless of the date on which the service, equipment, or supplies were most recently provided
- Waiving the penalty for failure to obtain Prior Authorizations when services are received at an in-network facility
- Participants with an immediate need should seek emergency care
- A Personal Health Assistants (PHA) can assist with verifying provider availability
- Keeping pharmacy customer service open 24 hours
- Participants in the impacted ZIP Codes can receive customized assistance from a PHA by calling (800) 252-8039
- Processing claims for emergency transport from one facility to another will be at the in-network benefit level
- Includes out-of-network provider reimbursement amounts previously established
- Continuing BCBSTX Member Service hours of operation from 7 a.m. – 7 p.m. Monday – Friday and 7 a.m. – 3 p.m. Saturday, Central time.

Note: Participants can call Magellan at (800) 729-2422 to access free, confidential counseling services and other resources, such as referrals to local non-profit organizations, shelters and additional community-based support. Onsite counseling services are available for a small fee.

Additional help for HealthSelect participants with a mailing address in one of the 60 counties covered by Governor Greg Abbott's disaster area proclamation:

- No penalty for failure to obtain PCP referral
- In-network benefits apply when services are received from an in-network HealthSelect provider
- No penalty for failure to obtain Prior Authorizations when services are received at an in-network HealthSelect facility
- Applies to all plans, not just HealthSelect in-area plans

Note: The above applies to participants even when their services need to be rendered outside of the declared counties

Continue to check the BCBSTX provider website and the Blue Review for additional information in the coming weeks.

Looking at Variability in Pricing Solutions Through Shared Data

To help make the health care system work better, Blue Cross and Blue Shield of Texas (BCBSTX) has implemented the **Benefits Value Advisor (BVA)**program. BVA helps members get cost estimates, schedule appointments and assists with benefit preauthorization.

How often someone uses health care services, where they go for care and how much they pay for care are a few of the foundational elements in the ongoing national struggle to control rising health care costs.
An independent study published by the Health Care Cost Institute shows that employers and insurers that provide private health care coverage can pay for services that vary widely in price, depending on the state where people live. Further, they found that prices can even vary across a broad range within the same cites and metropolitan areas, based on site of service and contract rates. Those price differences exist for even the most routine diagnostic procedures.

Wide differences in the price for common medical services comprises one potential cost driver that BCBSTX works to impact. We believe that variability of pricing is a leading cause of unnecessary health care costs for our members. For example, an MRI of the brain can cost anywhere from $443 to $4,273 in Houston, TX.

Broad ranges in pricing across the state are found in common, as well as high-cost procedures. Moreover, there is no consistent correlation between cost and quality (i.e., higher cost does not necessarily equate to higher quality).

While many health care consumers may have yet to establish a habit of researching how much a procedure will cost them in advance, BCBSTX is working to change that behavior. Our BVA program provides educational resources to help members learn more about CAT scans, MRIs, endoscopy and colonoscopy procedures, as well as surgeries such as joint replacement and bariatric surgery.

Amy Barbour, a customer service specialist in the BVA program, says the typical member's mindset about health care is at odds with how Americans generally approach other choices. "While people would never dream of not knowing the price of a part for a car repair," she says, "in the medical world, not knowing the costs doesn't seem to throw them for a loop."

But Barbour believes things are slowly changing. "Ten years from now," she says, "I think it will be unheard of to not know health care costs in advance."

At BCBSTX, we believe that **cost and quality transparency and actionable data** will enable payers and providers to better collaborate on ways to help make health care more affordable. BCBSTX is rolling out new data solutions this year and next to help inform providers' clinical decisions and perhaps give them deeper insights into their care costs and quality.

Providers also will have increased electronic access to members' health summaries before or at the time of service. With access to these health summaries, providers may see unmet health care needs to address, or they may be able to avoid the cost and inconvenience of a member receiving redundant or unnecessary treatment.

Additionally, new performance and quality reporting will be made available to help providers pinpoint and prioritize opportunities for cost and quality improvements. These tools make information transparent and therefore can help identify factors that explain the cost impact caused by variability in pricing.
These are just a few examples of how BCBSTX is helping to make the health care system work better, together with providers, for the benefit of health care consumers.

Pediatricians Warning Against Teens Using Marijuana

With marijuana now legal for recreational or medical use in 29 states and the District of Columbia, access and attitude toward it are relaxing. According to Seth D. Ammerman, M.D., FAAP, co-author of the American Academy of Pediatrics (AAP) clinical report, *Counseling Parents and Teens About Marijuana Use in the Era of Legalization of Marijuana*, "Marijuana is not a benign drug for teens as their brains are still developing. Marijuana may cause abnormal brain development."[1] This study did not address the use of cannabis for the treatment of children who suffer from severe refractory seizures and other critical conditions.

Teens who use marijuana regularly may develop serious mental health disorders including addiction, depression and psychosis. It dulls sensory awareness, motor control, coordination, judgment and reaction time. Marijuana can impair lung function. It decreases short-term memory, concentration, attention span and problem-solving skills; all which can interfere with learning.[2]

Government data shows almost 40 percent of U.S. high school students have tried marijuana. About 20 percent are current users and close to 10 percent first tried it before the age of 13. While the use has increased in recent years among teens age 18 and older, it has not increased among younger teens. Still, kids ages 12-17 increasingly think that marijuana use is not harmful.[3]

If teens decide to use marijuana, they typically do so by the age of 19. Pediatricians must continue to be cognizant of the impacts of marijuana use on teens' developing bodies and minds. As marijuana is being promoted for medical purposes, pediatricians should continue their efforts to prevent the use by teens.
Also, today's marijuana is much more potent and potentially riskier. The potency of marijuana is defined as the percentage of tetrahydrocannabinol (THC) in the dry weight. In 1975, the average potency of THC was 0.71 percent, in 1997 it was 3.71 percent and in 2014 it was 12 percent. Current strains can contain concentrations as much as 20 percent.

A new report from the AAP encourages pediatricians to screen preteens and teens for substance use, and offer interventions and treatment referrals with reinforcement techniques to abstain and resist peer pressure.[4]

References

[1] Ammerman S, Ryan S; Committee on Substance Use and Prevention. *Counseling Parents and Teens About Marijuana Use in the Era of Legalization of Marijuana*; 2017.
[2] Volkow, Nora; Baler, Ruben; Compton, Wilson; Weiss, Susan; *The New England Journal of Medicine*, *Adverse Health Effects of Marijuana Use*; June 5, 2014.
[3] National Institute on Drug Abuse, National Institute of Health; *Monitoring the Future Survey: High School and Youth Trends*; December 2016.
[4] American Academy of Pediatrics; *Nation's Pediatricians Warn of Rising Risks to Youths from Loosening Marijuana Law;* 2017

In Every Issue – October 2017

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

Topics:

- Authorizations and Referrals
- Benefits and Eligibility
- Claims
- Clinical Resources
- Electronic Options
- Pharmacy
- Provider General Information
- Rights and Responsibility

Authorizations and Referrals

Real-time Preauthorization and Predetermination Notifications

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

Notifications are faxed to the number either on file, or listed on the utilization management or clinical request. You can also check the status of your submitted request via iExchange®.

As a reminder, because we are sending confidential protected health information (PHI) to your fax machine, it should be in a secure location that is not accessible to those who do not have the authority to review member/patient PHI.

If you do not wish to receive faxed notifications, please contact your BCBSTX Network Management Representative.

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

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

Reminder: Utilization Management Review

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

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

See the provider manual for guidance on provider requirements when requesting services. The final

determination about what treatment or services should be received is between the patient and their health care provider.

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iExchange® Accepts Electronic Medical Record Attachments

Providers can submit electronic medical records attachments when necessary in support of benefit preauthorization requests to iExchange, the Blue Cross and Blue Shield of Texas (BCBSTX) online tool that supports online benefit preauthorization requests for inpatient admissions, medical, behavioral health and clinical pharmacy services.

Electronic medical record documentation may also be submitted via iExchange for predetermination of benefit requests. iExchange offers providers and facilities a secure, online alternative to faxing their patients protected health information. Visit iExchange on BCBSTX's provider website for additional information.

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.

2017 Blue Essentials℠ Benefit Option Highlights

Earlier this year, Blue Cross and Blue Shield of Texas (BCBSTX) announced the name change of their HMO Blue Texas℠ network to Blue Essentials. BCBSTX appreciates your participation in the new network and is excited to share additional information about a few health plans with access to the network.

The Blue Essentials network will be coupled with plan designs that help manage costs, and allow flexibility and customization like predefined deductibles, coinsurance and copayments for certain health care services. Below are highlights of three health benefit plan options that access the Blue Essentials network.

Blue Essentials:

- Helps members manage costs because they are required to select a primary care physician and get referrals for services with network providers.
- Covers out-of-network coverage, except for emergency services.
- Provides emergency and urgent care when members are traveling out of state.
- Offers customer support and reference tools to guide members with making informed decisions about their benefits.

Blue Essentials Access℠

- Allows "open access" within the Blue Essentials provider network where primary care physician selection and referrals are NOT required (as of Jan. 1, 2017). This access gives opportunities to contracted physicians and hospitals throughout the state of Texas.

- Provides an alternative solution for members who are looking for cost savings while still having the freedom to choose in-network providers without selecting a primary care physician or obtaining a referral to see a specialist.
- Offers emergency and urgent care when members go out of network or are traveling out of state.

HealthSelect℠ of Texas and Consumer Directed HealthSelect℠ Plan Design

Beginning Sept. 1, 2017, BCBSTX is administering HealthSelect of Texas and Consumer Directed HealthSelect for the Employees Retirement System of Texas (ERS). Eligible participants will access care through the Blue Essentials provider network in all 254 counties in Texas.

Health Plans with Access to the Blue Essentials Network

Benefit Plan/ Product Name	Network Code	Network	Mid- & Large Market Availability	Retail & Small Group Availability	Network Coverage	PCP Required	Referral Required	OON Benefits	Plan Design
Blue Essentials	HMO	Blue Essentials	51-151 Fully Insured; 151+ Fully Insured & Self-funded/	N/A	State wide	Yes	Yes	No	HMO
Blue Essentials Access	HMO	Blue Essentials	51-151 Fully Insured; 151+ Fully Insured & Self-funded/	N/A	State wide	No	No	No	HMO Open Access
HealthSelect of Texas	HME	Blue Essentials	ERS – Effective 9/1/2017	N/A	State wide	Yes (for in-network benefit level)	Yes (for in-network benefit level)	Yes	POS
Consumer Directed HealthSel	HME	Blue Essentials	ERS – Effective 9/1/2017	N/A	State wide	No	No	Yes	Open Access HDH

Please note: If you are currently a participating provider in the Blue Essentials provider network, no action is required on your part. However, if you would like to be contracted for the Blue Essentials provider network, please go to the Blue Essentials Network Participation page on BCBSTX's provider website or contact your Network Management Representative.

Watch for additional information regarding Blue Essentials in future editions of this newsletter and on BCBSTX's provider website.

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

Blue Essentials℠, Blue Advantage HMO℠ and Blue Premier℠ members require a referral from their Primary Care Physician/Provider (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 Blue Essentials, 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 Blue Essentials and Blue Advantage HMO, and for Blue Premier and Blue Premier Access℠, is available on the BCBSTX Provider website under Clinical Resources "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 Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual for more detail including when to utilize the Out-of-Network Enrollee Notification Forms for Regulated Business and Non-Regulated Business. In addition, see article below titled: **Enrollee Notification Form Required for Out- of-Network Care for Blue Choice PPO℠** and **Blue Advantage HMO℠** (for Blue Advantage Plus).

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

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

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

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

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

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

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 an RQI. If criteria are not met, or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM's ProviderPortal℠ 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 Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.*

Importance of Obtaining a Preauthorization/Referral

A preauthorization/referral is required for certain types of care and services. Although Blue Cross and Blue Shield of Texas(BCBSTX) participating physicians, professional providers and facility and ancillary providers are required to obtain pre-authorizations/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.

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

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.

Are Utilization Management Decisions Financially Influenced?

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

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

Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO℠ Network Sharing?
All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan if the member sees a contracted BCBS MA PPO provider.

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

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

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?
You can recognize a BCBS MA PPO member when their Blue Cross and Blue Shield Member ID card has the following logo:

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

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

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

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

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

1. Log in to the Availity Web Portal, the Availity Revenue Cycle Management portal or your preferred vendor

2. Enter required data elements
3. Submit your request

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

What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?
If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

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

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

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

What if I disagree with the reimbursement amount I received?
If there is a question concerning the reimbursement amount, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

Who do I contact if I have a question about BCBS MA PPO network sharing?
If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

Claims

Reminder: Medicare Advantage Plans Overpayment Recovery

Applies to: Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠

As a reminder, a new process was implemented for overpayment recovery on claims processed after Jan. 1, 2017, for Blue Cross Medicare Advantage PPO and Blue Cross Medicare Advantage HMO. The process includes:

- The Electronic Refund Management and Claim Inquiry Resolution tools on Availity™ are no longer available for government program claims.
- Request for refund letters will be sent by mail for all providers.

Please review your refund letter closely and remit your refund to the address indicated on the letter. If you identify an overpayment and wish to send a voluntary refund, please use the following grid to determine the appropriate address:

Original Claim Check Date	Send to Address
Check Date prior to 1/1/17	Blue Cross and Blue Shield of Texas P.O. Box 731431 Dallas, TX 75373-1431
Check Date 1/1/17 or after	Blue Cross and Blue Shield of Illinois Claims Overpayment 29068 Network Place Chicago, IL 60673-1290

If you are unsure about the original payment date, please send payments to:

Blue Cross and Blue Shield of Texas
Box 731431
Dallas, TX 75373-1431

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.

Benefit Categories Contained in IVR Phone System

The list of common benefit categories contained within the Blue Cross and Blue Shield of Texas (BCBSTX) Interactive Voice Response (IVR) phone system has been expanded as of June 19, 2017, to include additional common benefit categories.

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

An updated IVR benefit containment list is below. This list outlines those categories that were effective on Dec. 12, 2016, along with the additional categories implemented June 19, 2017.

As a reminder, this information is continually reviewed and may vary across different BCBSTX networks, products and/or group policies. There were no other benefit categories being added to the Federal Employee Program (FEP) IVR Contained Benefits in June 2017. The current contained Benefit Category lists are shown below.

Contained Benefit Categories Effective Dec. 12, 2016	Additional IVR Contained Benefit Categories Effective June 19, 2017
Allergy Colonoscopy Consultations Coordinated Home Care Electrocardiogram (EKG) Extended Care Facility Hospital Inhalation Therapy Laboratory Mammogram Office Services Office Visit Pap Smear Physical Exam Preventive Care Private Duty Nursing Ultrasound X-ray	23-hour Observation Air Ambulance Anesthesia Assistant Surgeon CAT Scan Dialysis Ground Ambulance Hospice Medical Supplies MRI Pathology PET Scan Prosthetics Prostate-specific Antigen (PSA) Sterilization

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

Note: The above listings are not applicable to Blue Cross Medicare Advantage (PPO)℠ or Blue Cross Medicare Advantage (HMO) ℠ government program member policies. For eligibility and benefits for these government programs via phone, refer to the number on the member's BCBSTX identification card.

As a reminder, checking eligibility and benefits electronically through Availity™ or your preferred web vendor is the quickest way to access BCBSTX member information. To learn more about online solutions, see the Provider Tools section of the BCBSTX provider website.

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

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Clinical Payment and Coding Policies Now Online

BCBSTX is now publishing Clinical Payment and Coding Policies on our website. These payment and coding policies describe BCBSTX's application of payment rules and methodologies for CPT®, HCPCS and ICD-10 coding as applied to claims submitted for covered services. This information is offered as a helpful general resource regarding BCBSTX payment polices and is not intended to address all reimbursement related issues.

New policies have been posted and existing policies will be added over time. We regularly adjust clinical payment and coding policy positions as part of our ongoing policy review processes. Check this newsletter and the News and Updates section on our website for newly adapted or revised policies.

Update to After-hours and Weekend Care Codes Payment Policy

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

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

Effective Jan. 1, 2017, BCBSTX will no longer reimburse facility-based or non-office based providers for CPT Codes 99053, 99056 and 99060. These codes will be considered inclusive of the primary procedure. Please contact your Network Management Representative if you have any questions or if you need additional information.

ClaimsXten™ Quarterly Updates

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

Blue Cross and Blue Shield of Texas (BCBSTX) will normally load this additional data to the BCBSTX claim processing system within 60 to 90 days after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSTX provider website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) also will be posted on the BCBSTX provider website.

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

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the C3 page. Additional information may also be included in upcoming issues of the *Blue Review*.

Checks of eligibility and/or benefit information are not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

Additional Code-auditing Software

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

This software further enhances the auditing of professional and outpatient facility claims for correct coding according to the Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT®), and Centers for Medicare and Medicaid Services (CMS) guidelines. Providers may use the Claim Inquiry Resolution Tool, available on the Availity™ Web Portal, to research specific claim edits.

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

ConVergence Point is a trademark of Verscend Technologies, Inc., an independent third party vendor that is solely responsible for its products and services.

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

Technical and Professional Components

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

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

Surgical Procedures Performed in the Physician's Office

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

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in a physician's or professional provider's office. To help determine how coding combinations on a claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind Blue Cross and Blue Shield of Texas' (BCBSTX) code-auditing software. Refer to the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3.

Please note the physician's and professional provider's reimbursement includes surgical equipment that 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 since the global physician's or professional provider's reimbursement includes staff and equipment.

Improvements to the Medical Records Process for BlueCard® Claims

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

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

Contracted Providers Must File Claims

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

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

Billing for Non-Covered Services

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

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

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

Avoidance of Delay in Claims Pending COB Information

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

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

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

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

Hospitals, and Routine Services and Supplies

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

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

area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

Clinical Resources

eviCore™ Current and Expanded Preauthorization Requirements

Back in October 2016, Blue Cross and Blue Shield of Texas (BCBSTX) contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to begin providing preauthorization requirements for certain specialized services for Blue Advantage HMO℠. Over the coming months, additional BCBSTX products and services are being added as indicated below.

The following is a summary of the pre-service authorizations for specialized clinical services that eviCore will manage. Be sure to closely review the effective dates and services included for each individual product as they do vary.

Blue Cross Medicare Advantage (HMO)℠ and Blue Cross Medicare Advantage (PPO)℠
Effective June 1, 2017:

- **Outpatient Molecular Genetic**
- **Outpatient Radiation Therapy**
- **Musculoskeletal**
  - Chiropractic
  - Physical and Occupational Therapy
  - Speech Therapy
  - Spine Surgery (Outpatient/Inpatient)
  - Spine Lumbar Fusion (Outpatient/Inpatient)
  - Interventional Pain
- **Outpatient Cardiology & Radiology**
  - Abdomen Imaging
  - Cardiac Imaging
    - Chest Imaging
    - Head Imaging
    - Musculoskeletal
    - Neck Imaging
  - Obstetrical Ultrasound Imaging
  - Oncology Imaging
- **Pelvis Imaging**
  - Peripheral Nerve Disorders (Pnd) Imaging
  - Peripheral Vascular Disease (Pvd) Imaging
  - Spine Imaging
- **Outpatient Medical Oncology**
- **Outpatient Sleep**
- **Outpatient Specialty Drug**

Blue Choice PPO℠ and Blue Premier℠ Fully Insured Members* (identified by TDI listed on their membership card)
Effective Aug. 1, 2017:

- Molecular and genomic testing
- Radiation oncology for all outpatient and office services

**Currently, the eviCore preauthorization requirement does not include Administrative Services Only (ASO) Blue Choice PPO or Blue Premier members.*

Blue Essentials℠ and Blue Essentials Access℠ Fully Insured Members* (identified by TDI listed on their membership card)
Effective Sept. 1, 2017:

- Molecular and genomic testing
- Radiation oncology for all outpatient and office services
- Advanced radiology imaging
- Sleep studies and sleep durable medical equipment

**Currently, the eviCore preauthorization requirement does not include Administrative Services Only (ASO) Blue Essentials or Blue Essentials Access members.*

Employee Retirement System of Texas (ERS): HealthSelect of Texas and Consumer Directed HealthSelect
Effective Sept. 1, 2017:

- Molecular and genomic testing
- Radiation oncology for all outpatient and office services
- Advanced radiology imaging
- Sleep studies and sleep durable medical equipment

Blue Advantage HMO and Blue Advantage Plus℠ HMO
Effective Oct. 3, 2016:

- Outpatient Molecular Genetics
- Outpatient Radiation Therapy

The updated Preauthorization/Referral/Notification Requirements Lists and the Prior Authorization and Referral List for ERS can be found on the Clinical Resources page of BCBSTX 's provider web site. These lists include the services that require preauthorization or prior authorization through eviCore for the effective dates listed above.

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

Preauthorization or ERS prior authorization through eviCore can be obtained using one of the following methods:

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

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

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

If you have any questions, please contact your BCBSTX Network Management Representative.

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

as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

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

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

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

Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

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 Blue EssentialsSM members, Blue Premier and Blue Advantage HMOSM members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) Blue Choice PPOSM subscribers. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

Quest Diagnostics Offers:

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

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

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

**Note: Physicians, professional providers or facility and ancillary providers who are contracted/affiliated with a capitated IPA/medical group and physicians, professional providers or facility or ancillary providers who are not part of a capitated IPA/medical group but who provide services to a member/subscriber whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.*

Medical Necessity Review of Observation Services

As a reminder, it is the policy of Blue Cross and Blue Shield of Texas (BCBSTX) to provide coverage for observation services when it is determined to be medically necessary based on the medical criteria and guidelines as outlined in the Milliman Care Guidelines. Claims for observation services are subject to post-service review, and BCBSTX may request medical records for the determination of medical necessity.

When medical records are requested, documentation should include the following information:

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

Coordination of Care Between Medical and Behavioral Health Providers

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

The Coordination of Care Form Available Online

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

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

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

If You Need Help Finding Behavioral Health Providers for Your Patients

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

Behavioral Health or Medical Case Management Services

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

Electronic Options

Multiple Online Enrollment Options Available in Availity™

Blue Cross and Blue Shield of Texas (BCBSTX) offers you multiple enrollment opportunities for electronic options through the Availity Web Portal. This is in addition to other electronic transactions available to you through Availity or your preferred web vendor portal. Instead of faxing or mailing paper enrollment forms, you can complete the online enrollment options listed below through Availity at no cost. Availity also provides single sign-on access to several online tools that offer greater convenience and security, without the need for another user ID and password.

Online Enrollment for EFT and ERA

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

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

Single Sign-on Access

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

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

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

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

Learn More

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

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

Register with Availity

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

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

**This excludes atypical providers who have not acquired a National Provider Identifier (NPI).*

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

Availity™ Claim Research Tool Offers Enhanced Status Results

Using an electronic route, such as the Availity Claim Research Tool (CRT), is the most convenient, efficient and secure method of requesting detailed claim status. The CRT tool now returns more detailed information than ever before.

The CRT allows registered Availity users to search for claims by member ID, group number and date of service, or by National Provider Identifier (NPI) and specific claim number, also known as a Document Control Number (DCN). With easy-to-read denial descriptions, the tool enables users to check the status of multiple claims in one view to obtain real-time claim status.

The CRT Search Results page now delivers the rendering provider ID and name submitted on the claim. Additionally, the claim status Service Line break-down returns:

- Diagnosis Code
- Copay
- Coinsurance
- Deductible
- Modifier
- Unit or Time or Mile

This necessary information is available within a few clicks, lessening the need to speak with a Customer Advocate. For additional information, refer to the CRT tip sheet, which can also be found on the Provider Tools page in the Education & Reference section of our provider website. As a reminder, you must be registered with Availity to utilize the CRT. For registration information, visit availity.com, or contact Availity Client Services at 800-282-4548.

Learn More About Availity
We host complimentary webinars for providers to learn how to use the CRT and other electronic tools to their fullest potential. You do not need to be an existing Availity user to attend a webinar. Go to our Provider Training website to view available webinars.

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 a Back to Basics: Availity 101 webinars.

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

Corrected Claim Request Change, Effective as of July 11, 2016

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

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

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

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

Paper Submission
More than 98 percent of the claims BCBSTX receives from providers are submitted electronically. BCBSTX encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer web vendors available to providers. If you are a registered Availity® 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.

Pharmacy

Reminder: Pharmacy Program Benefit Changes – Effective Jan. 1, 2017

Blue Cross and Blue Shield of Texas (BCBSTX) implemented pharmacy benefit changes on Jan. 1, 2017, for

some members with prescription drug benefits administered through Prime Therapeutics®.

Based on claims data, letters are sent from BCBSTX to alert members who may be affected by one or more of the 2017 pharmacy benefit changes. A summary of the changes, as outlined in the member letters, is included below for your reference.

Drug List Changes and Medication Coverage Revisions/Exclusions
Some members' plans may now be based on a new drug list:

1. **New Performance Drug List and Performance Select Drug Lists** – Some members may have one of these new drug lists, which are closed drug lists listing all covered medications only. As a result, some medications will move to a higher copay/coinsurance payment tier and select drugs/drug classes may be excluded from coverage. Additionally, if your patients had a prior authorization approval for a drug that is now excluded from coverage, you can submit a drug list coverage exception request to BCBSTX. Your patients may also ask you about therapeutic alternatives.
2. **Enhanced Drug List *(formerly known as Generics Plus Drug List)*** – Some members may move to this drug list, and as a result, select medications may move to a higher copay/coinsurance payment tier. Your patients may ask you about generics or lower cost alternatives.
3. Some members may also be affected by **annual or quarterly drug list changes**, such as drugs moving to a higher payment tier or excluded from coverage. Your patients may ask you about therapeutic or lower cost alternatives.
4. The **Standard Drug List** is now known as the **Basic Drug List**.
5. As a reminder, medications that have **not received FDA approval** are **not covered** under the BCBSTX pharmacy benefit.

Utilization Management Program Changes
Some members' plans may now be subject to new prior authorization and step therapy programs and/or dispensing limits. If you have a patient who is taking select medications included in these programs, he/she may need to meet certain criteria, such as an approval of a prior authorization request, for coverage consideration. Additionally, these programs may correlate to your patient's drug list.

Specialty Drug Changes
Starting Jan. 1, 2017, members with an individual benefit plan offered on/off the Texas Health Insurance Marketplace who are using a drug manufacturer's coupon or copay card will not have the specialty drug payment applied to their plan deductible or out-of-pocket maximum. This is unless the coupon is a permitted third-party cost-sharing payment. Your patients can contact BCBSTX if they have questions about this change.

Pharmacy Network Changes
Some members' plans may experience changes to the pharmacy network:

1. **CVS Exclusion** – Effective Jan. 1, 2017, CVS pharmacies™ and CVS pharmacies in a Target® store were removed from most members' pharmacy network.
2. **New Pharmacy Networks** – Some members' plans may move to a preferred network where prescriptions filled at these preferred tiered pharmacies offer the lowest copay/coinsurance amounts. 90- day supplies can also be filled at these preferred tiered pharmacies or through mail order for coverage consideration.

Members who continue to fill prescriptions at a pharmacy no longer in their network will pay more. In most cases, no action is required on your part for any of these pharmacy network changes as members can easily transfer prescriptions to a nearby in-network pharmacy. If your office stores pharmacy information on your patients' records, you may want to ask your patients which pharmacy is their new choice.

If your patients have questions about their pharmacy benefits, please advise them to call the Pharmacy Program phone number on their member ID card. Members also may visit bcbstx.com and log in to Blue Access for Members℠ for a variety of online resources.

**Changes to be implemented, as applicable, based on the member's 2017 plan renewal, or new plan effective date, unless otherwise noted. These changes do not apply to members with Medicare Part D or Medicaid coverage.*

A "preferred" or "participating" pharmacy has a contract with BCBSTX or BCBSTX's pharmacy benefit manager (Prime Therapeutics) to provide pharmacy services at a negotiated rate. The terms "preferred" and "participating" should not be construed as a recommendation, referral or any other statement as to the ability or quality of such pharmacy. Please note that changes to participating pharmacies may be made in the future.

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 and pharmacy choice is between the member and their health care provider.

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. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSTX and contracting pharmacies is that of independent contractors. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Pharmacy Benefit Tips

For Blue Cross and Blue Shield of Texas (BCBSTX) members with prescription drug benefits administered by Prime Therapeutics®, BCBSTX employs several strategies common to the health benefits industry to manage prescription drug benefits. These strategies may include formulary management, benefit design modeling, specialty pharmacy benefits, and clinical programs, among others. These programs allow BCBSTX members to have access to affordable quality health care. You can help support these initiatives by following the tips, guidelines and reminders below:

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

BCBSTX drug lists are regularly updated and can be found 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

Remind Patients about Covered Preventive Medications

Many BCBSTX health plans include coverage at no cost to the member for certain prescription drugs and over-the-counter (OTC) medicine products used for preventive care services and women's contraception.*

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.*

Submit 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.

Assist 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 may 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.

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 drug or classification of drugs is not a guarantee of benefits.

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

Dispensing QVT (Quantity Versus Time) Limits
To help minimize health risks and to improve the quality of pharmaceutical care, dispensing QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer's package insert.

For current Drug List Dispensing Limits, visit Pharmacy Program/Dispensing Limits on the BCBSTX provider website.

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

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

Provider General Information

Medicare Outpatient Observation Notice Requirement

Applies to: Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM
The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and critical access hospitals (CAH) to provide notification to individuals receiving observation services as outpatients for more than 24 hours.

Hospitals and CAHs are required to give the CMS-developed standardized notice – the **Medicare Outpatient Observation Notice (MOON)** – to a Medicare beneficiary or enrollee who has been receiving observation services as an outpatient for more than 24 hours. The notice must be provided no longer than 36 hours after observation services are initiated. To obtain a copy, visit the CMS website and then scroll down for copies of the CMS MOON instructions and forms in both English and Spanish.

The MOON will inform nearly one million beneficiaries annually of the reason the individual is an outpatient receiving observation services and the implications of observation services on cost sharing.

An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice. A signature must be obtained from the individual (or an individual qualified to act on their behalf) to acknowledge the receipt and understanding of the notice (or in cases of refusal of signature by such individual, signature by the staff member of the hospital or CAH providing the notice).

If you have any questions or if you need additional information, please contact your BCBSTX Network Management Representative.

Provider Training

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

After-hours Access Is Required

Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians/providers, specialty care physicians, professional providers, and facility and ancillary providers provide urgent care, and emergency care or coverage for care 24 hours a day, seven days a week. Providers must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

Acceptable after-hours access mechanisms may include:

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

For more detail, please refer to the provider manuals for Blue Choice PPOSM Physician, Professional Provider and Facility and Ancillary Provider Manual (Section B) and Blue, Blue Premier Physician, Professional Provider, Facility and Ancillary Provider Manual (Section B) available in the Education & Reference section of our provider website. Click on the "Manual" link (note, a password is required).

Medical Record Requests: Include Our Letter as Your Cover Sheet

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

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

Thank you for your cooperation!

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 Blue EssentialsSM members and Blue Advantage HMO^{SM} subscribers* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) Blue Choice PPO^{SM} 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 Blue Essentials members. Please note all other lab services/tests performed in the physician's or professional 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.*

Medical Policy Disclosure

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

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

Draft Medical Policy Review

To streamline the medical policy review process, you can view draft medical policies on the Blue Cross and Blue Shield of Texas (BCBSTX) provider website and provide your feedback online. If there are any draft medical

policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

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.

Rights and Responsibilities

Blue Choice PPO℠ Subscribers/Blue Advantage HMO℠ Member Rights and Responsibilities

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

Rights **Responsibilities**

Subscriber(s)/Member(s)	Subscriber(s)/Member(s)
You have the right to:	**You have the responsibility to:**
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, 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.

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/provider (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency or services are performed by your HMO participating OBGyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, to care for you. Including changes in your family status, address and phone numbers within 31 days of the change.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Notify your primary care physician/provider or HMO plan within 48 hours or as soon as reasonably possible after receiving emergency care services.
- Communicate complete and accurate medical information to health care providers.
- Call in advance to schedule appointments with your network provider and notify them prior to canceling or rescheduling appointments.
- Read your coverage documents for information about benefits, limitations, and exclusions.
- Ask questions and follow instructions and guidelines given by your provider to achieve and maintain good health.

Understand your health problems and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

Contact Us

View our quick directory of contacts for BCBSTX.

Update Your Information

Do you need to update your location, phone number, email or other important details on file with BCBSTX? Use our online forms to request information changes.

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bcbstx.com/provider