February 2018

CLINICAL RESOURCES

2018 Preauthorization List Updates

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

This notice has been updated to include a change to the Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Advantage℠ Current Procedural Terminology (CPT®) Preauthorization Code List.

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 were effective Jan. 1, 2018. If you are not participating in the Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO) networks, disregard the information pertaining to that plan.

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 have been updated to include the services that require preauthorization through BCBSTX and eviCore. The updated preauthorization lists are located on bcbstx.com/provider under Clinical Resources. For specific codes that apply, refer to the BCBSTX Medicare Advantage CPT Preauthorization Code List which was updated with a change to **no longer require preauthorization for the initial evaluation for procedure codes 97161-97163 and 97165-97167**. Requests for preauthorization for ongoing care may be submitted as early as seven days prior to the requested start date.

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 is 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.

HMO Plans – PCP Selection and Referral Requirements

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

- Blue Advantage HMO℠
- Blue Advantage Plus℠
- Blue Essentials℠
- Blue Essentials Access℠
- Blue PremierSM
- Blue Premier Access℠

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

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

The following table defines when a PCP and referrals to specialists (except OB-GYN) are required and when they are not required. (Note: Members can self-refer to OB/GYNs – no referrals are required.)

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

If an in-network physician, professional provider, ambulatory surgery center, hospital or other facility is not available in the member's applicable provider network, preauthorization is required for services by an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility, through either iExchange® or by calling the preauthorization number on the back of the member ID card.

Sample HMO ID cards and other benefit plan ID cards are available on the BCBSTX provider website.

Reminders:

- The Blue Essentials, Blue Advantage HMO and Blue Premier physician, professional provider, facility or ancillary providers are required to admit a patient to a participating facility, except in emergencies.
- Additional services for all HMO plans may require preauthorization. A complete list of services that require preauthorization is available on the BCBSTX provider website under Clinical Resources/Preauthorization/Notification/Referral Requirements Lists.
- Blue Advantage Plus and Blue Essentials Access are benefit plans that allow members to use out-of-network providers. However, members must understand the financial impact of receiving services from an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility.

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

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.

Annual Medical Record Data Collection for Quality Reporting Begins Feb. 1, 2018

Blue Cross and Blue Shield of Texas (BCBSTX) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS®) and the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS). HEDIS is the most widely used and nationally accepted effectiveness of care measurement available and the HHS requires reporting of QRS measures. These activities are considered health care operations under the Health Information Portability and Accountability Act Privacy Rule and patient authorization for release of information is not required. Additionally, Texas state law (Chapter 108 of the Texas Health and Safety Code) requires Health Maintenance Organizations in Texas to report HEDIS data, by service area to the Department of State Health Services on an annual basis.

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

A representative from BCBSTX or from our contracted vendor, CIOX, may be contacting your office or facility between February 2018 and May 2018 to set up appointments for onsite visits or to set up an expected delivery date via fax, provider portal or U.S. Mail. As part of the request, you will receive a letter introducing the background and authorizing agencies for the HEDIS and QRS data request, a medical record request list with members' names and other identifying demographics, and the medical record

information needed for identified measures. If you have any questions about medical record requests, please contact the representative listed on the provider letter requesting the medical record information.

HEDIS is a registered trademark of NCQA.

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

Behavioral Health Program Changes for Boeing Members, Effective Jan. 1, 2018

The Boeing Company (Boeing) has made the decision to change administrators for its Behavioral Health (Mental Health and Substance Abuse) benefits offered under Boeing-sponsored health care plans. The previous administrator was Beacon Health Options.

As of Jan. 1, 2018, Boeing plan members' behavioral health benefits are now administered through Blue Cross and Blue Shield of Texas(BCBSTX). Boeing members received notification of this transition beginning in August 2017. Additional member communications on the topic were mailed through December 2017. Member ID cards were updated with BCBSTX Behavioral Health contact information and mailed to members in December 2017. Boeing members were advised that they will need to utilize BCBSTX contracted providers, effective beginning Jan. 1, 2018.

If you treat patients who are Boeing members, please follow your normal process for checking eligibility and benefits, obtaining benefit preauthorization, using our Provider Finder® to assist with in-network referrals, and submitting claims for BCBSTX members. If you or your patients have questions, contact the number on the member ID card for assistance.

Beacon Health Options is an independent company that is contracted through Boeing. Beacon Health Options does not provide BCBSTX products or services. Beacon Health Options is solely responsible for the products and services it provides.

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

Skilled Nursing Facility (SNF) Benefit Change for Federal Employee Plan (FEP)

How do you treat a senior patient with an **FEP Standard Option health plan** who is not enrolled in Medicare Part A and needs rehabilitation that a nursing home does not offer? Starting Jan. 1, 2018, these patients will be covered for up to 30 days per benefit year of inpatient SNF care.

Here are some requirements that you need to know:

- The patient must be enrolled in Blue Cross and Blue Shield of Texas' (BCBSTX) **case management program** before being admitted to an SNF.
- Per the Federal Employee Health Benefit Plan, before pre-certifying the SNF admission, a patient's signed consent to be enrolled in the case management program must filed with BCBSTX. When the patient transfers from an acute care facility, discharge staff will collaborate with the BCBSTX case manager to ensure the consent paperwork is completed by the patient or the patient's guardian.

- When applying for precertification, the requesting provider and discharging acute care facility must submit a detailed description of the patient's clinical status and proposed treatment plan to BCBSTX for review. The treatment plan includes:

    - Rationale for inpatient care
    - Estimated length of stay
    - Medical and rehabilitation therapies to be provided during the stay, including frequency
    - Preliminary short and long-term goals
    - Plan for discharge, including discharge location and ongoing care

- An SNF representative must provide BCBSTX with updates on the patient's status at least every seven days. Updates convey progress toward goals, as well as changes to the treatment and the discharge plan.

- The SNF's attending physician must write the admission orders **within 24 hours** of a patient's admission.

- **Within 16 hours** of admission, patients who are admitted primarily for rehabilitation must be seen by a physical therapist and have a treatment plan in place. These patients must get at least two hours of physical and occupational therapy, a minimum of five days per week. Documentation must be provided to BCBSTX.

- **Within 12 hours** of admission, patients on a ventilator must be seen by a pulmonologist. Respiratory therapy must always be available.

For benefit approval, a patient's information can be faxed to BCBSTX at 877-404-6455.

The new utilization management guidelines for SNF services have been added to the FEP Medical Policy Manual. This manual is available to members at www.fepblue.org.

If you have any questions regarding this update or to verify a patient's eligibility, please call FEP Customer Service at 800-972-8382.

Preventive Care Guidelines Are Available

Each year, recommendations from the Centers for Disease Control and Prevention, the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and other professional organizations are reviewed by medical staff at Blue Cross and Blue Shield of Texas (BCBSTX) to update the Preventive Care and Wellness Guidelines related to preventive care, health screenings and immunizations.

The guidelines offer specific recommendations and should be considered for:

1. Children from birth to 17 years
2. Adults 18 years and older
3. Adults 65 years and older

The 2017-18 Preventive Care Guidelines are available on the BCBSTX website.

The guidelines indicate that recommendations may vary, especially if there are risks involved. In addition, recommendations are not intended as medical advice, nor meant to be a substitute for your individual medical judgement or that of other health care professionals. Members are directed to their physician for individualized advice on the recommendations provided.

If you have questions or comments about the guidelines, please contact the Quality Improvement Programs department at 800-863-9798.

Requesting Predetermination of Benefits

As a reminder, predetermination of benefits requests may be **submitted electronically** to Blue Cross and Blue Shield of Texas (BCBSTX) through iExchange®, our online benefit preauthorization and predetermination of benefits tool. Providers may also upload attachments, check status and obtain online approval information via iExchange. This online tool is available to physicians, professional providers and facilities contracted with BCBSTX. iExchange may be accessed directly or through the Availity™ Web Portal and is designed to help save you time by reducing the amount of calls and written inquiries submitted to BCBSTX.

If you need to submit a paper predetermination of benefits request to BCBSTX, it is important to send the pertinent medical documentation using our Predetermination Request Form. This form and others are available in the Education & Reference Center/Forms section on the BCBSTX provider website.

Beginning Dec. 1, 2017, written predetermination requests must be submitted using the Predetermination Request Form. Beginning Jan. 1, 2018, paper requests that are received by BCBSTX without the Predetermination Request Form will be returned to the submitting provider, along with instructions to resend the request using the appropriate form.

Checking eligibility and benefits is always an important first step, prior to submitting predetermination of benefits and other pre-service requests. Eligibility and benefits requests may be submitted electronically through Availity or your preferred web vendor. **Predetermination of benefits requests are not a substitute for the eligibility and benefits process.**

To learn more about iExchange and other electronic options, visit the Provider Tools section in our online Education & Reference Center. For personalized online training regarding electronic tools, contact our Provider Education Consultants at PECS@bcbstx.com.

Note: This information does not apply to Blue Cross Medicare Advantage HMO℠ or Blue Cross Medicare Advantage PPO℠ members.

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

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 provides collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or Medecision. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

Preauthorization and Referral Requirements Lists Changed Jan. 1, 2018

As of Jan. 1, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) changed the preauthorization requirements for Blue Choice PPO℠, Blue Essentials℠, Blue Essentials Access℠, Blue Premier℠ and Blue Advantage HMO℠.

The changes include **three new health advocacy solutions 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.

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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2018 Updates to the Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMOSM 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.

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Know the Requirements for Preauthorization/Prior Authorization Rules and Retrospective Reviews for Medical Necessity

Certain services require preauthorization/prior authorization and the requirements are specific to each BCBSTX network. BCBSTX posts the Preauthorization/Notifications/Referral Requirements Lists for all of its networks (e.g., Blue Advantage HMOSM, Blue EssentialsSM, Blue PremierSM, etc.) on the BCBSTX provider website. Preauthorization/prior authorization are required to allow for medical necessity review. Claims for services rendered without preauthorization/prior authorization for services requiring it will be denied and providers will be held responsible. Please be aware, retrospective reviews for medical necessity will not be performed for any HMO plans except in limited special circumstances.

CLAIMS & ELIGIBILITY

Electronic Commerce Services Hours Update; Educational Webinars Available

Blue Cross and Blue Shield of Texas (BCBSTX) supports the use of Electronic Data Interchange (EDI) transactions and related online tools for increased security and efficiency of daily operational, financial and administrative processes. We want to make it easier for you to conduct business with us and electronic solutions can help.

BCBSTX's Electronic Commerce Services Center is available to assist if you have questions or if you experience issues with EDI transactions or online tools. Beginning March 5, 2018, the Electronic Commerce Services Center hours of operation will change to the following schedule:

- Monday through Thursday – 8 a.m. to 4:30 p.m. CT
- Friday – 8:30 a.m. to 3 p.m. CT

You may contact our Electronic Commerce Services Center for assistance by emailing ecommerceservices@bcbstx.com or calling 800-746-4614. If sending an email, make sure to include any pertinent information needed to research your issue.

Educational Webinars

To learn more about EDI transactions and other electronic options available to providers, refer to the Electronic Commerce page on the BCBSTX provider website. BCBSTX also hosts educational webinars to assist you with getting connected, and navigating online tools and resources. To register for currently available sessions, click on the links below to locate a convenient date and time.

- Availity™
- Remittance Viewer

Be sure to check back to the BCBSTX provider website for future sessions added to the Educational Webinar Sessions page.

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Zero Copay for Preventative Services Reminder

Are you up to date on preventive services benefits? Blue Cross and Blue Shield of Texas (BCBSTX) would like to remind you that there are no copays for preventative services for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠. Blue Cross Medicare Advantage covers a full range of preventive services to help keep patients healthy, help find problems early and determine when treatment is most effective.

Physicians should let members know which of these services is right for them. For a detailed list of the services with zero copay you may access: Are You Up-To Date on Your Preventive Services. In addition, you should check eligibility and benefits electronically through Availity™ or your preferred Web vendor.

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

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Processing Claims for Preventive Colonoscopies

Accurate claims billing is essential to receiving correct payment for a preventive care service like a diagnostic colonoscopy. The initial reason a procedure was performed determines whether it is covered without member cost-sharing. For example, when the initial reason for a colonoscopy is to screen for colorectal cancer, it is considered preventive under the United States Preventive Services Task Force (USPSTF) guidelines that drive ACA requirements. That procedure should be billed using the applicable CPT modifier 33. However, the CPT modifier 33, does not apply to non-preventive colonoscopies, such as those done to evaluate or follow up on signs, symptoms or pre-existing conditions.

Currently for HealthSelect℠ of Texas, Consumer Directed HealthSelect℠ of Texas, HealthSelect℠ and Consumer Directed HealthSelect℠ Out-of-State, the prior authorization requirement is waived for preventive colonoscopies performed by in-network providers when the intent of the procedure is preventive and billed with modifier 33, regardless of the findings.

Tips on Using Modifiers for Preventive Services

Sometimes it can be difficult to know when to use which modifiers. Here are some tips that may help:

- If the purpose of the procedure is to screen for colorectal cancer and the service becomes diagnostic during the procedure, modifier 33 may be used.
- Modifier 33 is not used for non-preventive colonoscopies or other non-preventive procedures.
- A colonoscopy procedure will process at the no-cost sharing benefit level as long as modifier 33 is present.
- Colonoscopies not billed with one of the preventive modifiers will not be processed as a preventive screening.

Frequently Asked Questions about Preventive Colonoscopies

1. What colonoscopy procedures is BCBSTX defining as preventive?

A service associated with a screening colonoscopy must pay at the preventive benefit level. If a procedure is billed as a screening, colonoscopy benefits will be applied as preventive based on the intent of the test and not on the findings. If a problem is found during the screening and a procedure is performed to address the problem (such as polyp removal), the claim will still be paid as preventive with no cost sharing – as long as it has been billed with modifier 33. If the procedure is not billed as preventive, it will not be paid as a preventive screening.

2. What services are considered part of the screening colonoscopy?

- Colonoscopy screening procedure
- Pathology services
- Anesthesiology (if necessary)
- Outpatient facility fee

A service that is directly related to a screening colonoscopy is considered to be part of the screening colonoscopy.

3. Will BCBSTX adjust a claim for a colonoscopy?

If a member advises that a colonoscopy was intended to be preventive, BCBSTX will research the claims history and potentially adjust the claim, if applicable. There are a number of factors that could impact the way BCBSTX will reimburse for a colonoscopy procedure. Reasons that may lead to the claim being paid

with member cost-sharing include number of visits; age limits; use of a non-network provider; procedure billed as diagnostic or medical; symptoms or history.

The provider may need to submit a corrected claim if they did not bill the colonoscopy as preventive when, in fact, it was a preventive procedure.

4. What if a problem is found during the colorectal screening? Does it change the way the claim is paid?
If a procedure is billed as a preventive screening, BCBSTX will assume that colonoscopy benefits should be applied based on the intent of the test and not on the findings. If a problem is found during the screening and a procedure is performed to address the problem (such as polyp removal), the claim will still be paid as preventive with no member cost sharing – as long as it has been billed using the appropriate preventive modifiers. If the procedure is not billed as preventive, it will not be paid as a preventive screening.

5. For Texas plans that include a prior authorization requirement, how are colonoscopies handled?
Providers should refer to the current preauthorization/prior authorization requirements lists to determine if authorization is required for colonoscopies.

For more information about the USPSTF recommendation on screening for colorectal cancer see http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm.

This material is for informational purposes only and is not the provision of legal advice. If you have any questions regarding the law, you should consult with your legal advisor.

Verification of eligibility and/or benefit information 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.

MAO Coverage of Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease PAD)

The Centers for Medicare and Medicaid Services (CMS) has determined the cost and reimbursement for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) will be covered, for calendar years 2017 and 2018 only, by original fee-for-service Medicare. Providers should bill necessary SET items and services obtained by beneficiaries enrolled in MA plans to original fee-for-service Medicare. For 2019 and subsequent years, providers should plan to bill SET items and services to the beneficiaries' MA plan unless notified otherwise."

Consistent with $1862(a)(1)(A) of the Act, Medicare Administrative Contractors will consider whether SET for PAD services are reasonable and necessary and reimbursable by original Medicare for Medicare beneficiaries enrolled in MA plans in CY 2017 and 2018.

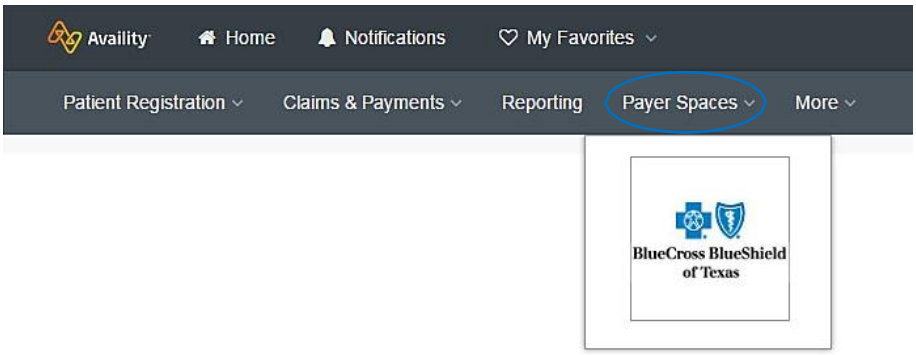
Please review the CMS guidance article as soon as possible.

Find BCBSTX Resources in Availity™ Payer Spaces

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

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

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



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

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

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

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

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Government Programs: 835 Electronic Remittance Advice (835 ERA) Update

This notice applies to government programs providers servicing the following Blue Cross and Blue Shield of Texas (BCBSTX) members:

- Blue Cross Medicare Advantage℠*
- STAR, STAR Kids and CHIP

This an update to a March 2017 announcement, which advised that missing ERA files could not be reloaded for claims submitted for members enrolled in any of the above-referenced Medicare Advantage and BCBSTX Medicaid plans. Therefore, impacted providers were instructed to refer to the paper Provider Claim Summary (PCS) sent by regular mail for remittance information on government programs claims.

Effective Nov. 30, 2017, government programs providers enrolled to receive the 835 ERA from BCBSTX may request redelivery of missing ERA files, to their designated receivers, issued since Jan. 1, 2017. Please note that ERA files originally issued prior to Jan. 1, 2017 cannot be reloaded. To request redelivery of ERAs for government programs claims, you may contact Provider Customer Service at the number on the member's ID card. Paper PCSs will continue to be mailed for providers who are not enrolled for ERA.

Not enrolled for ERA? Providers may enroll online for ERA and also make any necessary set-up changes through the Availity™ Web portal at no cost. 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. To register for Availity, visit their website at availity.com and complete the online application today.

For more information on 835 ERA enrollment and related topics, visit the Electronic Commerce / EFT & ERA section of our Provider website.

**Including the product types of HMO, PPO, HMO-POS and HMO-SNP (if applicable).*

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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, SV101-2 = [CPT/HCPCS code]	Loop 2400, SV202-1 = HC Loop 2400, SV202-2 = [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.

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EDUCATION & REFERENCE

Colon Cancer Screenings Goal: 80% Member Participation in 2018 – Will You Commit?

In collaboration with the American Cancer Society and the National Colorectal Cancer Roundtable, Blue Cross and Blue Shield of Texas (BCBSTX) and Dr. Esteban López, BCBSTX Chief Medical Officer, have signed a pledge to have 80 percent of our members ages 50-75 screened for colorectal cancer (CRC) by the end of 2018.

Dr. López said, "Overall health is important to us at Blue Cross and Blue Shield of Texas. We strongly encourage all our members age 50 and older to get screened for colon cancer. Members younger than 50 with risk factors for colon cancer may need screening starting at an earlier age. We are reaching out to you, as their providers, to help get the word out and to make colorectal cancer screening a priority."

How far away are we from reaching this goal? In 2017, the National Healthcare Effectiveness Data and Information Set (HEDIS®) PPO average was 58.3 percent compared to BCBSTX's commercial PPO HEDIS result of 50 percent.

We need your help to reach this goal! Over the next few months we will be providing articles on CRC screenings, as well as barriers to those screenings. These articles will provide useful information such as:

- CRC screening test options and selections most suitable for your patients
- Overcoming barriers to CRC screenings

What influences these results? You do! The biggest influencer to motivate patients to get screened is you and your staff. Identify your patients who need it, talk to them about the importance of CRC screenings and then get them screened! Once this happens, they can be easily tracked for annual follow-up.

What actions can you take to make a difference?

- Easily identify patients by using colored folders or flagging the EMR for those ages 50-75 and start that conversation.
- Have standing orders for CRC screenings for those ages 50-75 and follow through with them.
- Direct your most persuasive and educated staff to answer questions and concerns, and help patients commit and complete CRC screenings.

HEDIS is a registered trademark of NCQA.

2017 Annual HEDIS® and QRS Reports

Blue Cross and Blue Shield of Texas (BCBSTX) has a quality improvement program (QIP) to better serve our members. The purpose of the QIP is to monitor and help improve the care and service our members receive from BCBSTX contracted providers. We focus on preventive health, safety and condition management. QIP helps meet the needs of our members in our Blue Essentials℠ HMO, Blue Advantage HMO℠ and Blue Choice℠ PPO Small Business Health Options Program (SHOP) health plans.

There is a standard way to measure important areas of care and service called Health Care Effectiveness Data and Information Set (HEDIS). These measures were developed by the National Committee for Quality Assurance, and are widely used to measure health care performance in the U.S.

The Centers for Medicare & Medicaid Services has a similar set of measures called the Quality Rating System (QRS). These measure similar areas of care and are specifically for members enrolled in Marketplace health care plans.

Through the QIP, BCBSTX measures how we are doing against the goals we've set. The table below summarizes how we are doing on selected measures.

Care Provided to BCBSTX Members	2017 Quality Compass National Average	HEDIS Rates: Blue Essentials HMO	QRS Rates: Blue Advantage HMO	QRS Rates: BlueChoice PPO SHOP PPO
Prevention and Screening				
Childhood Immunization • Combination 3 Rate: 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV	73%	55%	73%	85%
Breast Cancer Screening	71%	61%	57%	67%
Cervical Cancer Screening	74%	67%	47%	66%
Colorectal Cancer Screening	60%	38%	38%	54%
Respiratory Conditions				
Appropriate Testing for Children with Pharyngitis	84%	81%	72%	83%
Medication Management for People with Asthma • Total – Medication Compliance 75%	49%	43%	48%	60%

Comprehensive Diabetes Care				
Comprehensive Diabetes Care • Hemoglobin A1c (HbA1c) Testing • HbA1c Control (<8.0%) • Eye Exam (retinal or dilated exam) • Medical Attention for Nephropathy	90% 51% 51% 89%	84% 28% 21% 88%	89% 48% 34% 89%	89% 42% 36% 87%
Overuse/Appropriateness				
Appropriate Treatment for Children with Upper Respiratory Infection	88%	75%	76%	82%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	28%	22%	19%	7%
Medication Management				
Annual Monitoring for Patients on Persistent Medications – Total	83%	84.5%	86%	85%
Prenatal/Postpartum Care				
Prenatal and Postpartum Care • Timeliness of Prenatal Care • Postpartum Care	81% 70%	65% 32%	80% 66%	82% 56%

Results are rounded to the nearest percentage. HEDIS is a registered trademark of NCQA

Provider Manual Update

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

New Addition

We added section M to our Blue Essentials℠, Blue Advantage HMO℠ and Blue Premier℠ Provider Manual, which is for the Employee Retirement System of Texas (ERS) Participants Benefit Plan using the Blue Essentials Network. This is an additional resource designated to assist you with ERS HealthSelectSM and Consumer Directed HealthSelect℠ participants who became eligible with BCBSTX on Sept. 1, 2017.

We will continue providing disclosures on our website and in future issues of Blue Review. We encourage you to review both resources as you provide care to your patients. As a provider, it is your responsibility to review and comply with these changes.

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

PHARMACY PROGRAM

Effective Jan. 1, Sensipar® (cinacalcet) No Longer Separately Reimbursable Under Medicare Part D for ESRD

The change described in this article affects members who are using the medication Sensipar (cinacalcet) to treat an End Stage Renal Disease (ESRD) condition. Effective Jan. 1, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined the drug Sensipar will no longer be separately reimbursable under the Medicare Part D benefit when administered for hemodialysis. Instead, members with ESRD may be able to continue Sensipar therapy from their dialysis center within the bundled hemodialysis payment.

Members who are receiving Sensipar as part of their hemodialysis treatment should be referred to their nephrologist and/or dialysis center to discuss treatment options. If a member is not using Sensipar to treat an ESRD condition, the coverage change with Sensipar does not affect their approval; these members can continue receiving the drug at their pharmacy under their Part D coverage.

Please read the CMS guidance article related to Sensipar: Medicare-Learning-Network-MLN Matters.

Pharmacy Benefit Tips

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

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

   BCBSTX drug lists are regularly updated and can be found on the Pharmacy Program page on the BCBSTX provider website.

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

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

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

   - ACA $0 Preventive Drug List
   - Women's Contraceptive Coverage List

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

4. **Assisting members with drug list exceptions**
   If the medication you wish to prescribe is not on your patient's drug list or the preventive care lists, a drug list exception can be requested. You can call the customer service number on the member's ID card to start the process, or complete the online form.

Visit the Pharmacy Program page for more information.

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

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

CMS GUIDANCE NOTIFICATIONS

Provider Payments for Influenza Vaccines for 2017-2018 Flu Season

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

The Centers for Medicare & Medicaid Services (CMS) has issued guidance regarding payments to providers for influenza virus vaccines furnished in the 2017-2018 flu season, which began on Aug. 1, 2017.

You are able to access CMS notifications that are also located in the Medicare Learning Network – (MLN Matters) notifications on CMS.gov, as well as on our Blue Cross and Blue Shield of Texas provider website. These notices from CMS are informational and in some cases, require changes as you care for your patients. The notifications can be regulatory updates, regulatory reminders or require action by you as a provider rendering services. Please review the CMS notifications by going to CMS.gov.

Also, please read the CMS guidance article related to Influenza Vaccine Payment Allowances – Annual Update for 2017-2018 Season, as soon as possible: Medicare-Learning-Network-MLN Matters.

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

CMS Guidance Notifications

Applies to: Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM
The Centers for Medicare and Medicaid Services (CMS) routinely publishes notifications that provide CMS guidance to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare and one of the Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO) Plans.

These CMS notifications are in the Medicare Learning Network (MLN Matters) on CMS.gov and on our BCBSTX provider website, and may include informational regulatory updates and reminders, as well as required actions or changes by the provider rendering services. As such, it is important for providers to review these notifications and ensure your staff is aware of these notifications. We are including the following weblink for your information: CMS notifications regarding the Jimmo Settlement.

Continue reviewing our website and the *Blue Review* for changes. If you have any questions, please contact your Network Management Representative.

NOTICES & ANNOUNCEMENTS

Provider Webinars Scheduled for 2018

Do you have new staff? Or just need some refreshers? Blue Cross and Blue Shield of Texas (BCBSTX) has posted complimentary educational webinar sessions on the BCBSTX provider website. These online training sessions give you the flexibility to attend live sessions. Provider billers, utilization areas and administrative departments will benefit from these webinars. New sessions for 2018 have been added for the following topics:

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

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

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Update to the Durable Medical Equipment/Prosthetics and Orthotics Fee Schedule Effective Dec. 1, 2017

As of December 1, 2017, updates have been made to the following schedule:

- Durable Med Equipment/Prosthetics & Orthotics

To view this information on the BCBSTX provider website, go to the General Reimbursement Information section under the Standards and Requirements menu, enter the password and click submit. Under **Reimbursement Schedules & Related Information** locate the **Ancillary topic** and then select **Durable Medical Equipment/Prosthetics & Orthotics**.

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

BlueOptions℠ Benefit Plan Design No Longer Offered Beginning Dec. 31, 2017

Since Dec. 31, 2017, the BlueOptions benefit plan product is no longer offered as a BCBSTX product. BlueOptions provided enhanced benefits to BCBSTX members who obtained care from Blue Choice PPO℠ physicians who were recognized through the BlueCompare℠ program for cost efficiency and quality performance. BlueCompare for Physicians, the program that measures quality for certain specialties, will continue providing performance reporting to physicians and members. Please note that the elimination of this benefit plan does not affect any other networks. If you have questions, please contact your BCBSTX Network Representative.

New Medical Record Retrieval Vendor for Blue Card Plan Member Records

The "risk adjustment" requirement under the Affordable Care Act (ACA) requires Blue Cross and Blue Shield of Texas (BCBSTX) to meet data submission and coding accuracy standards. Member medical records are necessary to help ensure that these requirements are satisfied.

Currently, BCBSTX works with Verscend to retrieve medical records for all Blue Card Plan members to support Healthcare Effective Data and Information Set (HEDIS®), the risk adjustment requirement under ACA and government programs.

Effective Jan. 1, 2018, Inovalon will replace Verscend as the new medical records retrieval vendor. Between now and Jan. 1, 2018, you may receive requests for medical records from both Verscend and Inovalon as the transition is completed on Jan. 1, 2018.

Both Verscend and Inovalon are independent companies and contractually bound to preserve the confidentiality of members' protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Please note that patient authorized forms are not required for disclosures of members' medical records to Verscend or Inovalon.

As set forth in your Agreement with BCBSTX, you are required to respond to requests for medical records from BCBSTX. Such compliance is also required for requests for medical records from BCBSTX's designees, such as Verscend and Inovalon, in support of risk adjustment, HEDIS and government programs within the requested timeframe. BCBSTX is working diligently to ensure this process is followed.

For your convenience, medical records may be submitted in the following ways:

Inovalon

- Fax: 877-221-0604
- Email: EMRService@inovalon.com (send secure)
- Mail: Inovalon Document Processing, 7777 Market Center Ave, Suite E, El Paso, TX 79912

Verscend

- Upload the record image to Verscend's secure portal and enter your password that is included with your Verscend request. Select the files to be uploaded.
- Fax: 888-231-9601
- Mail: Verscend, 66 E. Wadsworth Park Dr., Draper, UT 84020

Providers are permitted to disclose PHI to BCBSTX without authorization from the member when both the provider and BCBSTX have or had a relationship with the member and the information relates to the relationship. See 45 CFR 164.506(c)(4). For more information regarding the HIPAA Privacy Rule, please visit hhs.gov/ocr/privacy.

If you have any questions about sending medical records to Verscend or Inovalon, contact your BCBSTX Network Representative.

HEDIS is a registered trademark of NCQA

STANDARDS & REQUIREMENTS

BCBSTX Requires Adherence to Vaccine Guidelines

Timely vaccines protect the health of children and adults, saving lives and ensuring the safest, most effective disease prevention possible. To help keep Blue Cross and Blue Shield of Texas (BCBSTX) members safe, doctors treating them should adhere to guidelines recommended by the U.S. Food and Drug Administration (FDA) and Advisory Committee on Immunization Practices (ACIP).

Two categories of vaccines may have been administered in a manner that doesn't align with FDA and ACIP guidelines:

- Human Papillomavirus (HPV) prevention
- Prevention of shingles resulting from the herpes zoster virus

If these vaccines are given to BCBSTX patients, we will:

- Continue reimbursing claims that are medically necessary, and supported by the FDA and ACIP guidelines
- Consider vaccines administered outside of the FDA and ACIP recommendations as experimental, investigational or unproven, and will periodically review such claims for reimbursement
- Recover reimbursements for these vaccines administered outside of the FDA and ACIP recommendations per our contracts

HPV Vaccination Guidelines

Gardasil®, Gardasil 9 and Cervarix are vaccines for the prevention of HPV infections and associated diseases, including cancers. Administration of these vaccines is recommended for males and females between 9 and 26 years old. Vaccination at ages 11 or 12 is optimal. Since 2006, these vaccines have been administered in three doses, with the second dose at one or two months after the first, and the third dose six months after the first. In October 2016, for patients between 9 and 14 years old, the ACIP recommendation was updated to two doses, with the second dose at six to 12 months after the first. For patients between 15 and 26 years old, the three-dose regimen is still recommended.

Shingles Vaccination Guidelines

Zostavax is a vaccine that prevents shingles and its complications. Zostavax is recommended as a single dose by the FDA at age 50 or older, and by the ACIP at age 60 or older. BCBSTX considers the vaccine medically necessary for anyone age 50 or older in recognition of the FDA guidance.

Immunization Schedule

Review the Preventative Services Policy CPCP006 for details on our complete, approved immunization schedule. The schedule can be found on the Clinical Payment and Coding Policies page under the Standards & Requirements tab on the BCBSTX provider website.

Third-party brand names are the property of their respective owner.

In Every Issue – February 2018

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
- eviCore™
- Pharmacy
- Provider General Information
- Rights and Responsibility

Authorizations and Referrals

Importance of Obtaining a Preauthorization/Referral

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

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 pre6determination requests while waiting on the mailed notification letters. The faxed notification will be in addition to the notification letter sent via mail to the address we have on file.

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

If a preauthorization/referral request is received from an out-of-network (OON) provider and the member/subscriber does not have an OON benefit, BCBSTX will contact the ordering provider to discuss

network options. However, if a member/subscriber has an OON benefit, OON benefits will apply, which could result in a higher cost sharing.

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

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

iExchange is a trademark of 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.

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 section D Referral Notification Program on the bcbstx.com/provider website.

AIM RQI Reminder

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

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

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

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

Notes:

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

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

Are Utilization Management Decisions Financially Influenced?

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

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

Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)[SM]

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

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

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

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

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

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

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

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

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

- Log in to the Availity Web Portal or your preferred vendor
- Enter required data elements
- Submit your request

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

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

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

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

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

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

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

Claims

EFT and ERA Information Available Online

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

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

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

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

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Notice of Changes to Billing and Documentation Information and Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) has implemented changes to clarify existing policies related to billing and documentation requirements for the BlueChoice® PPO, Blue Advantage HMO℠, Blue Essential℠, Blue Premier℠, Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ plans effective Sept. 15, 2017, as reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual in Section 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 way test codes are billed, including frequency of testing. Abusive billing, insufficient or lack of documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100 percent review of medical records for such claims submitted.

Limitations and Conditions
Reimbursement is subject to:

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

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

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

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

Medicare Advantage Plans Overpayment Recovery

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

As a reminder, the following applies to overpayment recovery on claims processed after Jan. 1, 2017, for Blue Cross Medicare Advantage PPO and Blue Cross Medicare Advantage HMO:

- 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 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

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Benefit Categories Contained in IVR Phone System

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

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

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

Contained Benefit Categories 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)SM or Blue Cross Medicare Advantage (HMO) SM government program member policies. For eligibility and benefits for these government programs via phone, refer to the number on the member's BCBSTX identification card.

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

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

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questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Clinical Payment and Coding Policies Now Online

BCBSTX is now publishing Clinical Payment and Coding Policies on our website. These payment and coding policies describe BCBSTX's application of payment rules and methodologies for Current Procedural Terminology (CPT®), HCPCS and ICD-10 coding as applied to claims submitted for covered services. This information is offered as a helpful general resource regarding BCBSTX payment 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™ Rules

Blue Cross and Blue Shield of Texas (BCBSTX) implemented 4 new rules to the ClaimsXten software database in September 2017. These 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 *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.

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 *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. CPT copyright 2015 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Additional Code-Auditing Software

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

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

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

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Technical and Professional Components

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

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

Surgical Procedures Performed in the Physician's Office

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

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

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

Improvements to the Medical Records Process for BlueCard® Claims

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

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

Contracted Providers Must File Claims

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

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA 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 (his 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

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.

BCBSTX Lab Guidelines

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for Blue Essentials℠, Blue Premier and Blue Advantage HMO℠ members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) Blue Choice PPO℠ subscribers. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

Quest Diagnostics offers:

- 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.*

Blue Cross Medicare Advantage (PPO)℠ Lab Guidelines

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

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

For locations or questions contact:

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

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

Medical Necessity Review of Observation Services

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

post- service review, and BCBSTX may request medical records for the determination of medical necessity.

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

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

Coordination of Care Between Medical and Behavioral Health Providers

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

The Coordination of Care Form Available Online

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

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

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

If You Need Help Finding Behavioral Health Providers for Your Patients

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

Behavioral Health or Medical Case Management Services

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

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.

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eviCore™

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 HMOSM. In 2017, additional BCBSTX products and services were added as indicated below.

To determine which specialized clinical services and the effective dates of those services which require preauthorization/prior authorization through eviCore refer to the Preauthorization/Referral/Notification Requirements Lists and the Prior Authorization and Referral List for ERS found on the Clinical Resources page of BCBSTX's provider web site.

Some of the types of clinical services that may require eviCore authorization are:

- 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

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

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

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

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

For all other services that require a referral and/or authorization as noted on the Preauthorization/Referral Requirements Lists or the Prior Authorization/Referral List for ERS, continue to use iExchange®. iExchange is accessible to 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 f or payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Pharmacy

Dispensing QVT (Quantity Versus Time) Limits

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

Prescription Drug Lists

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

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

Provider General Information

Fee Schedule Updates

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

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

BCBSTX New Employer Group Plan – Employees Retirement System of Texas (ERS)

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

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

ERS participants plan options:

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

ERS participants can be identified through their BCBSTX ID card:

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

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

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

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

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

Provider Training

BCBSTX is proud to offer complimentary educational webinar sessions. These online training sessions give you the flexibility to attend live sessions. Provider billers, utilization areas and administrative departments will benefit from these webinars. Please visit 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 PPO℠ Physician, Professional Provider and Facility and Ancillary Provider Manual (Section B) and Blue, Blue Premier Physician, Professional Provider, Facility and Ancillary Provider Manual (Section B) available in the Education & Reference section of our provider website. Click on the "Manual" link (note, a password is required).

Medical Record Requests: Include Our Letter as Your Cover Sheet

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

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

Medical Policy Disclosure

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

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

Draft Medical Policy Review

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

View draft medical policies. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

Rights and Responsibilities

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

RIGHTS	RESPONSIBILITIES
Subscriber(s)/Member(s)	**Subscriber(s)/Member(s)**
You have the right to:	You have the responsibility to:
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 needs 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.
- Candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.

Member Rights – You Have the Responsibility to:

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

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

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

Contact Us
View our quick directory of contacts for BCBSTX.

Update Your Information
Do you need to update your location, phone number, email or other important details on file with BCBSTX? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local Network Management Representative to have up to 10 of your office email addresses added.

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