BlueCross BlueShield of Texas
Blue Review
A Provider Publication

October 2015

(Electronic distribution October 8, 2015)

BCBSTX Announces Changes for Individual Plans in 2016

Evolving Health Care Market

The health insurance market has evolved significantly in the last couple of years with the Affordable Care Act (ACA), and Blue Cross and Blue Shield of Texas (BCBSTX) remains committed to offering sustainable and affordable health plan options to all of our members. BCBSTX offers numerous products today, but we continually look to the future to identify ways we can better meet the needs of our members, both individuals and groups. In 2016, BCBSTX will be offering products that will be available in all 254 Texas counties and offered both on and off the Health Insurance Marketplace.

BCBSTX has always been dedicated to helping our members access quality care at the right time, resulting in the best possible outcomes. Managed care, like an HMO, makes health care simple. That means it's easy to use and easy to manage the cost of care. It includes a primary care physician who knows health care and can guide patients through an informed decision-making process. These types of affordable plans have been popular among individuals purchasing their own insurance.

Changes for Individual Plans

For the upcoming open enrollment period, which opens Nov. 1, 2015, BCBSTX will be making some changes to our Blue Advantage HMO product offerings statewide. Providers who are interested in participating in our networks can request participation through BCBSTX's provider portal at bcbstx.com/provider. Please watch for more details about our product offerings in an upcoming *Blue Review* article.

As such, BCBSTX will no longer offer its Blue Choice PPO to individual members, also known as "retail" members. A retail member is anyone who buys their own insurance (under 65 years of age) that is not provided by an employer or through a government program (Medicare, Medicaid, or CHIP).

Many of your BCBSTX patients will **NOT** be impacted by this change, including:

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

Personalized Transition of Care

We will be transitioning your patients who currently have the Blue Choice PPO plan to a new plan we are rolling out in 2016 or they may choose a different plan during open enrollment. Members have a choice of using In-network providers or choosing an out of

network provider at a higher co-share. Members are encouraged to choose a primary care physician and work with their physician to ensure approvals are in place for coverage for their ongoing health care needs. BCBSTX will not provide extended authorizations for the Texas PPO on/off exchange past Dec. 31, 2015.

Plan options and descriptions will be available mid-October. We will work with you and your patients to minimize the impact of this change to their ongoing care, particularly if they need to transfer their care to other providers participating in our networks.

We understand that some of your impacted patients may be undergoing a complex course of treatment under your care (cardiology, cancer, pediatrics, pregnancy, etc.). We realize this type of care is critical, and we encourage you and your patients to contact BCBSTX through the phone numbers below. Our member advocates will work closely with your patients to create a personalized transition of care plan.

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

Your patients can also learn about providers that are participating in our networks in their area by viewing our Provider Finder® on bcbstx.com. Providers who do not currently participate but would like to participate in our networks may initiate the contracting process through the BCBSTX provider website.

Verification of Benefits

As a reminder, **patient eligibility and benefits should be confirmed prior to every scheduled appointment**. Eligibility and benefit quotes include membership, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. When services are not covered, please notify your patients that you will bill them directly. Confirming benefits and eligibility is in the best interest of both your patient and your office.

Our diverse portfolio of product offerings is part of BCBSTX's efforts to meet its goal of increasing access and affordability of health care products to our members and the communities we serve. Making it easier for you and your staff to conduct business with us is equally important. We appreciate your patience, cooperation and support as we all work to adapt to the new landscape of health care.

If you have any questions, please call your network management representative:

BCBSTX Provider Relations Office Locations	Telephone Number	Fax Number
Austin	512-349-4847	512-349-4853
Corpus Christi	361-878-1623	361-852-0624
Dallas, East Texas	972-766-8900 / 800-749-0966	972-766-2231
El Paso	915-496-6600, press 2	915-496-6611 915-496-6611
Houston, Beaumont	713-663-1149	713-663-1227
Lubbock, Amarillo	806-783-4610	806-783-4666
Midland, Abilene, San Angelo	432-620-1406	432-620-1428
San Antonio	361-878-1623	361-852-0624

Join Us for October ICD-10 Direct Data Entry Claim Submission Webinars

Blue Cross and Blue Shield of Texas (BCBSTX) strongly encourages electronic submission of all professional and institutional claims for greater efficiency, accuracy and security of data. Additionally, with electronic claim submission, electronic reports are generated and sent automatically to confirm receipt and identify errors that need to be rectified prior to adjudication and payment.

Your clearinghouse, practice management system and/or other vendor(s) should be able to support transactions with ICD-10 as of the Oct. 1, 2015, compliance deadline. However, if your practice management system or electronic vendor is unable to submit compliant claims on your behalf you may submit your own electronic claims one-by-one via the Availity™ Web portal using the Direct Data Entry option. After each claim is submitted electronically, a transaction report will be returned in Availity to advise if the submission was accepted by the payer.

We invite you to join us for a webinar to learn more. Select your preferred date and time to register now:

Wed., Oct. 7 – 9 a.m. to 10:30 a.m., CT
https://hcsc.webex.com/hcsc/j.php?RGID=rca2e16f396a4690e79d4e3cadc65baf5

Fri., Oct. 9 – 11 a.m. to 12:30 p.m., CT
https://hcsc.webex.com/hcsc/j.php?RGID=rbba7cddf4db6a721b8bbec54e0e557ac

Mon., Oct. 12 – 1 p.m. to 2:30 p.m., CT
https://hcsc.webex.com/hcsc/j.php?RGID=rd1aae18bebf58f687cd300eae5d44782

Thurs., Oct. 15 - 9:30 a.m.to 11 a.m., CT
https://hcsc.webex.com/hcsc/j.php?RGID=r711d75431eeedcbbc4fa185905616c79

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

Pharmacy Program Updates Effective Oct. 1, 2015

Standard Drug List (Formulary) Changes

Based on the availability of new prescription medications and the Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some revisions were made to the Blue Cross and Blue Shield of Texas (BCBSTX) standard drug list effective Oct. 1, 2015.

Brand Medications Added to the Drug List, Effective Oct. 1, 2015

Preferred Brand[1]	Drug Class/Condition Used for
Arnuity Ellipta	Asthma
Pazeo	Opthalmic Antihistamine
NovoEight	Hemophilia

Effective Oct. 1, 2015, dispensing limits were added for the following drugs:

Drug Class and Medication[1]	Product Strength(s)	Dispensing Limit
Diabetes (GLP-1 Receptor Agonists)		
Bydureon (exenatide)	2 mg syringe	4 syringes per 28 days
Fibromyalgia		
Lyrica (pregabalin)	25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg capsule	90 capsules per 30 days
Lyrica (pregablin)	225 mg, 300 mg capsule	60 capsules per 30 days
Lyrica (pregablin)	20 mg/mL oral solution	900 mL solution per 30 days
Hypercholesterolemia (HoFH)		
Juxtapid	5 mg, 10 mg	30 capsules per 30 days
Oral PAH		
Tyvaso starter kit	0.6 mg/mL	1 kit per 180 days
Tyvaso institutional starter kit	0.6 mg/mL	1 kit per 180 days
Tyvaso	0.6 mg/mL, 4 pack carton	7 packages per 28 days
Tyvaso	0.6 mg/mL refill kit	1 package per 28 days
Ventavis	10 mcg/mL, 20 mcg/mL	270 ampules per 30 days
Thrombopoietin Receptor Agonists		
Promacta	25 mg	30 tablets per 30 days
Promacta	75 mg	60 tablets per 30 days

Utilization Management Program Changes

Effective Oct. 1, 2015, the Proton Pump Inhibitors (PPI) step therapy program was removed from all BCBSTX prescription drug benefit plans. Members are encouraged to use available less costly options, such as a covered prescription-strength generic or over-the-counter product.

Targeted drugs added to current pharmacy PA standard programs, Effective Oct. 1, 2015

Drug Category	Targeted Medication(s)[1]
Doxycycline/Minocycline	Doxycycline 75 mg, Doxycycline 150 mg capsules, Doxycycline
Erythropoiesis Stimulating Agents (ESAs)	Mircera
Pulmonary Arterial Hypertension (PAH)	Tyvaso, Ventavis

[1]*Third-party brand names are the property of their respective owners*

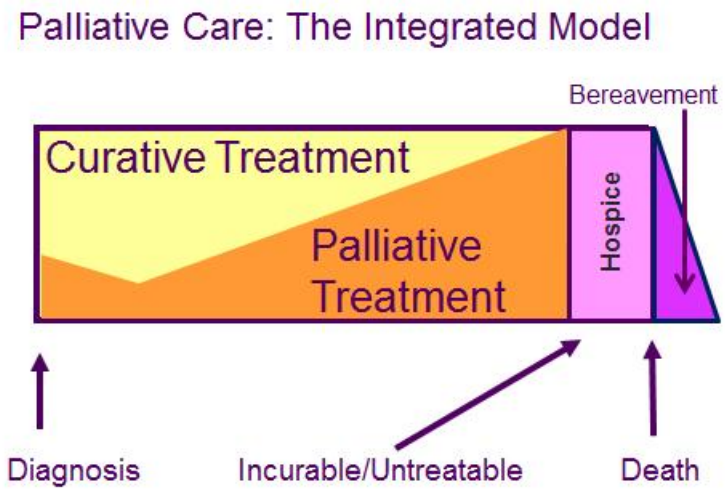
Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSTX, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in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

Integrated Palliative Care in Action: What Does It Look Like?

This is the last in a series of three articles.

Because patients and providers will often mistakenly equate palliative care with hospice care, there is confusion as to what role palliative care may play for the patient who is still receiving or who desires disease-focused therapies. In a previous article, the optimal model of palliative care was depicted as a simple graph.



The model above illustrates the integration between attempts to modify disease trajectory and assessments for unmet palliative needs, which span physical, emotional, social and spiritual realms. This model is designed to allow medical teams to provide complete care of the patient and improve overall quality of life. The following patient examples demonstrate this model working at its highest level, where conversations start early and guide the later transitions in care planning.

When Renee* was diagnosed with an aggressive lymphoma in early 2013, like many patients, she was focused on a cure. Her disease showed some response to the first-line chemotherapy regimens. By June, unfortunately, her cancer was growing despite those therapies. Renee made the decision to transition her care to a specialized cancer center.

During her first hospital stay for a new chemotherapy regimen, she requested a palliative care consultation. Her oncologist and hospital physician were surprised, but consulted the palliative care team nonetheless. Renee spoke of her desire to continue pursuing disease-modifying therapies, while planning for the possibility that her cancer might not get better.

She discussed her work in patient relations at a nearby hospital, and how often she observed people growing more and more ill without open conversations about what was really happening to them. Renee spoke of hip pain that was worsening and making it difficult for her to be as active as she wanted to be. The team examined her medications and recommended adjustments during her hospital stay, which improved her walking significantly.

Renee expressed the desire to follow up in the outpatient palliative clinic, and she has done so for the past six months. The physicians and nurses have supported Renee through subsequent chemotherapy and radiation treatments by addressing ongoing pain and nausea. They listened to her concerns about how her husband is coping with her illness and discussing when, in her view, the burdens of further treatment will outweigh possible benefits. She hopes to have the social worker speak with her husband about the questions that he has regarding what her path looks like if the cancer can be controlled, and if it can't.

In general, palliative care has had a more natural relationship with oncology than with other medical disciplines, but this is changing.

Consider the story of Betty,* an elderly female with severe COPD and heart failure. Her pulmonologist employed excellent primary palliative care practice by focusing on maximizing her physical function and initiating conversations about the progressive debility Betty would experience as a result of her illness.

Eventually, the pulmonologist reached out to the palliative care clinic for assistance with managing her severe shortness of breath. Betty and her children developed a relationship with both teams that lasted for two years.

When an interventional procedure led to difficulty with her breathing, Betty's family faced the decision of whether or not to place her on a ventilator. As a result of the previous conversations with the pulmonary and palliative teams, the family understood the ramifications of intubation and did not believe that this would be consistent with Betty's goals or wishes.

With noninvasive breathing support, Betty's breathing improved, and she was able to pursue acute inpatient rehabilitation to become stronger. The palliative care team remained involved in her care, helping to manage opioid medications that she used to ease her breathlessness.

When Betty and her family needed more support at home, the palliative care team helped arrange for home hospice care. She spent most of the last 18 months of her life at home, with her family, and occasionally traveling to family reunions.

Renee and Betty benefitted tremendously from early palliative care practice. Both pursued curative, disease-modifying therapies in conjunction with aggressive symptom management and future care planning. Both felt stronger and more active because the physical manifestations of their two diseases were addressed.

For Renee, facing the uncertain outcome of her illness has been simpler because of conversations that are allowing her to plan how she would want to spend her final days if her cancer proves unresponsive. For Betty, when the ultimate path of her illnesses was clear, she and her family were empowered by the previous conversations with their providers to set limits on the type of interventions she wanted to receive.

This model of health care, which integrates palliative care principles into patient evaluation earlier, is the goal.

**The names of the patients have been changed to protect their privacy and comply with privacy laws.*

Dr. Jessica Montalvo, assistant professor in the Section of Palliative Care at Northwestern University Feinberg School of Medicine, has provided this information for Blue Review readers.

Antipsychotic Drug Use in Elderly Patients with Dementia

The Centers for Medicare & Medicaid Services (CMS) and the CMS National Partnership to Improve Dementia Care in Nursing Homes have set a new goal to achieve a 25 percent reduction in antipsychotic drug use within nursing homes by the end of 2015, with a 30 percent reduction by the end of 2016. Eleven states met the previous 2012 goal to reduce antipsychotic drug use within nursing homes by 15 percent.

A Black Box warning was released by the U.S. Food and Drug Administration (FDA) in 2005, which notified health care professionals that patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death. The Black Box warning was based on a review of 17 placebo-controlled trials showing a 1.6 to 1.7 times greater increase in death with the use of atypical antipsychotics compared with the placebo group[1]. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (pneumonia) in nature. Additional studies have found the increased risk of death is similar between conventional and atypical antipsychotics**.**

Atypical antipsychotics are associated with significant weight gain and metabolic changes, such as hyperlipidemia and an increased risk of diabetes. Conventional antipsychotics are additionally associated with movement disorders such as akathisia, parkinsonism and dystonia. Side effects may be more prominent in elderly patients, as they may have altered metabolism of medications due to physiologic changes. The long half-lives of some antipsychotics are also concerning, as patients may experience prolonged lethargy and sedation. Patients and/or caretakers should be aware of the risks of taking an antipsychotic prior to initiating therapy. Baseline weight, blood glucose level and lipid panels should be established and then monitored when a patient begins taking an antipsychotic.

Despite the FDA Black Box warning, a U.S. Department of Health and Human Services Office of Inspector General (OIG) report released in 2011 showed 88 percent of atypical antipsychotic drug claims in nursing homes were for patients with dementia[2]. The report also showed 83 percent of atypical antipsychotic drug claims were for non-FDA labeled indications (off-label indications).

In addition to the antipsychotic reduction targets, CMS is surveying nursing facilities that dispense antipsychotics for: chemical restraints, unnecessary drugs, quality of care, standards of care, physician review and drug regimen review. CMS regulations state that each nursing home resident's drug regimen must be free from unnecessary drugs that are used in excessive doses for excessive durations, without adequate monitoring and indications for their use, or in the presence of adverse consequences. Besides increased CMS scrutiny, law firms are also becoming increasingly aggressive in their liability claims against nursing homes. A variety of claims against nursing facilities are being attributed to the use of antipsychotics, including: tardive dyskinesia, gynecomastia, diabetes, pancreatitis, neuroleptic malignant syndrome, suicide, cardiovascular events and death.

Blue Cross and Blue Shield of Texas (BCBSTX) is using the GuidedHealth® clinical rules platform to review claims data that it receives to help identify members who have had a claim for an anti-dementia medication and who also have a recent pharmacy claim for an antipsychotic drug. Prescribing physicians of these identified members are sent

informational letters on a quarterly basis to help increase awareness and promote patient safety.

[1]Schneider LS, Dagerman KS, Insel P. Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomized placebo-controlled trials. JAMA. 2005; 294:1934–1943.

[2]Department of Health and Human Services. Office of Inspector General. (May 2011) Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents. OE-07-07-00150.

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NOTICES AND ANNOUNCEMENTS

Completing the Transition to ICD-10

In accordance with the U.S. Department of Health and Human Services (HHS) mandate, valid ICD-10 codes are required on claims submitted to Blue Cross and Blue Shield of Texas (BCBSTX) for dates of service or inpatient discharge dates on or after Oct. 1, 2015.

ICD-10 codes also are required for benefit preauthorization requests submitted on or after Oct. 1, 2015. Use of other codes, such as Current Procedural Terminology (CPT®), HCPCS and Revenue Codes, is not affected by the transition to ICD-10.

Here are some key points to keep in mind:

- **Use of ICD-10 is federally mandated.** All Health Insurance Portability and Accountability Act (HIPAA) covered entities must comply, regardless of each patient's type of health insurance.
- **Coding directly in ICD-10 is encouraged.** Coding in ICD-9 and mapping to ICD-10 may be seen as an interim solution, but is not recommended as a best practice.
- **ICD-10 is date of service/discharge date driven.** Resubmission or adjustments of previously filed claims must be submitted with the code set used on the original claim.

- **Only one code set per claim is allowed (all ICD-9 or all ICD-10).** Claims that contain both ICD-9 and ICD-10 codes will not be accepted.
- **Non-compliant claims may be rejected by your clearinghouse before reaching BCBSTX.** You will need to watch electronic reports and work with your clearinghouse to correct and submit affected claims.

Visit the ICD-10 page in the Standards and Requirements section of our website at bcbstx.com/provider for answers to frequently asked questions, among other resources. Also watch the News and Updates for announcements, such as dates and times of educational webinars. If you need assistance with ICD-10 questions, email us at icd@bcbstx.com, or contact your local Network Management Representative.

Asthma Care Reminder

The National Institute of Health (NIH) National Asthma Education and Prevention Program recommends that patients with persistent asthma should be treated with an inhaled corticosteroid. According to the NIH National Heart, Lung, and Blood Institute guidelines, chronic inhaled corticosteroid use is safe in adults and children, and can be the most effective and preferred first-line control therapy for asthma[1].

Inhaled corticosteroids improve asthma control more effectively than any other long-term control medications. An analysis of eight cohort and ecologic studies conducted strongly suggest that inhaled corticosteroids, when taken regularly, can decrease the number of hospitalizations for asthma by up to 80 percent[2].

Pharmacy claims often show that asthma patients rely on albuterol rescue inhalers as the primary treatment for their asthma. A patient refilling their albuterol rescue inhaler more than once a month may be an indication that their asthma is not being appropriately treated.

If your patients are not adherent to, or are resistant to taking their inhaled corticosteroid as directed, please discuss and address their concerns. Some reasons patients may not be taking inhaled corticosteroids are:

- Concerns about taking a steroid medication (inhaled corticosteroids have fewer and less severe systemic side effects than oral steroids),
- Lack of immediate relief that albuterol inhalers can provide,
- Difficulty remembering twice daily dosing,
- Improper inhaler technique (have your patient demonstrate their technique while in the office), and
- In rare cases, thrush (prevented by rinsing mouth after use).

It is highly recommended that you work with your patient to create an asthma action plan. An asthma action plan can be a written, individualized worksheet showing your patient the steps to take in order to prevent their asthma symptoms worsening. Also, for patients with persistent asthma, assess their symptoms and determine if an inhaled corticosteroid is appropriate.

Blue Cross and Blue Shield of Texas (BCBSTX) uses the GuidedHealth® clinical rules platform to review claims data that it receives to help identify members who have had a claim for an asthma rescue inhaler but have not received an inhaled corticosteroid. The prescribing physicians of these identified members are sent informational letters on a quarterly basis to help increase awareness and promote patient safety.

BCBSTX is also committed to working with communities to help improve pediatric asthma care. Through a collaboration with the American Lung Association of the Upper Midwest (ALAUM), BCBSTX is supporting the Enhancing Care for Children with Asthma Project, a program that implements community-based interventions to improve the health outcomes of children with asthma. For more information about the Enhancing Care for Children with Asthma Project, visit the ALAUM at lung.org.

[1.] *Global Strategy for Asthma Management and Prevention. Global Initiate for Asthma (GINA) 2012.*

[2.] *Suissa, Samy et al. Inhaled corticosteroids: Impact on asthma morbidity and mortality. J Allergy Clin Immunol. 2001. Jun;107(6):937-44.*

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed 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

IN EVERY ISSUE

BCBSTX Implements Changes in Maximum Allowable Fee Schedule

Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule used for Blue Choice PPO℠, HMO Blue Texas℠, Blue Advantage HMO℠ (Independent Provider Network and THE Limited Network only), and ParPlan effective Nov. 1, 2015.

Changes will be implemented in the maximum allowable fee schedules used for the Blue Cross Medicare Advantage PPO℠ and Blue Cross Medicare Advantage HMO℠ effective Jan. 1, 2016.

- The methodology used to develop the maximum allowable fee schedule for Blue Choice PPO, HMO Blue Texas and Blue Advantage HMO will be based on 2015 CMS values posted on the CMS website as of Jan. 16, 2015, for those

services for which the BCBSTX reimbursement is based on CMS values.

- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.
- Blue Choice PPO, HMO Blue Texas, Blue Advantage HMO and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility).
- The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year.
- The NDC Fee Schedule will be updated monthly.

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

Reimbursement changes will be posted under "Reimbursement Changes and Updates" in the Reimbursement Schedules section on the BCBSTX provider website. The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted.

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

As a provider for Blue Cross and Blue Shield of Texas (BCBSTX), you are obligated to be aware of subscribers' rights and informed of subscribers' responsibilities. Our health plan subscribers 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)	**Subscriber(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	• Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.

• Participate with practitioners in making decisions about your health care.	• Follow the plans and instructions for care you have agreed to with your practitioner.
• Be treated with respect and recognition of your dignity and your right to privacy. • A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. • Voice complaints or appeals about the organization or the care it provides.	• Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

HMO Blue Texas Member Rights & Responsibilities

Member Rights – You Have the Right to:

- Receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policy.
- Participate with practitioners in making decisions about your health care.
- Be treated with respect and recognition of your dignity and your right to privacy.
- A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.

Member Rights – You Have the Responsibility to:

- Meet all eligibility requirements of your employer and the Health Maintenance Organization (HMO).
- Identify yourself as an HMO member by presenting your ID card and pay the copayment at the time of service for network benefits.
- Establish a physician/patient relationship with your primary care physician (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OBGyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, in order to care for you. Including changes in your family status, address and phone numbers within 31 days of the change.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Notify your primary care physician or HMO plan within 48 hours or as soon as reasonably possible after receiving emergency care services.
- Communicate complete and accurate medical information to health care providers.
- Call in advance to schedule appointments with your network provider and notify them prior to canceling or rescheduling appointments.

- Read your coverage documents for information about benefits, limitations, and exclusions.
- Ask questions and follow instructions and guidelines given by your provider to achieve and maintain good health.
- Understand your health problems and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

Fee Schedule Updates

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

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

After-hours Access Is Required

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

Acceptable after-hours access mechanisms may include:

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

For more detail, please refer to the provider manuals for **Blue Choice PPO℠ Physician and Professional Provider** (Section B) and **HMO Blue Texas℠ / Blue Advantage HMO℠ Physician and Professional Provider** (Section B) available on our provider website at bcbstx.com/provider. Click on the "Education & Reference" tab, then click on "Manuals" and enter the password.

BCBS Medicare Advantage PPO Network Sharing

What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO℠ network sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or

living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

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

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

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

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

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

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

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

arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

How do I verify benefits and eligibility?
Call BlueCard Eligibility at 800-676-BLUE (800-676-2583) and provide the BCBS MA PPO member's alpha prefix located on the member's ID card.

You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:

- Log in to the Availity Portal, the Availity Revenue Cycle Management Portal or your preferred vendor
- Enter required data elements
- Submit your request

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

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

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

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

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

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

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

Medical Record Requests: Include Our Letter as Your Cover Sheet

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

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

Thank you for your cooperation!

Technical and Professional Components

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

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

Surgical Procedures Performed in the Physician's Office

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

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

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

AIM RQI Reminder

Physicians and professional providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPO members and HMO Blue Texas members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician'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 or HMO Blue Texas RQI, log in to AIM's provider portal at aimspecialtyhealth.com and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive a RQI. If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM's ***Provider****Portal*$_{SM}$ uses the term "Order" rather than "RQI."

Notes*:*

1. *HMO Blue Texas physicians or professional providers who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group regarding outpatient high-tech diagnostic imaging services.*
2. *Facilities cannot obtain a RQI from AIM on behalf of the ordering physician.*
3. *The RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX PPO or HMO coverage are included in the program.*

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

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

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

Quest Diagnostics Offers:

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

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

For physicians and professional providers located in the HMO capitated lab counties, only the lab services/tests indicated on the Reimbursable Lab Services list will be

reimbursed on a fee-for-service basis if performed in the physician's or professional provider's office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician's or professional provider's office will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list at bcbstx.com/provider under the General Reimbursement Information section located under the Standards and Requirements tab.

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

Fee Schedule Updates

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

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

Improvements to the Medical Records Process for BlueCard® Claims

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

As always, we will request that you submit your medical records to BCBSTX if needed for claims processing.

Requests for medical records from other Blues Plans before rendering services, as part of the preauthorization process, should be submitted directly to the requesting Plan.

Pass-through Billing

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

The performing physician or professional provider should bill for these services unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

- The service of the performing physician or professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician or professional provider.

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

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

- **AS modifier:** A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used *ONLY* if they assist at surgery.)

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

Contracted Providers Must File Claims

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

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

Medical Policy Disclosure

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

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

Draft Medical Policy Review

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

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

No Additional Medical Records Needed

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

Predetermination does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

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

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

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

Preauthorization does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

Avoidance of Delay in Claims Pending COB Information

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

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

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

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

Billing for Non-covered Services

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

In the event that BCBSTX determines that a proposed service is not a covered service, the physician or professional provider must inform the subscriber in writing in advance. This will allow the physician or professional provider to bill the subscriber for the non-covered service rendered.

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

Dispensing QVT (Quantity Versus Time) Limits

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

Visit the BCBSTX provider website at bcbstx.com/provider to access the 2015 Standard Drug List Dispensing Limits and 2015 Generics Plus Drug List Dispensing Limits.

Prescription Drug Lists

Throughout the year, the BCBSTX Clinical Pharmacy Department team frequently reviews the prescription drug lists. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

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

Are Utilization Management Decisions Financially Influenced?

BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial

incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

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

Contact us
Access a directory of BCBSTX contacts line.

Update Your Contact Information

Accurate provider directories are an important part of providing BCBSTX members with the information they need to manage their health.

To update your contact information, please submit your correspondence via:

- fax: 972-231-9664
- mail: P.O. Box 650267, Dallas, TX, 75265-0267.

You should submit all changes at least 30 days in advance of the effective date of change.

If your specialty, practice information/status or board certification is not correct on the BCBSTX Provider Finder®, or if you would like to have a subspecialty added, please contact your Network Management office.

In addition, BCBSTX periodically identifies providers who have not submitted claims for a period of one year. We make an effort to contact each provider to confirm their information. If the provider does not respond, we will initiate a network termination. Similarly, BCBSTX will inactivate any tax identification numbers (TINs) under which there have been no claims submitted for a period of one year.

Blue Review is published for Blue Choice PPO℠, HMO Blue Texas℠, Blue Cross Medicare Advantage (PPO)℠, Blue Cross Medicare Advantage (HMO)℠, Blue Advantage HMO℠ and ParPlan contracting physicians and other health care providers. To contact the editor, email BlueReviewEditor@bcbstx.com.

The information provided in *Blue Review* does not constitute a summary of benefits, and all benefit information should be confirmed or determined by calling the customer service telephone number listed on the back of the member ID card.

BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent, third-party vendors mentioned in this newsletter. The vendors are solely responsible for the products or services they offer. If you have questions regarding any of the products or services mentioned in this periodical, please contact the vendor directly.

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