May 4, 2018

NOTICES & ANNOUNCEMENTS

Annual Rights and Responsibilities Notification

Thank you for choosing to be a participating practitioner with Blue Cross and Blue Shield of Texas (BCBSTX). Please review the information below for the latest information that could affect your practice.

Your Rights

As a participating practitioner of our network, you have the right to review information submitted to support your credentialing application, and receive the status of your credentialing or recredentialing application, upon request.

Providers have the responsibility to work directly with the reporting entity(ies) to correct erroneous information and/or conflicting information within 30 calendar days. All corrections must be submitted in writing to our Enterprise Credentialing Department, your assigned Network Management Consultant or a Medical Director to avoid future delays in processing your information for consideration in BCBSTX networks.

Mail: 1001 E. Lookout Drive
Richardson, Texas 75082
Fax: 972-766-2137
Email: CredentialingCommittee@bcbstx.com

Please Note: Credentialing decisions will not be made until the applicant has responded or if the response has exceeded the 30 calendar days allocated.

Applicants who only see patients in an office setting and do not have hospital admitting privileges at a network hospital may attest to having coverage for hospital admissions by submitting a signed Hospital Coverage letter. You can find a copy of this letter by visiting the Forms section under Education and Reference on the BCBSTX provider website.

Care Management Programs: Case Management and Disease Management

BCBSTX Case Management (CM) and Disease Management (DM) staff work with enrolled members to increase their knowledge about their condition and help them better manage crisis events when they occur. CM and DM staff support the member and practitioner relationship, and aid communication between them. Members are encouraged to discuss issues and questions with their practitioner, develop a “shared decision making” partnership with their practitioner and take an active role in managing their own health.

Member compliance with physician treatment plans is monitored, including keeping appointments, compliance with medications and completing ordered tests. Program interventions are designed to coordinate with the activities of a member’s treating practitioners, specifically their primary care physician and/or appropriate specialist.

As a practitioner, you may refer a member for these care management programs at any time by calling the number on the back of the member's identification (ID) card. A clinician will collaborate with you to provide our members with available resources and additional support.

Member Rights and Responsibilities
As a BCBSTX practitioner, it is important that you are aware of our members' Rights and Responsibilities. Our health plan members can find their Rights and Responsibilities in their benefit booklet or on our website.

Member Rights and Responsibilities include:

- A right to receive information about BCBSTX, our services, our providers and facilities, and member rights and responsibilities.
- A right to be treated with respect and recognition of the member's dignity and right to privacy.
- A right to participate with providers in making decisions about the member's health care.
- A right to have a candid discussion of appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about BCBSTX or the care we provide.
- A right to make recommendations regarding our members' Rights and Responsibilities policy.
- A responsibility to provide, to the extent possible, information that BCBSTX and the provider and facility need to provide care.
- A responsibility to follow the plans and instructions for care that the member has agreed to with their provider.
- A responsibility to understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

Utilization Management Decisions
BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. Utilization Management (UM) determinations are made by licensed clinical personnel based on the:

- benefits policy (coverage) of a member's health plan,
- evidence-based medical policies and medical necessity criteria, and the
- medical necessity of care and service.

All UM decisions are based on appropriateness of care and service, and existence of coverage. BCBSTX prohibits decisions based on financial incentives, nor does BCBSTX specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The criteria used for UM determinations are available upon request. Please call the Customer Service or Health Advocate number on the back of the member's ID card.

Pharmacy Benefits
As a participating practitioner, you are given a list of drugs that are reviewed and updated throughout the year.

For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for the drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines.

For more information regarding our Pharmacy programs, visit the Pharmacy Program section on the BCBSTX provider website. For Federal Employee Program (FEP) members, information can be found at

fepblue.org/pharmacy. We encourage you to check the website regularly and watch for updates in this newsletter.

You can find the following information on our website:

- Formulary lists, including restrictions and preferences
- How to use our pharmacy procedures
- An explanation of limits or quotas
- How you can provide information to support an exception request
- The process for generic drug substitutions, therapeutic interchange and step-therapy protocols

BCBSTX distributes the Roles and Responsibilities Notification to our practitioners annually to keep you informed about important topics that impact you and your practice.

Submitting Documentation Requested from BCBSTX

To expedite the submission of requested documentation when providers receive a letter from Blue Cross and Blue Shield of Texas (BCBSTX), providers should always place a copy of the letter as the 1st piece of documentation and the supporting documentation behind the letter. This will assist BCBSTX to get the requested documents to the appropriate area in a timely manner. 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.

For example, when receiving a letter requesting medical records:

1. first, attach a copy of the BCBS letter,
2. then add the medical records next and
3. lastly, add any other supporting documentation at the end.

Be sure to review the "Avoid Claim Delays" tip under the Claims and Eligibility menu of the provider website for this and other Claim Filing Tips.

If you have any questions, please contact provider customer service at 800-451-0287.

Multiple Procedure Payment Reduction Effective July 1, 2018 for Certain Diagnostic Cardiovascular and Ophthalmology Procedures

Effective July 1, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) will implement a multiple procedure payment reduction (MPPR) to the technical component (TC) modifier of certain diagnostic cardiovascular and ophthalmology procedures billed by physicians and providers on a CMS-1500 claim form.

MPPR applies to the following plans:

- Blue Advantage HMOSM and Blue Advantage Plus℠ HMO
- Blue Choice PPO℠
- Blue EssentialsSM and Blue Essentials Access℠
- Blue PremierSM and Blue Premier Access℠
- PAR Plan

The MPPRs for multiple diagnostic cardiovascular or ophthalmology services will be applied when more than one of the services is billed for the same patient on the same day. It will apply to modifier TC-only services and to the technical component portion of global services. The MPPRs do not apply to

professional component (modifier 26) services. A list of cardiovascular and ophthalmology services subject to MPPRs is included in this notice.

BCBSTX provides general reimbursement information policies, fee schedule request forms and fee schedule information on the BCBSTX provider website. To view this information, visit the "General Reimbursement Information" section under the Standards and Requirements tab. Under the All Product News section, MPPR changes and updates will be posted under "Multiple Procedure Payment Reductions."

Cardiovascular Services
For cardiovascular services, full payment is applied to the technical component service with the highest allowable under the BCBSTX fee schedule. Payment is made at 75% of the technical component allowable for the identified subsequent services when performed by the same provider for the same patient on the same day.

The following is an example of how the MPPR applies to cardiovascular services:

Sample Cardiovascular Payment Reduction

Modifier	Code #1 Allowed	Code #2 Allowed	Total Allowed prior to 7/1/18	Total Allowed 7/1/18 or after	Payment Calculation
26	$77.00	$65.00	$142.00	$142.00	no reduction
TC	$427.00	$148.00	$575.00	$538.00	$427.00 + (.75 X $148.00)
Global	$504.00	$213.00	$717.00	$680.00	$504.00 + $65.00 + (.75 X $148.00)

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 to the Educational Webinar/Workshop sessions 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.

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. 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 Availity or Medecision. These vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

LET'S FOCUS ON BEHAVIORAL HEALTH

Texas Behavioral Health Provider Education Session

On May 10, 2018, Blue Cross and Blue Shield of Texas (BCBSTX) will host an education session to help behavioral health providers learn more about the medical necessity criteria used for identifying behavioral health needs, coordination of care, case management/utilization management and the importance of HEDIS® measures. The session will also include website navigation on how to find medical policies and claims information on the BCBSTX provider website.

We appreciate the opportunity to provide this training for our behavioral health providers.

Please **RSVP by email to** AncillaryContracting@bcbstx.com with the subject line of "**RSVP for BH Webinar**" by Tuesday, May 8, 2018. Once you have RSVP'd, you will receive a registration link for the training session.

May Is Mental Health Awareness Month

As a health care provider, you're aware that mental health conditions are the result of multiple, linking events or sources such as genetics, environment, lifestyle, stressful job or home life, traumatic events, and biochemical processes and brain structure. A study* has shown that 50 percent of mental health conditions begin by age 14 and 75 percent of all chronic mental health conditions begin by age 24. The normal personality and behavior changes of adolescence may mimic or mask symptoms of a mental health condition. Early engagement, intervention and support are crucial to improving outcomes.

Stabilization and recovery are possible, especially when the disease process and treatment are started early and the patient plays a strong role in their own treatment. Screening your patients, and educating them and their family members are keys to improved health outcomes and quality of life.

Magellan Healthcare® has provided a Behavioral Health Toolkit that supplies Blue Cross and Blue Shield of Texas(BCBSTX) Blue Essentials℠, Blue Advantage HMO℠ and Blue Premier℠ contracted providers with screening instruments and the information necessary to assist in making behavioral health referrals and assessments. Knowing that early engagement and interventions are crucial, we encourage you to use these tools.

BCBSTX provider manuals also provide information on Behavioral Health. The provider manuals can be accessed on the BCBSTX provider website under Standards and Requirements.

LifeTimes
Also, you may share these articles with your patients from our LifeTimes health and wellness website, which is available in both English and Spanish:

Teen Depression: More than Just a Phase
English
Spanish

The Science of Happy: You Don't Have to Be Born That Way
English
Spanish

Calming Down High Anxiety
English
Spanish

**National Quality Measures Clearinghouse™, Glascoe & Sharpio, 2007*

Blue Cross and Blue Shield of Texas (BCBSTX) contracts with Magellan Behavioral Health, Inc. ("Magellan"), an independent company, to administer BCBSTX's managed mental health program.

Video Series: Blue Promise℠ – Depression and Chronic Conditions

Depression can impact chronic diseases and other medical conditions in many ways. In this Blue Promise video, BCBSTX president, **Dr. Dan McCoy**, talks with **Dr. Conway McDanald**, BCBSTX's chief medical officer and vice president of Behavioral Health, about how mental health can impact overall health.

Behavioral Health: Let's Talk About It!

It's no secret that behavioral health issues are often kept quiet by those who are being treated for them. Sadly, some people may be unaware they have a treatable condition, and some may still find themselves feeling marginalized because of the continuing social stigma surrounding mental health.

The **first step to bridging the gap** may be simply talking to your patients more about behavioral health. People with behavioral health issues should not feel embarrassed to come forward, particularly when it comes to reaching out to their health care providers who may help. To get the discussion started, we'll be including more behavioral health articles in *Blue Review* over the coming months.

In March, our Making the Health Care System Work™ online magazine published The Intersection of Physical and Behavioral Health Care. It explores ways in which behavioral and physical health symptoms may fuel each other, as well as some of the ways data analytics are helping BCBSTX further integrate behavioral health.

In future issues of *Blue Review*, we'll also be including more information on our behavioral health program. It seeks to help identify members who may need education, care coordination and other types of support to help them better manage their health. We look forward to sharing additional behavioral health information and resources with you that you may share with your patients.

PHARMACY

Pharmacy Program Updates: April Drug List and Utilization Management Changes

Review the pharmacy network, drug list, dispensing limit and utilizations management program changes that went into effect April 1, 2018.

Blue Cross Medicare Advantage Pharmacy Provider

To help keep costs low, Blue Cross Medicare Advantage℠ has formed a preferred network of pharmacies that members may use to receive plan benefits at a lower copay than the other standard network pharmacies. Preferred network pharmacies include H-E-B, Walgreens and Albertsons pharmacies. Other pharmacies are available in our network.

Members save on monthly copay's by using a preferred pharmacy vs. a standard network pharmacy. Preferred pharmacies include:

- Albertsons
- H-E-B
- Walgreens

For more information about **Blue Cross Medicare Advantage** benefits or formulary, please call 1-877-608-2698 (HMO Plans) and 1-866-943-5656 (PPO Plans).

Please visit bcbstx.com/Medicare to view the complete formulary and list of pharmacies.

BCBSTX Approves Coverage of New Shingles Vaccine Shingrix

Blue Cross and Blue Shield of Texas (BCBSTX) now covers Shingrix, a new two-dose vaccine approved by the Food and Drug Administration (FDA) in October 2017 for reducing shingles and related nerve pain. Until recently, the only vaccine available for shingles was Zostavax®, which is 51 percent effective. Clinical trials show Shingrix is 91 percent effective.

For immunocompetent adults ages 50 and older, the Advisory Committee on Immunization Practices (ACIP) recommends Shingrix over Zostavax. They also recommend that immunocompetent adults who have already had Zostavax also get Shingrix.

BCBSTX covers two doses of Shingrix administered to patients ages 50 and older, even if they have already received Zostavax based on current ACIP recommendations. It is important to check eligibility and benefits information to confirm details regarding copays, coinsurance and deductibles before administering this vaccine to BCBSTX members.

Vaccine	Shingrix	Zostavax
Dosage schedule	Two doses (2nd dose 2-6 months later)	One dose
Vaccine description	Recombinant, adjuvanted	Live-attenuated
FDA recommended age	Adults 50 and older even if previously vaccinated with Zostavax	Adults 50 and older
Overall efficacy by year 3*	91%	51%
Administration site	Intramuscular	Subcutaneous
CPT® Code	90750 - Zoster (shingles) vaccine, (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection	90736 - Zoster (shingles) vaccine (HZV), live, for subcutaneous injection

*Zostavax and Shingrix prescribing information

For more information on Shingrix, see the Center for Disease Control and Prevention's Jan. 26, 2018, edition of Morbidity and Mortality Weekly Report. Or see the FDA-approved prescribing information for Shingrix. Should you have any questions, please contact your BCBSTX Network Management Representative.

Details on our complete, approved immunization schedule can be found on the BCBSTX provider page under Standards & Requirements, Clinical Payment and Coding Policies, "Preventive Services Policy CPCP006."

Please note that verification of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, 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.

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

PREAUTHORIZATION INFORMATION

ERS Prior Authorization Requirement Update – 491 Outpatient Procedures Removed

Blue Cross and Blue Shield of Texas (BCBSTX) has been closely monitoring the Prior Authorization requirements to ensure proper protocols are in place. After receiving feedback from the provider community, BCBSTX has reviewed the Employee Retirement System of Texas' (ERS) HealthSelect℠ of Texas and Consumer Directed HealthSelect℠ prior authorization requirements which resulted in the removal of 491 outpatient procedures retroactively effective Sept. 1, 2017.

Providers should refer to the "ERS Outpatient Procedures No Longer Requiring Prior Authorization" list under Preauthorizations/Notifications/Referral Requirements on the provider website for a list of the codes being removed.

BCBSTX will be reviewing applicable claims that denied for lack of Prior Authorization and claims that include any of the 491 outpatient procedures that no longer require Prior Authorization and they will be adjusted as appropriate for payment. Additionally, BCBSTX will review any appeals and grievances to determine if an appeal or grievance is no longer appropriate.

For a list of all the prior authorization and referral requirements for ERS participants, refer to Preauthorizations/Notifications/Referral Requirements on the provider website**.**

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

New Preauthorization Requirements for Blue Choice PPO℠ H-E-B Members

Blue Cross and Blue Shield of Texas (BCBSTX) has updated the Blue Choice PPO Self Insured (without health advocacy solutions) preauthorization list to include a preauthorization requirement for Non-Emergent Air Ambulance for H-E-B members only (Identified by Group # 091043) effective June 1, 2018.

An updated Blue Choice PPO Self Insured Groups (without health advocacy solutions) Preauthorization/Notifications/Referral Requirements List which includes the services listed above which require preauthorization for HEB members only for dates of service beginning June 1, 2018 is located on the provider website under Preauthorization/Notifications/Referral Requirements. Services performed without authorization may be denied for payment and you may not seek reimbursement from members/subscribers.

Providers can use iExchange® to preauthorize the non-emergent air ambulance services. iExchange is accessible to all physicians, professional providers and facilities. For more information or to set up a new iExchange account, please go to the iExchange page on the BCBSTX provider website.

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 benefit preauthorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact BCBSTX Provider Customer Service at 1-800-451-0287.

Infusion Therapy Prior Authorization Requirements for ERS HealthSelect℠ of Texas and Consumer Directed HealthSelect℠ Participants

Below is a clarification regarding the prior authorization requirements through Blue Cross and Blue Shield of Texas (BCBSTX) for infusion therapy for **HealthSelect of Texas** and **Consumer Directed HealthSelect** participants:

- Home infusion therapy (HIT) requires an authorization through BCBSTX, regardless of the drug being administered.
- Infusion therapy performed in an office setting only requires prior authorization if the drug being administered is listed on the ERS Specialty Drug Prior Authorization List as a specialty drug requiring prior authorization for HealthSelect of Texas and Consumer Directed HealthSelect.

For services that require a referral and/or preauthorization, as noted on the Prior Authorization and Referral Requirements Lists, you can use iExchange® or call the prior authorization number on the back of the participant's ID card. iExchange is accessible to physicians, professional providers and facilities contracted with BCBSTX. You can learn more information about iExchange or set up a new account under Clinical Resources on the provider website.

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

CLAIMS & ELIGIBILITY

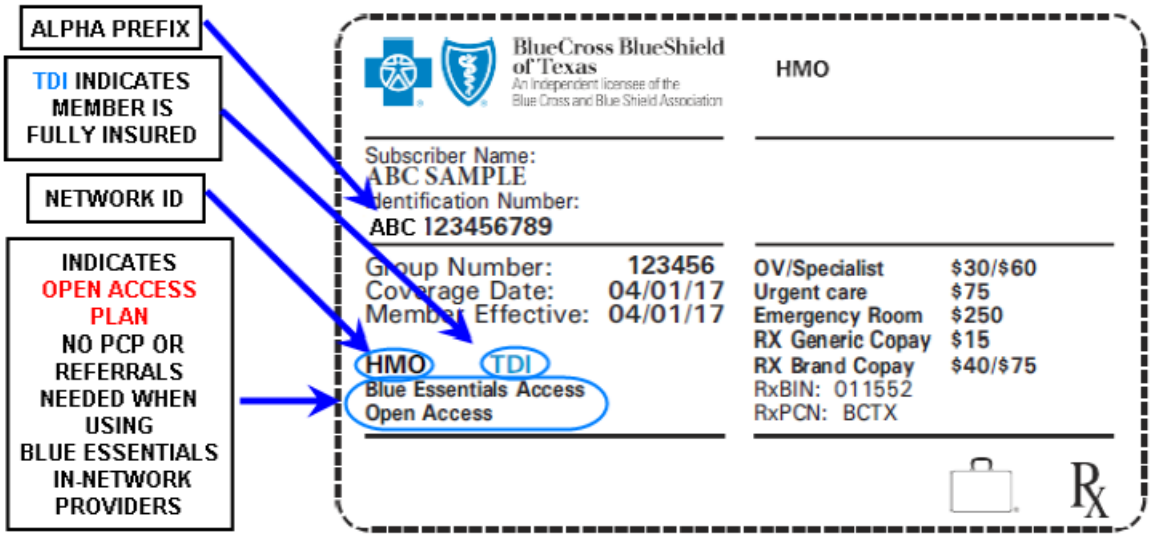
Modifier 25 and Modifier 59 Frequently Asked Questions (FAQ)

A Modifier 25 and 59 FAQ can be found under Claims Filing Tips - Submitting Claims in the Claims and Eligibility section of the BCBSTX website. The FAQ defines modifiers 25 and 59, provides an effective date for the recent modifier validation in our coding software, and provides information and direction if a provider receives a denial resulting from the modifier review. If you have any questions, please contact your Network Management Representative.

Blue Essentials Access℠ Benefit Plan

Blue Cross and Blue Shield of Texas (BCBSTX) introduced a new benefit plan option, **Blue Essentials Access**, that went into effect on Jan. 1, 2017. This is a reminder to providers that Blue Essentials Access is an "open access" plan that does not require BCBSTX members to select a primary care provider (PCP) or obtain a referral for specialist services when the member utilizes in-network Blue Essentials providers. All other HMO plan benefits remain the same.

Additional information regarding **Blue Essentials Access** can be found in the *Blue Essentials℠, Blue Advantage HMO℠ and Blue Premier℠ Physicians, Professional Providers, Facility and Ancillary Providers - Provider Manual* on our provider website under the "Standards and Requirements" section.
Below is a copy of a sample ID Card for Blue Essentials Access for your reference.



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

Correction to 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 Premier℠
- Blue Premier Access℠

Corrections to clarify Blue Advantage Plus HMO and Blue Essentials Access are bolded in the table below.

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 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 in-network OB/GYNs – no referrals are required.) 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.

Additional services for all HMO plans may require preauthorization. A complete list of services that require preauthorization or a referral for in and out of network benefits is available on the BCBSTX provider website under Clinical Resources/Preauthorization/Notification/Referral Requirements.

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

*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.

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.
- Blue Advantage Plus is a benefit plan that allows 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.

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.

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.

Services Rendered by Providers to Related Members and/or Self

As a reminder, standard BCBSTX benefit plans *exclude* coverage for services rendered by a provider to any member of their family related by blood or marriage. Certain benefit plans also exclude coverage for self-administered services. If a provider's family member has questions about this policy, they can call the toll-free Customer Service phone number on the back of their member ID card for assistance. For more information, please contact your Network Representative.

Availity® Claim Research Tool Offers Enhanced Claim Status Results

One of the most convenient, efficient and secure methods of requesting detailed claim status from Blue Cross and Blue Shield of Texas (BCBSTX) is by using an online option such as the Availity Claim Research Tool (CRT)*.

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). The CRT also enables users to check the status of multiple claims in one view to obtain near real-time claim status, with easy-to-read denial descriptions.

The 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 important 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 in the Education and Reference Center/Provider Tools section of our website at bcbstx.com/provider. 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.

Join us for a webinar! BCBSTX hosts complimentary Back to Basics: 'Availity 101' Webinars for providers to learn how to use the CRT and other electronic tools to the fullest potential. You do not need to be an existing Availity user to attend a webinar. To register online now for an upcoming webinar, visit the Provider Training in the Education and Reference Center section of our Provider website.

***The CRT is not available for government programs claims.** To check claim status in the Availity web portal for government programs (Medicare Advantage and Texas Medicaid) claims, providers should use the **Claim Status Inquiry tool**, instead of the CRT. The Availity **Claim Status Inquiry** tool is located under the **Claims & Payments** tab on the Availity home page.

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

CLINICAL RESOURCES

Overcoming Barriers to Colorectal Cancer Screening

Thank you for your continued support and interest in colorectal cancer (CRC) screenings. An article in the February 2018 *Blue Review* newsletter, **Colorectal Cancer Screening: 80% by 2018, Will You Commit?** discussed the efforts of Blue Cross and Blue Shield of Texas (BCBSTX), the American Cancer Society® and the National Colorectal Cancer Roundtable to have 80 percent of BCBSTX's members, ages 50 to 75, screened for CRC by the end of 2018. A March *Blue Review* article, titled **Colorectal**

Cancer Screening Options and Statistics – Get the Conversation Started Today, discussed the various CRC screening methods available.

Our CRC screening initiative series now continues with how to **overcome barriers to CRC screening**.

CRC screening can be a highly effective preventive measure that offers patients improved outcomes. The U. S. Preventive Services Task Force has found convincing evidence that screening for CRC through a variety of different methods can accurately detect early-stage CRC and adenomatous polyps.

The rates of new CRC cases and deaths among U.S. adults ages 50 years or older are decreasing due to an increase in screenings and changes in some risk factors (e.g., a decline in smoking). Still, overcoming barriers may be challenging.

Patient Concerns

A 2017 BCBSTX member survey asked members why they chose **not** to complete a CRC screening. The primary reasons included:

- lack of symptoms or family history, and
- procrastination.

After the at-home test concept was introduced to survey respondents, scores for likelihood to utilize an at-home CRC screening option went from 36 percent to 69 percent. Messages that focused on at-home privacy and insurance coverage resonated most with members.*

Let's take a closer look at patient concerns and sample approaches you can take to overcome them.

Embarrassment or Awkwardness

- Patients feel embarrassed about bowel functions and/or tests that involve stool collection.
- Inform patients that there are several screening options available, including simple take-home tests that can be done in the privacy of their own homes.

Misconceptions about Cancer and Cancer Screening

- Some patients feel that being asymptomatic equates to an absence of cancer.
- Sensitivity to personal and cultural fears about cancer itself is important. Let patients know that many people diagnosed with colon cancer do not have any symptoms or a family history, which is why screening is so important.

Lack of Information

- Information about available testing options and processes isn't always readily available.
- Discuss the variety of CRC screening test options, as well as individual considerations that may impact CRC screening test selection. Offer a questionnaire at the time of check-in to expedite the CRC screening selection and to allow the patient time to formulate questions about the CRC screening.
- Once a CRC screening option is agreed upon, explain the expectations and process. Assure the patient that medications for discomfort will be provided for CRC screening procedures. Patient brochures and information are available through your local American Cancer Society office.

Concerns Regarding Costs and/or Interruption of Daily Life Responsibilities

- Although CRC screening is a preventive measure, there may be out-of-pocket costs. Loss of work and/or lack of transportation may be a concern with a flexible sigmoidoscopy or colonoscopy. Inform patients that preventing CRC or finding it early does not have to be expensive. There are simple, affordable tests available.
- Encourage patients to contact their BCBSTX customer service advocates, using the phone number on the back of their ID card, to discuss benefits and coverage.

Provider Concerns

Office Visit Time Constraints

- Addressing acute or chronic conditions may take precedence over preventive care during a visit.
- Train staff to identify patients with gaps in preventive care to allow focused and efficient use of provider time. Office systems that "flag" patients needing a CRC screening are helpful. Having printed materials available in waiting rooms may also encourage conversations.

Familiarity with Recommended CRC Screening Options

- Various factors will determine which option is best for each patient.
- Check out our previous article, "Colorectal Cancer Screening Options and Statistics – Get the Conversation Started Today," which addressed available CRC screening methods, such as direct visualization tests and stool based tests.

Office Process

- Identify a CRC screening champion in your office to train staff in identifying patients who are due for screening.
- Standing orders will allow key staff to assess, implement and follow-up with patients regarding their selected CRC screening option.
- Stock Fecal Immunochemical Testing (FIT) kits in the office to dispense during visits. **When patients agree to FIT testing, allow them to open the kit, handle the materials and complete the paperwork**. The mystery will be removed if the patient can see the test and ask questions. They will be more likely to complete the CRC screening if they feel confident in the process.

Resources to Follow up on Positive CRC Screening

- You may be concerned that patients with positive CRC screening results may not have access to gastroenterologists or cancer treatment specialists.
- Review the availability of local resources to alleviate this concern or have patients call the number on the back of their member ID card to discuss resources.

LifeTimes®

Let your patients know they can find information about cancer on our LifeTimes health and wellness website. Several articles focus on the importance of colorectal cancer screening, such as: Growing Cancer Risk for Younger Adults: What You Should Know.

**Source: Corporate Strategy: CRC Screening Insights Survey, BCBSTX, May 2017*

NETWORK PARTICIPATION

Keep Your Information Updated to Receive Quick and Accurate Payments

To provide the best service to you and your patients, it's very important that all the information BCBSTX has about your practice is current and accurate. Be sure to let us know about any changes to your practice address, email and/or physician rosters. Keeping us informed of any changes to your information helps us pay your claims more quickly and accurately. It also makes it easier for your patients to get current and correct information on Provider Finder®. Please update your information by completing the Demographic Change form. Note: Changes may take up to 30 business days to complete. Please consider the impact of your change(s) and the timeliness of your submissions.

STANDARDS & REQUIREMENTS

Quality Improvement Program Information Available to Providers

Blue Cross and Blue Shield of Texas (BCBSTX) has a Quality Improvement Program to better serve our members. The program focuses on preventive health, behavioral health, patient safety, and condition management. By collaborating with physicians, providers and health care professionals, the quality improvement programs help promote safe and appropriate care. It also encourages the efficient use of resources, which ultimately helps reduce health care costs and improves member satisfaction with their health plan.

The Quality Improvement Program includes many activities which develop, review, and monitor services provided including but not limited to:

- Member complaints and appeals,
- Member and provider satisfaction,
- Utilization management statistics and systematic measurement of clinical care (e.g., such as cancer screenings), immunizations and chronic conditions (e.g., asthma and diabetes)

Member care and service are evaluated on a regular basis to determine whether members are receiving appropriate care and service and that they are satisfied with the BCBSTX health plan.

Information regarding the Quality Improvement Program is available in the provider manuals. These manuals are available online at www.bcbstx.com/provider under Standards and Requirements. To receive a written summary of the Quality Improvement Program, which includes outcomes, please call the **Quality Improvement Programs Department** at **800-863-9798**.

EDUCATION & REFERENCE

Tackling Prescribing Patterns to Combat the Opioid Crisis

Is there a way to keep opioids out of the hands of those who don't legitimately need them? Check out the Tackling Prescribing Patterns to Combat the Opioid Crisis article on our Making the Health Care System Work℠ news portal.

DID YOU KNOW?

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. It includes a collection of articles to assist provider offices in servicing BCBSTX patients. 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
- CMS Guidance Notifications
- Education & Reference
- 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 preauthorizations/referrals, it is also the responsibility of the member/subscriber to confirm that this action has been taken for services that require a preauthorization/referral.

To determine if a service requires a referral or preauthorization, refer to the Preauthorizations/Notifications/Referral Requirements Lists under Clinical Resources on bcbstx.com.

Preauthorizations/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.

Preauthorizations are required to allow for medical necessity review. 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. Retrospective reviews for medical necessity will not be performed for any HMO plans except in limited special circumstances.

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

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

If 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 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)℠

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 Provider 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.

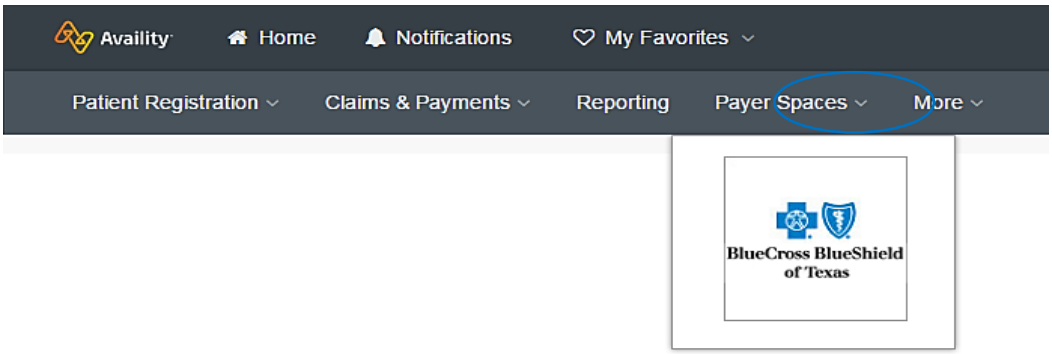
Claims

Find BCBSTX Resources in Availity® Payer Spaces

Have you recently been searching in the Availity Provider 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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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® Provider 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 Essentials℠, 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 F 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.

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
• 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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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™ 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.

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 Provider Portal to research specific claim edits.

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

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

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

Technical and Professional Components

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

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

Surgical Procedures Performed in the Physician's Office

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

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

Please note the physician's and professional provider's reimbursement includes surgical equipment that 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 (Health Insurance Portability and Accountability Act of 1996) to add a requirement that if a patient self pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

Billing for Non-Covered Services

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

If Blue Cross and Blue Shield of Texas (BCBSTX) determines that a proposed service is not a covered service, the physician, professional provider, facility or ancillary provider must inform the

member/subscriber in writing in advance. This will allow the physician, professional, facility or ancillary provider to bill the member/subscriber for the non-covered service rendered.

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

Avoidance of Delay in Claims Pending COB Information

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

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

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

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

Hospitals, and Routine Services and Supplies

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

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

Clinical Resources

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)SM 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.

CMS Guidance Notifications

CMS Notifications for 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 located in the Medicare Learning Network (MLN Matters) on CMS.gov and in the BCBSTX News and Updates section of the provider website under CMS Notifications Medicare Advantage Plans 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 are aware of them.

Education & Reference

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. 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.

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 Provider 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 Provider 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.

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 Health Insurance Portability and Accountability Act-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

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® Provider 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 Preauthorization Requirements

Blue Cross and Blue Shield of Texas (BCBSTX) contracts with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to administer preauthorization requirements for certain specialized services and products for BCBSTX members.

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 found on the BCBSTX provider web site.

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 all physicians, professional providers and facilities. Learn more about iExchange or set up a new account on BCBSTX’s provider website.

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

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

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if a member requires benefit preauthorization or prior authorization. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX’s provider website.

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

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

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

Pharmacy

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

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

RIGHTS	RESPONSIBILITIES
Subscriber(s)/Member(s)	**Subscriber(s)/Member(s)**
You have the right to:	You have the responsibility to:
Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities. Make recommendations regarding the organization's subscribers' rights and responsibilities policy.	Provide, to the extent possible, information that your health benefit plan and practitioner/provider 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 highest 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