



Dec. 7, 2016

Claims & Eligibility

Important Changes Impacting Claims Submissions for BCBSTX Medicare Advantage Plans

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will administer updates and changes that will have an impact on claims submissions for Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM (Medicare Advantage plans). These changes will assist in streamlining claims processing and improving efficiencies of claims routing to our primary claims adjudicator.

The changes are as follows:

New Payer ID

- The Payer ID for the Blue Cross Medicare Advantage plans will change to **66006** for claims submitted on and after **Jan. 1, 2017**. Providers who are not registered with [Availity](#)[®] and Experian[®] Health ([ecare online](#)) should contact their clearinghouse to confirm the new Payer ID for this plan (as other clearinghouses may assign their own unique number).
 - Please note that the Blue Cross Medicare Advantage member ID cards will contain the following applicable state alpha prefix:

State	PPO	HMO
Texas	ZGD	ZGJ
Illinois	XOD	XOJ
New Mexico	YID	YIJ
Oklahoma	YUX	YUB
Montana	YDJ	YDL

- The above state alpha prefix must be submitted using the new Payer ID **66006**, even for members who seek services from you when out of state. **You will no longer use the commercial payer IDs for out-of-state members with these prefixes.** Claims with these prefixes will be rejected if submitted to the commercial payer ID.

Electronic Inquiry Submission Updates

- Effective for services rendered on and after Jan. 1, 2017, Blue Cross Medicare Advantage eligibility, and benefit and claim status inquiry transactions will have a new drop-down with payer options available within the [Availity web portal](#).
- Blue Cross Medicare Advantage providers will no longer have access to the Claim Research Tool on Availity. Claim status can be obtained through Availity or your current web vendor via the electronic 276 claim status inquiry process.

New Electronic Funds Transfer (EFT) Payment Cycle

- Payment cycles for EFT will be changing from daily to weekly. BCBSTX will make weekly EFT payments for Blue Cross Medicare Advantage plans effective Jan. 1, 2017.

Paper Claim Mailbox Address and Fax Number for Non-delegated Providers (No changes for RPO/EPIC/VOP providers)

- The paper claim mailbox address and fax number for Blue Cross Medicare Advantage Plans non-delegated providers will change to:

Blue Cross Medicare Advantage
c/o Provider Services
P.O. Box 3686

Scranton, Pa. 18505
Fax: 855-674-9192

- Effective Feb. 1, 2017, claims received at the old BCBSTX mailbox will be rejected with a letter informing providers to resubmit to the above correct mailbox.

New Processes and Format for Payments

- EFT trace number:
 - Blue Cross Medicare Advantage Plans will start with a source code of “M” instead of “C”
- A new process will be implemented for claims overpayment recovery:
 - ERM (Electronic Refund Management) claims refund and inquiry process post Jan. 1, 2017, will **not** be available through ERM.
 - Request for refund letters will be sent by mail for all providers.
 - Providers may submit requested and voluntary refunds to the new lockbox listed above.

Electronic Remittance Advice (835 ERA)

- 835 ERA files will be distributed to the address associated with the billing provider's Tax ID, rather than being distributed to multiple locations.
- EPS (Electronic Payment Summary) will not be available for providers post Jan. 1, 2017. However, for ERA and non-ERA receivers, Provider Claim Summaries (PCS) will be sent by mail.
- As a current ERA receiver for Blue Cross Medicare Advantage plans, you will not need to re-enroll under the new Payer ID.
- The Payer ID on the 835 ERA will now match the Payer ID that is submitted on the claim (if submitting Blue Cross Medicare Advantage claims using 66006, then the ERA Payer ID will also reflect 66006).

We appreciate your patience during this transition. BCBSTX will be providing additional information on these changes in the coming months. These changes will be noted on the [BCBSTX website](#) and in the provider manuals accordingly. Please continue to watch for further information on the BCBSTX website and in this newsletter.

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

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

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Clinical Resources

Reminder: 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reminders:

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

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

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

Eligibility and Benefit Quotes

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

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

Electronic Options

Enroll Now for ERA and EFT through Availity®

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) enrollment process will only be available electronically through Availity. When Availity is used to complete the ERA and EFT real-time enrollment, providers will receive a confirmation letter acknowledging the effective date of registration, which eliminates the burden of follow up associated with the paper enrollment process.

Benefits of enrolling for ERA through Availity:

- Faster remittance delivery
- Automatic posting capabilities
- Designate delivery to a specific clearinghouse or vendor

Benefits of enrolling for EFT through Availity:

- Quicker receipt of payments
- No more waiting on mailed paper checks
- Direct deposit into bank account of choice

Once an organization is enrolled for ERA, providers and billing services gain the ability to use the Availity Remittance Viewer. This tool permits you to search, view, save and print remittance information, even if the ERA is delivered to an appointed receiver. Learn more about the [Remittance Viewer](#).

Online ERA and EFT enrollment is available to registered Availity users. To register for Availity, simply go to availity.com and sign up today. For assistance with ERA and EFT registration through Availity or use of the Remittance Viewer tool, email a Provider Education Consultant at ECommerceHotline@bcbsil.com or call 800-746-4614.

The current paper ERA and EFT enrollment forms on the BCBSTX provider website will be removed after Jan. 31, 2017, on bcbstx.com/provider.

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Provider Claim Summary Paper-to-electronic Conversion Coming March 1, 2017

Blue Cross and Blue Shield of Texas (BCBSTX) recognizes that immediate access to the Provider Claim Summary (PCS) is vital for posting patient accounts and reconciling financials. Often times, providers who receive this information via post office mail are waiting on delivery, which delays administrative processes.

As of Dec. 12, 2016, a new report viewer application will be available in the BCBSTX branded Payer Spaces section on the [Availity® web portal](#). This new tool permits you to readily view, download, save and/or print the PCS online as often as needed. This report viewer offers you the opportunity to obtain claim outcome results for multiple patients in one central location.

Effective March 1, 2017, claim summary information will be delivered through this online report viewer application, rather than distribution via paper mailing. This online alternative is an additional offering to our other electronic tools through Availity. If you currently rely on paper claim summaries, Availity registration is strongly recommended to gain access to the report viewer application.

Providers who are already enrolled for [Electronic Remittance Advice](#) from BCBSTX will continue receiving their remittances electronically. They will also have the same opportunity to view, download and/or print the claim summary as a complimentary option.

Exceptions to continue receiving paper mailings may be considered for extenuating circumstances. To submit this type of exception or request training for online applications, email PECS@bcbstx.com. Otherwise, beginning March 1, 2017, claim summary information will be accessible exclusively on the report view application on Availity. Additionally, providers will be directed to make use of the BCBSTX report view application if an exception request is not received by Feb. 17, 2017. The exception review process may require up to five business days before a response is returned.

BCBSTX supports an array of online tools to registered Availity users, including the report viewer, at no additional cost. To register, simply go to availity.com, select Register and then complete the online application.

Additional communications regarding the change will be published in upcoming issues of this newsletter and on our provider website.

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Reminder: Phone System Update for Eligibility and Benefits

With the addition of several benefit categories to the Interactive Voice Response phone system, the option for agent assistance will be removed Dec. 12, 2016, for common benefit categories.

BCBSTX strongly encourages providers to check patient eligibility and benefit information prior to every scheduled appointment, so having quick access to this data is imperative. The fastest and most efficient way to obtain eligibility and benefits information is electronically through [Availity®](#), or your preferred web vendor. Taking advantage of electronic options allows retrieval of needed information at your convenience.

If eligibility and benefits are unable to be verified online, the same information is often readily accessible through our IVR phone system. Additionally, a confirmation number will be provided for your records after the phone system has completed the quote.

Attend the Back to Basics: Availity 101 Webinars

To learn more about obtaining eligibility and benefits electronically, join us for a complimentary Back to Basics: "Availity 101" webinar. Visit the [Provider Training page](#) in our online [Education and Reference Center](#) for additional information. Or, register below by selecting a session date and time below.

[Dec. 8, 2016 – 11 a.m. to noon CT](#)

[Dec. 15, 2016 – 11 a.m. to noon CT](#)

[Dec. 22, 2016 – 11 a.m. to noon CT](#)

For more advanced training on our online tools and resources, email our [Provider Education Consultant team](#).

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

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Pharmacy Program

Reminder: Updates to the Diabetes Blood Glucose Meter Program

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

Standards & Requirements

Reminder: 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.

[Fee Schedule Update for Blue Choice PPOSM and ParPlan for Applied Behavior Analysis and Related Services](#)

Effective Feb. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule used for Blue Choice PPO and ParPlan for Applied Behavior Analysis (ABA) and related services.

The fee schedule changes for Blue Choice PPO are located under [General Reimbursement Information](#) on the bcbstx.com/provider website.

Brief descriptions of the changes:

- Effective Feb. 1, 2017, the fee schedule for CPT codes 0359T-0374T specific for Applied Behavior Analysis and related services will be updated.
- The payable units will be limited to one unit per day for the following codes: 0359T, 0370T, 0371T and 0372T.
- Additionally 0359T will be limited to two assessments per 12-month period.

BCBSTX also provides general reimbursement information policies, fee schedule request forms and fee schedule information under the [General Reimbursement Information](#) section on the [provider website](#). Reimbursement changes and updates are posted under "Reimbursement Changes/Updates" in the Professional Reimbursement Schedules section. 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.

Please be advised that this reimbursement information contains confidential information proprietary to BCBSTX. The use and disclosure of this information is restricted under Texas Insurance Code Section 1301.136(b), Texas Insurance Code Section 843.321(b) and the terms of your BCBSTX agreements.

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

Reminder: Physician Payment Policies for Members Enrolled in Blue Cross Medicare Advantage HMOSM and Blue Cross Medicare Advantage PPOSM

Effective Feb. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will enhance our review and application of our physician payment policies applicable to Blue Cross Medicare Advantage PPO and Blue Cross Medicare Advantage HMO.

There are no changes required by providers. The payment policies for the Blue Cross Medicare Advantage plans will continue to be based on nationally accepted means of claims payment, which include:

- Medicare's:
 - National bundling edits, including the Correct Coding Initiative (CCI)
 - Modifier usage
 - Global surgery rules
- AMA CPT coding guidelines
- Regional Medicare policies
- National specialty academy guidelines (coding and clinical).

As a valued provider, please continue to render services to our members and submit your claims accordingly. The goals of this endeavor are to:

- Enable you and your billing staff to more readily understand our payment of claims given the widespread use of these policies and source criteria utilized above.
- Identify that the service or drug being requested is medically necessary and appropriate by following up-to-date medical recommendation treatment plans that are not duplicated

This is one of many things we are doing to make the health care system work better by focusing on improving health care delivery. We want our members to receive the best health outcomes for all of the dollars spent on their care.

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

Urinary Drug Test (UDT) Fee Schedule Update

Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the Urinary Drug Test (UDT) series CPT codes maximum allowable fee schedule used for Blue Choice PPOSM, Blue PremierSM, Blue EssentialsSM (formerly HMO Blue TexasSM), Blue Advantage HMOSM and ParPlan members effective **Feb. 1, 2017**.

Periodically, BCBSTX reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our members' benefit plans and meet BCBSTX's guidelines.

Below is a brief description of the change:

Professional claims submitted on a HCFA 1500 for Urinary Drug Test (UDT) 80000 series CPTs and billed with or without the CMS specified G code replacements on the same HCFA 1500 claim, will not be reimbursed by BCBSTX effective February 1, 2017. However, the CMS specified G HCPCS code replacements for the UDT 80000 series codes (see grid below) will be considered for reimbursement according to our fee schedule posted [General Reimbursement Information](#) section.

HCPCS Codes	Drug Test Class
G0480	1-7
G0481	8-14
G0482	15-21
G0483	22 or more

BCBSTX provides general reimbursement information policies, fee schedule request forms and fee schedule information under the [General Reimbursement Information](#) section on the [provider website](#). Reimbursement changes and updates are posted under "Reimbursement Changes/Updates" in the Professional Reimbursement Schedules section. 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.

Please remember that if services are rendered directly by the provider, the services may be billed by the provider. However, if the provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services.

For additional information, please refer to both the monthly [Blue Review](#) newsletter and [Provider Manuals](#). Please be advised that the reimbursement information being disclosed within this notification contains confidential information proprietary to BCBSTX. The use and disclosure of this information is restricted under Texas Insurance Code Section 1301.136(b), Texas Insurance Code Section 843.321(b) and the terms of your BCBSTX, Blue Choice PPO, Blue Premier, Blue Essentials formerly HMO Blue Texas, and Blue Advantage HMO agreements.

For ancillary provider questions, please feel free to email your questions to bcbstxancillarycontracting@bcbstx.com or if you need additional information, please contact your [Network Management Representative](#).

Reminder: Annual Medical Record Data Collection for Quality Reporting Begins Feb. 1, 2017

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

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

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

BCBSTX or as stated within the provider's individual contract.

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

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

HEDIS is a registered trademark of NCQA.

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

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

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

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

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

Reminders

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

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

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

Notices and Announcements

Reminder: HMO Blue TexasSM Name Change to Blue EssentialsSM and Product Update

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will change the name of the HMO Blue Texas network to Blue Essentials. Existing HMO Blue Texas agreements will remain in effect under the new **Blue Essentials** name. This notification of the name change does not require any action on your part. As with any name change, there will be a transition period before the HMO Blue Texas name will cease to exist. You will continue to see HMO Blue Texas collateral information for a period of time in 2017.

Blue Essentials, formerly HMO Blue Texas, will maintain the same features including:

- Product design and benefits are not changing.
- Members are still required to select a primary care physician and get referrals for services with network providers.
- No out-of-network coverage, except for emergency services.
- Support, tools and guidance are available to help our members make informed decisions and the best use of their benefits.

Additionally, there is a new benefit plan option effective Jan. 1, 2017, that will be called **Blue Essentials Access**. This new benefit plan option allows “open access” within the **Blue Essentials** provider network (formerly HMO Blue Texas) where PCP selection and referrals are **NOT** required. All other HMO requirements remain unchanged.

BCBSTX will be providing additional information in the coming weeks on the provider website at bcbstx.com/provider and in **Blue Review**.

If you have any questions, please contact your BCBSTX [Network Management Representative](#).

New Health Benefit Plan ‘Blue Essentials AccessSM’ Offers More Options for Members

Effective Jan, 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) is offering a new benefit plan **Blue Essentials Access**, which is designed to give members access to the **Blue EssentialsSM** (formerly HMO Blue TexasSM) provider network of contracted physicians and hospitals throughout the state of Texas. This plan provides an alternative solution for members who are looking for cost savings while still having the freedom to choose in-network providers without selecting a primary care physician (PCP) or obtaining a referral to see a specialist. Also, emergency and urgent care is available when members go out-of-network or are traveling out of state.

Our growing selection of new benefit plan offerings reflects BCBSTX’s commitment to increasing access to affordable, quality health care services for our members in all 254 Texas counties.

The Blue Essentials Access plan is designed to:

- Allow members the benefit option of “open access” within the Blue Essentials provider network where PCP selection and referrals are **not** required.
- Help manage costs and enable flexibility and customization, including features like predefined deductibles, coinsurance and copayments for certain health care services.
- Provide members’ access to the statewide Blue Essentials network.

Reminder: The **Blue Essentials** benefit plan will maintain the same standard HMO features including:

- Benefit plan design and benefits are not changing.
- Members still being required to select a primary care physician and get referrals for services with in-network providers.
- No out-of-network coverage, except for emergency services.
- Support, tools and guidance to help members make informed decisions and the best use of their benefits.

The updated **Blue Essentials/Blue Essentials Access** Preauthorization/Referral Requirements list is located in the [General Reimbursement Information](#) section of the BCBSTX provider website.

Please refer to [Provider Finder](#)[®] to assist you in finding contracted doctors or hospitals within the Blue Essentials network for the Blue Essentials and Blue Essentials Access benefit plans for your patients.

If you have any questions, please contact your [Network Management Representative](#).

Telephonic Medical Services Now Available for Blue Advantage HMOSM/Blue Advantage PlusSM HMO, and Blue Choice PPOSM Fully Insured Members through MDLIVE

Effective Jan. 1, 2017, telephonic medical services will be available to Blue Cross and Blue Shield of Texas (BCBSTX) Blue Advantage HMO/Blue Advantage Plus HMO members, and Blue Choice PPOSM fully insured members through MDLIVE.

[MDLIVE](#) is a telehealth provider of online and on-demand health care delivery services and software that benefit patients, hospitals, employers, payers, physician practice groups and accountable care organizations.

Physicians who live in Texas will have the option to continue providing telephonic health care services to their patients in an effort to strengthen provider/patient relationships and maximize continuity of care with the same provider. Additionally, physicians can choose to become a "preferred" MDLIVE provider and perform telehealth services outside of his/her own patients by calling 888-450-1572 or going to the following link [MDLIVE.com](#).

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

In Every Issue – December 2016

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

Topics:

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

Authorizations and Referrals

Contact eviCore to Pre-certify Outpatient Molecular and Genomic Testing, and Outpatient Radiation Therapy for Blue Advantage HMOSM and Blue Advantage PlusSM Members

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

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

- Outpatient molecular and genomic testing
- Outpatient radiation therapy

eviCore preauthorization's for outpatient molecular and genomic testing and outpatient radiation therapy can be obtained using one of the following methods:

- The [eviCore Healthcare Web Portal](#) is available 24/7. After a one-time registration, you are able to initiate a case, check status, review guidelines, view authorizations/eligibility and more. The Web Portal is the quickest, most efficient way to obtain information.
- Providers can call toll-free at **855-252-1117** between 7 a.m. to 7 p.m. (CT) Monday through Friday.
- More specific program-related information can be found on the [eviCore implementation site](#).
- Refer to the [eviCore implementation site](#) and select the BCBSTX health plan for provider training orientation presentations.

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

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

BCBSTX and eviCore will be providing additional information in the coming weeks on the provider website and in *Blue Review*, including:

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

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

iExchange® Accepts Electronic Medical Record Attachments

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

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

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if benefit preauthorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the [Eligibility and Benefits](#) section on BCBSTX's provider website.

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

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

Blue EssentialsSM (formerly known as HMO Blue TexasSM), **Blue Advantage HMOSM** and **Blue PremierSM** members require a referral from their Primary Care Physician (PCP) before receiving services from a specialty care physician or professional provider (except for OBGYNs). The referral must be initiated by the member's PCP, and must be made to a participating physician or professional provider in the same provider network.

If an in-network physician, professional provider, ambulatory surgery center, hospital or other facility is not available in the member's applicable provider network, **preauthorization is required** for services by an

out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility, through iExchange or call the preauthorization number 1-855-462-1785.

Reminders:

- The **Blue Essentials, Blue Advantage HMO and Blue Premier** physician, professional provider, facility or ancillary provider is required to admit the patient to a participating facility, except in emergencies.
- **Additional services may also require preauthorization.** A complete list of services that require preauthorization for **Blue Essentials** and **Blue Advantage HMO**, and for **Blue Premier** and **Blue Premier AccessSM**, is available on the BCBSTX Provider website. Under the 'Standards and Requirements' tab, click on [General Reimbursements](#) (password is 'manual') and scroll down to the "Preauthorization/Notification/Referral Requirements Lists".

Blue Advantage PlusSM HMO Point of Service (POS) is a benefit plan that allows those members to use out-of-network providers. However, it is essential that those members understand the financial impact of receiving services from an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility. Prior to referring a Blue Advantage Plus enrollee to an out of network provider for non-emergency services, please refer to Section D Referral Notification Program, of the Blue Essentials (formerly known as **HMO Blue Texas**), **Blue Advantage HMO** and **Blue Premier Provider Manual** for more detail including when to utilize the **Out-of-Network Enrollee Notification Forms** for [Regulated Business](#) and [Non-Regulated Business](#). In addition, see article below titled: [Enrollee Notification Form Required for Out-of-Network Care for Blue Choice PPOSM and Blue Advantage HMOSM \(for Blue Advantage Plus\)](#).

[Enrollee Notification Form Required for Out-of-Network Care for Blue Choice PPOSM and Blue Advantage HMOSM \(for Blue Advantage Plus\)](#)

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

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

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

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

For additional information, refer to the [Provider Manual's](#) section D **Referral Notification Program** on the bcbstx.com/provider website.

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

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

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

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

AIM RQI Reminder

Physicians, professional providers and facility and ancillary providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPOSM subscribers when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's, professional provider's or facility or ancillary provider's office, a professional provider's office, the outpatient department of a hospital or a freestanding imaging center:

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

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

AIM's **ProviderPortal**SM uses the term "Order" rather than "RQI."

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

Notes:

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

Importance of Obtaining a Preauthorization/Referral

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

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

If a member/subscriber does not obtain a preauthorization/referral for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

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

If a preauthorization/referral request is received from an out-of-network (OON) provider and the member/subscriber does not have an OON benefit, BCBSTX will contact the ordering provider to discuss network options. However, if a member/subscriber has an OON benefit, OON benefits will apply, which could result in a higher cost sharing.

Are Utilization Management Decisions Financially Influenced?

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

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

Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

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

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

What does the BCBS MA PPO network-sharing mean to me?

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

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

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a BCBS MA PPO member when their Blue Cross and Blue Shield Member ID card has the following logo:



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

Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?

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

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

What if my practice is closed to new local BCBS MA PPO members?

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

How do I verify benefits and eligibility?

Call BlueCard[®] Eligibility at 800-676-BLUE (800-676-2583) and provide the BCBS MA PPO member's alpha prefix located on the member's ID card.

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

- Log in to the [Availity web portal](#), the [Availity Revenue Cycle Management portal](#) or your preferred vendor
- Enter required data elements
- Submit your request

Where do I submit the claim?

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

What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?

If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO Network Sharing?

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

What is the BCBS MA PPO member cost sharing level and co-payments?

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

May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?

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

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

Who do I contact if I have a question about BCBS MA PPO network sharing?

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

Claims

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

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

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

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

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Fee Schedule Updates

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

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

Technical and Professional Components

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

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

Surgical Procedures Performed in the Physician's Office

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

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

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

Reminder: Pass-through Billing

Blue Cross and Blue Shield of Texas (BCBSTX) does not permit pass-through billing. Pass-through billing occurs when the ordering physician, professional provider or facility or ancillary provider requests and bills for a service, but the service is not performed by the ordering physician, professional provider or facility or ancillary provider.

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

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

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

- **AS modifier:** A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used *ONLY* if they assist at surgery.)
- **SA modifier:** A supervising physician should use this modifier when billing on behalf of a PA, APN or CRNFA for **non-surgical** services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that *DOES NOT* include surgery.)

Improvements to the Medical Records Process for BlueCard® Claims

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

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

Contracted Providers Must File Claims

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

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

Billing for Non-covered Services

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

In the event that 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.

Flucelvax Quadrivalent Billing Update

The American Medical Association released CPT[®] code 90674 (Influenza virus vaccine, quadrivalent [ccIIV4], derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage), which best describes Flucelvax Quadrivalent – a new flu vaccine for the 2016-2017 flu season. This code will be effective Jan. 1, 2017. Until the effective date, Blue Cross and Blue Shield of Texas (BCBSTX) feels Flucelvax Quadrivalent is appropriately billed with CPT code 90749.

Implantable Device Versus Medical Supply/Material

We have received a number of questions from providers about billing for implants. To help address the topic, we have provided a reminder about the National Uniform Billing Committee definition of an implant.

National Uniform Billing Committee (NUBC) definition of an implant:

- Revenue Code 274 – Prosthetic/orthotic devices
- Revenue Code 275 – Pacemaker
- Revenue Code 278 – Other Implants

An implantable device is that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Also included is an object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.

Examples of other implants reported under revenue code 278 include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds (not an all-inclusive list).

Supplies that are not implantable should be submitted as supply charges. In conjunction, a device is not a “material or supply furnished incident to a service.” Items used as routine supplies should not be submitted as an implant. Guide wires, catheters and clips that are used during surgery but do not remain in the body are used the same way as an instrument and are not “implanted” should not be submitted as an implant.

Additional reference and definition of implantable devices, supplies and material can be located in the UB04 Editor and the website of the implantable device’s manufacturer.

Online Portal Applications Help Expedite Administrative Workflows

Does your office or organization ever ask: “Is this patient eligible for Blue Cross and Blue Shield Texas (BCBSTX) benefits? Does this service require preauthorization? or How did my claim process?” If so, these questions and so many more can be answered in a matter of seconds with a few key strokes using an online portal application, such as Availity®.

Electronic options deliver real-time resolutions, avoiding disapproved services and optimizing your payment. You can confirm patient coverage, preauthorize services and post payments with a few simple clicks.

Not only can you conduct HIPAA-compliant transactions online, using Availity you can also:

- Submit pre- and post-exam transactions
- Conduct pre-service requests
- Complete post-service reconciliations
- Update provider demographics
- Enroll for electronic remittance and fund transfers

If you have not registered and would like to learn more about Availity, and our online referral and preauthorization tool iExchange®, register for one of the [Back to Basics: Availity 101 webinars](#) being held weekly through December.

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

Implantable Device Versus Medical Supply/Material

We have received a number of questions from providers about billing for implants. To help address the topic, we have provided a reminder about the National Uniform Billing Committee definition of an implant.

National Uniform Billing Committee (NUBC) definition of an implant:

- Revenue Code 274 – Prosthetic/orthotic devices
- Revenue Code 275 – Pacemaker
- Revenue Code 278 – Other Implants

An implantable device is that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Also included is an object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.

Examples of other implants reported under revenue code 278 include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds (not an all-inclusive list).

Supplies that are not implantable should be submitted as supply charges. In conjunction, a device is not a “material or supply furnished incident to a service.” Items used as routine supplies should not be submitted as an implant. Guide wires, catheters and clips that are used during surgery but do not remain in the body are used the same way as an instrument and are not “implanted” should not be submitted as an implant.

Additional reference and definition of implantable devices, supplies and material can be located in the UB04 Editor and the website of the implantable device’s manufacturer.

Hospitals, and Routine Services and Supplies

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

- Any supplies, items and services that are necessary or otherwise integral to the provision of a

specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.

- All items and supplies that may be purchased over-the-counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

Clinical Resources

Coordination of Care Between Medical and Behavioral Health Providers

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

Here are few resources available to you through BCBSTX:

1. The Coordination of Care Form Available Online

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

- To provide member treatment information **to** another treating provider
- To request member treatment information **from** another treating provider

It is important to note that a written release to share clinical information with members' medical providers must be obtained prior to the use of this form. BCBSTX recommends obtaining a written release prior to the onset of treatment.

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

2. If You Need Help Finding Behavioral Health Providers for Your Patients

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

3. Behavioral Health or Medical Case Management Services

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

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

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

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

Specific questions were added to the following areas:

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

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

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

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

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

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

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

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

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

Electronic Options

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

As a reminder, effective July 11, 2016, corrected claim requests for previously adjudicated claims must be submitted as electronic replacement claims, or on the appropriate professional (CMS-1500) or institutional (UB-04) paper claim, and Claim Review form.

Electronic Submission

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

claim will be issued a new BCBSTX claim number and subsequently deny based on the re-adjudication of the original claim.

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

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

Paper Submission

More than 98 percent of the claims BCBSTX receives from providers are submitted electronically. BCBSTX encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer web vendors available to providers. If you are a registered Availity® web portal user, you have access to submit direct data entry replacement claims electronically, at no additional cost.

As of July 11, 2016, any changes to a claim that are specified **only** on the Claim Review form (or via a letter) will be returned with a notice advising resubmission on the appropriate CMS-1500 or UB-04 paper claim form. Paper claim submitters are required to indicate "corrected claim" on the paper claim form and the accompanying Claim Review form.

Pharmacy

Reminder: Pharmacy Benefit Tips

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

1. Prescribing Drugs Listed on the Formulary

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

BCBSTX formularies are regularly updated and can be found under [Pharmacy Program](#) on the BCBSTX provider website.

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

- Blue Cross MedicareRx (PDP)SM: bcbstx.com/medicare/part_d_druglist.html
- Blue Cross Medicare Advantage (HMO)SM and (PPO)SM: bcbstx.com/medicare/mapd_drug_coverage.html
- Blue Cross Medicare Advantage Dual Care (HMO SNP)SM: bcbstx.com/medicare/snp_drug_coverage.html
- Texas STAR: bcbstx.com/star/prescription-drugs/drug-coverage
- Texas CHIP: bcbstx.com/chip/prescription-drugs/drug-coverage

2. Reminding Patients of Covered Preventive Medications

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

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

**Not available for all plans. Members should call the customer service number on their ID card to help determine what benefits may be available, including any requirements, limitations or exclusions that apply. Please refer to the member's certificate of coverage.*

3. Submitting Necessary Prior Authorization Requests

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

4. Assisting Members with Formulary Exceptions

If the medication you wish to prescribe is not on your patient's drug or the preventive care lists, a formulary exception can be requested. You can call the customer service number on the member's ID card to start the process, or complete the online form at: myprime.com/en/coverage-exception-form.html.

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

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

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

Dispensing QVT (Quantity Versus Time) Limits

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

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

Prescription Drug Lists

Throughout the year, the 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

Provider Training

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

Reminder: Medicare Marketing Guidelines for Providers

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

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

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

The above list provides just a sampling of important points for your convenience. For a more in-depth review of the guidelines that are applicable to providers, please refer to the [Provider Medicare Marketing Guidelines](#) excerpt.

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

*LIS refers to low-income subsidy

**SHIPs are Senior Health Insurance Assistance Programs

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

After-hours Access Is Required

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

Acceptable after-hours access mechanisms may include:

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

For more detail, [please refer to the provider manuals](#) for **Blue Choice PPOSM Physician, Professional Provider and Facility and Ancillary Provider Manual** (Section B) and **Blue Essential** (formerly known as **HMO Blue TexasSM**), **Blue Advantage HMOSM**, **Blue Premier Physician, Professional Provider, Facility and Ancillary Provider Manual** (Section B) available in the Education & Reference section of our provider website. Click on the "Manual" link (note, a password is required).

Medical Record Requests: Include Our Letter as Your Cover Sheet

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

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

Thank you for your cooperation!

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

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

Quest Diagnostics Offers:

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

For more information about Quest Diagnostics lab testing solutions or to establish an account, contact

your Quest Diagnostics Physician Representative or call **866-MY-QUEST** (866-697-8378).

For physicians, professional providers or facility and ancillary providers located in the HMO capitated lab counties, only the lab services/tests indicated on the Reimbursable Lab Services list will be reimbursed on a fee-for-service basis if performed in the physician's, professional provider's or facility or ancillary provider's office for Blue Essentials (formerly known as HMO Blue Texas) members. Please note all other lab services/tests performed in the physician's, professional provider's or facility or ancillary provider's offices will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list in the [General Reimbursement Information](#) section located under the Standards and Requirements tab.

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

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

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

To [view draft medical policies](#) go to our provider website and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

No Additional Medical Records Needed

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

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

Rights and Responsibilities

Blue Choice PPOSM Subscribers/Blue Advantage HMOSM Member Rights and Responsibilities

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

Rights**Responsibilities**

Subscriber(s)/Member(s)	Subscriber(s)/Member(s)
<p>You have the right to:</p> <ul style="list-style-type: none"> • Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities. • Make recommendations regarding the organization's subscribers' rights and responsibilities policy. 	<p>You have the responsibility to:</p> <ul style="list-style-type: none"> • Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.
<ul style="list-style-type: none"> • Participate with practitioners in making decisions about your health care. 	<ul style="list-style-type: none"> • Follow the plans and instructions for care you have agreed to with your practitioner.
<ul style="list-style-type: none"> • Be treated with respect and recognition of your dignity and your right to privacy. • A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. • Voice complaints or appeals about the organization or the care it provides. 	<ul style="list-style-type: none"> • Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

Member Rights – You Have the Right to:

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

Member Rights – You Have the Responsibility to:

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

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

Disclaimer

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Blue Cross and Blue Shield of Texas (BCBSTX) makes no endorsements, representations, or warranties about any products or services offered by independent third-party vendors mentioned in this newsletter. The vendors are solely responsible for the products or services offered by them. If you have any questions about the products or services mentioned in this newsletter, contact the vendor directly.

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