



Issue 2, 2010

Quest Diagnostics, Inc., is new exclusive HMO and preferred statewide PPO/POS clinical reference lab provider

Effective June 1, 2010, Quest Diagnostics, Inc. will become the **exclusive** outpatient clinical reference laboratory provider for HMO Blue® Texas members* and will become the **preferred statewide** outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice® (PPO/POS) members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free standing ambulatory surgery centers).

Quest Diagnostics Offers:

- On-line scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto www.QuestDiagnostics.com/patient or call **888-277-8772**.
- Convenient patient access to more than 220 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 setup an account, contact your Quest Diagnostics' Physician Representative or call **866-MY-QUEST**.

For physicians 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 office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician's office will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list at www.bcbstx.com/provider under the General Reimbursement Information section.

Effective June 1, 2010, Laboratory Corporation of America (LabCorp) will no longer be a contracted provider for HMO Blue Texas.

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

Care Comparison tool offers data transparency

In September 2009, we unveiled a new online Care Comparison tool that allows our members to review costs for specific procedures performed at hospitals, ambulatory surgery centers and free-standing radiology centers in the Blue Cross and Blue Shield of

Texas (BCBSTX) provider network. Members also can review the volume of services performed by each facility and can obtain other information based on factors most important to them. The Care Comparison tool is available to all BCBSTX members and providers on our Web site at www.bcbstx.com.

In our ongoing initiative to enhance transparency – availability and accessibility – of Care Comparison data, a flash demo will be added in April 2010 to assist members with their navigation and procedure searches. Additionally, the number of inpatient and outpatient procedures displayed will increase from 35 to 54. The data reported will cover procedures performed from July 1, 2008, through June 30, 2009, paid through Sept. 30, 2009.

BCBSTX is committed to sharing information with our members that is useful, accessible and easy to understand. We believe that a well-informed consumer will make better health care decisions. Watch the “What’s New” section of our Provider Web site at www.bcbstx.com/provider for additional announcements and information regarding this and other BCBSTX initiatives.

To new users of EFT, ERA and EPS

If you are one of the growing number of Blue Cross and Blue Shield of Texas (BCBSTX) providers who have signed up for electronic funds transfer (EFT), electronic remittance advice (ERA) and electronic payment summary (EPS), thank you for utilizing these electronic transactions. If your office has not yet enrolled for EFT, ERA and EPS, we encourage you to explore these time and money-saving options.

Whether you’re a current user or considering enrollment, we have a variety of online resources available to help you feel confident and informed. Visit the EFT/ERA page in the Electronic Commerce section of our Provider Web site, where you will find our EFT and ERA enrollment forms, an electronic options tutorial, answers to frequently asked questions (FAQs) and more.

EPS formatting tips

The EPS is delivered by BCBSTX as a text file so that you can receive it in conjunction with your ERA.* The EPS contains the same information as the paper provider claim summary (PCS). You can save the EPS as an electronic file for future retrieval, or choose to select and print some or all of the document.

Here are some formatting tips for proper viewing upon downloading your EPS to help ensure that it looks like the PCS:

- Open the document in Microsoft Word, WordPad, etc.
- Set the page layout as landscape rather than portrait.
- For the font style, select Courier New.
- For the point size, select 8 point.

*Note: If you are using a billing agent, the EPS goes to the receiver/vendor/clearinghouse. Delivery or posting specifications are determined by the vendor, not BCBSTX. Therefore, you should check with your receiver/vendor/clearinghouse to determine whether or not special software may be needed to view the EPS file.

PCS to EPS: 30-day transition reminder

If you are a new Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS) enrollee, you will continue to receive your paper provider claim summary (PCS) for 30 days after you start receiving your ERA and EPS files. This 30-day transition period is designed to help your office make a gradual switch from paper to electronic processing. When the transition period ends, the PCS will be discontinued and you will receive only the ERA/EPS going forward.

If you enrolled for ERA/EPS directly or through your clearinghouse/billing agent more than a month ago, you may have continued to receive both the ERA/EPS and the PCS in your office for longer than 30 days. Be advised that your PCS will now be discontinued. Going forward, you will receive only the ERA/EPS.

If you are unsure whether or not your office is enrolled for ERA/EPS, or if you believe that you are no longer enrolled through your current clearinghouse/billing agent, contact our Electronic Commerce Center at 800-746-4614 for assistance.

Electronic transactions – 2010 holiday schedule reminder

Although it is possible for providers to receive electronic funds transfer (EFT), electronic remittance advice (ERA) and electronic payment summary (EPS), as well as transmit electronic media claims (EMCs) and retrieve payment reports at almost any time during the year, it is important to keep in mind that corporate and legal banking holidays may cause delays in EFT, ERA/EPS and EMC processing.

- The BCBSTX Electronic Data Interchange (EDI) system is available Monday through Sunday, 24 hours a day, seven days a week.
- Blue Cross and Blue Shield of Texas (BCBSTX) will be closed on “holiday observed” dates. Claims will not be processed on holiday observed dates.*
- Claims transmitted during the holidays will be processed the following business day.**
- Legal banking holidays will add a day to the normal EFT schedule, with the EFT payment becoming available the next business day after the file is sent to the bank.
- Payment reports, such as ERA and EPS, for claims processed on a business day following an observed holiday will be available for retrieval the next business day.

Holiday name	Calendar date	BCBSTX Holiday observed date	Legal banking Holiday observed date
New Year's Day	Friday, Jan. 1	Friday, Jan. 1	Friday, Jan. 1
Martin Luther King Jr. Day	Monday, Jan. 18	Monday, Jan. 18	Monday, Jan. 18
President's Day	Monday, Feb. 15	(Not observed)	Monday, Feb. 15
Memorial Day	Monday, May 31	Monday, May 31	Monday, May 31
Independence Day	Sunday, July 4	Monday, July 5	Monday, July 5
Labor Day	Monday, Sept. 6	Monday, Sept. 6	Monday, Sept. 6
Columbus Day	Monday, Oct. 11	(Not observed)	Monday, Oct. 11
Veterans Day	Thursday, Nov. 11	(Not observed)	Thursday, Nov. 11

Thanksgiving	Thursday, Nov. 25	Thursday, Nov. 25 and Friday, Nov. 26	Thursday, Nov. 25
Christmas Eve	Friday, Dec. 24	Friday, Dec. 24	Friday, Dec. 24

* The BCBSTX corporate holiday schedule is subject to change.

** Customers will receive EMC real-time reports on the day of transmission. For the Availity®

Availity is a registered trademark of Availity, L.L.C., an independent, third-party vendor. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by this vendor. Availity is solely responsible for the products and services it offers. If you have any questions regarding the products or services offered by Availity, you should contact them directly.

New Be Smart. Be Well.® topic launches with redesigned site

Our Be Smart. Be Well. Web site [www.besmartbewell.com] has a sleek new look to help engage our members' interest in this online health and wellness resource. We're also working to keep the content fresh by regularly adding new material, such as information about sexually transmitted disease (STD), the latest topic to be added to the Be Smart. Be Well. online library.

Each Be Smart. Be Well. topic features videos combining information from subject matter experts with the very personal stories of those who have been affected. With the STD topic, your patients will meet Molly, who never thought herpes could happen to her, and Ida, who lives with HIV. The easy-to-follow "Habits to Have" section offers tips that may help your patients on the road to making smarter, healthier choices.

The goal of Be Smart. Be Well. is simple: to help our members stay healthier and safer through increased awareness and easy-to-use information. We encourage you to remind your patients to visit besmartbewell.com today for information on a variety of topics, including traumatic brain injury (TBI), caregiving, drug safety and mental health.

Changes affect Walmart associates in 2010

Effective Jan. 1, 2010, health plan benefits for all Walmart associates are administered by Arkansas Blue Cross and Blue Shield. In addition, New Directions Behavioral Health will begin providing utilization management services for Walmart's health plan participants.

Identification (ID) card As of Jan. 1, 2010, Arkansas Blue Cross and Blue Shield will become the single Blue Plan administering health plan benefits for Walmart associates. Coverage was previously provided by Blue Cross Blue Shield of Alabama, Health Care Service Corporation (HCSC) or Arkansas Blue Cross and Blue Shield, depending upon where the Walmart associate worked. Walmart associates who currently have coverage through other Blue Plan will receive new ID cards, reflecting a new alpha prefix of WMW.

You should request the new ID card from Walmart associates at the time of service. To ensure accurate claims processing:

- Verify the new ID card, reflecting the new WMW prefix and update the patient file.

- Submit claims to your local Blue Plan using the exact ID card number, inclusive of alpha prefix. Do not add, omit or alter any characters from the member ID number.
- Claims must be filed under the ID card prefix that is/was in effect at the time the service was rendered.
- To check eligibility, benefits and pre-certification requirements, send an electronic eligibility inquiry to your local Blue Plan or call 800-676-BLUE (2583) and provide the three letter alpha prefix.
- If you have questions, contact your local BCBSTX network representative.

 BlueCross. BlueShield.			
<hr/> John Doe			
Identification Number WMW123456789W			
<hr/>			
Group No.	123456		
Plan Codes	021/521	RxBIN:	610575
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 BlueAdvantage Administrators of Arkansas <small>An Independent Licensee of the Blue Cross and Blue Shield Association</small>		www.blueadvantagearkansas.com	
Hospitals or physicians: File claims with local BlueCross and/or BlueShield Plan.		Customer Service: 1-866-823-3790 Prenotification: 1-800-451-7302 Provider Locator: 1-800-810-2583 Pharmacy Benefits*: 1-877-850-0185 Dental Benefits*: 1-800-462-5410 Ask Mayo Clinic*: 1-800-418-0758	
Medical Services: You may pre-notify your admission by calling the Prenotification number prior to any scheduled or non-emergency hospital admission.		*Not a BlueCross and BlueShield product.	
Associates: To find a PPO Provider in your service area or when traveling, call the Provider Locator number.		BlueAdvantage Administrators of Arkansas P.O. Box 1460 Little Rock, AR 72203 BlueAdvantage Administrators of Arkansas, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.	
D7 OOS			

Pharmacy updates: pharmacy compounding

Pharmacy compounding is an ancient practice in which pharmacists combine, mix or alter ingredients to create unique medications that meet specific needs of individual patients. Compounding is a practice that continues to attract the scrutiny of the U.S Food and Drug Administration (FDA), mainly because of instances where compounded drugs have endangered public health.

The FDA considers virtually all compounded drugs as unapproved new drugs for which safety and efficacy have not been demonstrated with the type of data the FDA requires to approve a new drug. However, the FDA also considers “traditional compounding” to be a valuable service and does not take enforcement action against these practices. The FDA defines traditional compounding as customizing a drug for someone who is allergic

to a dye or preservative in an FDA-approved medicine, or compounding a liquid dosage form specifically for a younger patient. Compounding does not generally include mixing or reconstituting commercial products in accordance with the manufacturer's instructions or the product's approved labeling.

Red flags and enforcement activities by the FDA

The emergence during the past 10-15 years of firms with pharmacy licenses making and distributing unapproved new drugs in a way that is clearly outside the bounds of traditional pharmacy practice is of great concern to the FDA. FDA enforcement has been directed to those pharmacies whose activities raise the kinds of concerns normally associated with a drug manufacturer and whose compounding practices result in significant violations of the new drug, adulteration or misbranding provisions of the federal Food, Drug, and Cosmetic Act (FDCA). In addition, unlike commercial drug manufacturers, pharmacies are not required to report adverse events associated with compounded drugs.

In a May 2007 consumer newsletter, the FDA reported knowing of more than 200 adverse events involving 71 compounded products since 1990. Examples of some of these adverse events included three deaths due to contaminated compounded intravenous solutions and the blinding of two patients, as well as damaged eyesight to others from a bacterially contaminated compounded product used in cataract surgery. In a 2001 FDA survey of compounded drug products, the agency found 34 percent of the products tested failed standard quality tests (usually failing potency analyses) as opposed to a less than two percent failure rate for commercially produced drug samples. Examples of medications included in the testing sample included sterile injectables (e.g. dipyridamole, papaverine, phentolamine, etc.), pellet implants (e.g. estradiol), ophthalmic solutions/ointments (e.g. ciprofloxacin, dexamethasone, timolol, etc.), inhalation (e.g. tobramycin) and oral products (e.g. progesterone, estradiol, etc.).

As a consequence, the FDA has issued a number of warning letters to pharmacies that specialize in female hormone products (bioidentical hormone replacement therapies), anti-infective inhalation products, sustained-release/delayed-release/extended-release products and local anesthetic pain products. FDA warning letters have also been sent in cases where the FDA believes pharmacy communications (advertisements, Web site information, etc.) contain false and misleading claims about product safety, effectiveness and superiority to FDA-approved and commercially available products. When contemplating further action against compounding pharmacies, the FDA considers whether the pharmacy engages in the following acts:

- Compounding drugs in anticipation of receiving prescriptions, except in very limited quantities in relation to the amounts of drugs compounded after receiving valid prescriptions.
- Compounding drugs that were withdrawn or removed from the market for safety reasons.
- Compounding finished drugs from bulk active ingredients that are not components of FDA-approved drugs (e.g. estriol) without an FDA-sanctioned investigational new drug application (IND).
- Receiving, storing or using drug substances without first obtaining written assurance from the supplier that each lot of the drug substance has been made in an FDA-registered facility.
- Receiving, storing or using drug components not guaranteed or otherwise determined to meet official compendia requirements.

- Using commercial-scale manufacturing or testing equipment for compounded drug products.
- Compounding drugs for third parties who resell to individual patients, or offering compounded drug products at wholesale to other state-licensed persons or commercial entities for resale.
- Compounding drug products that are commercially available in the marketplace or that are essentially copies of commercially available FDA-approved drug products. In certain circumstances, it may be appropriate for a pharmacist to compound a small quantity of a drug that is only slightly different than an FDA-approved drug that is commercially available. In these circumstances, the FDA will consider whether there is documentation of the medical need for the particular variation of the compound for the particular patient.
- Failing to operate in compliance with applicable state laws regulating the practice of pharmacy.

What are we experiencing?

PrimeTherapeutics, Inc. (Prime), a separate company providing pharmacy benefit manager (PBM) services for Blue Cross and Blue Shield of Texas, has identified the billing practices of non-traditional compounding pharmacies as one of the most common reasons network pharmacies are placed on corrective action plans (CAPs) or other related actions. As a result of ongoing claims auditing activities, Prime has been able to identify a number of pharmacies with questionable compounding practices.

Examples of inappropriate practices include submitting pharmacy claims with incorrect or invalid NDCs according to the compounding log; claims for compounds that contain medications that are not covered by Medicare Part D based on their intended route of administration; marketing of compounded drugs utilizing a non FDA-approved aerosolizing device; and compounding copies or near copies of FDA-approved commercially available drugs.

In two instances, during further research following an on-site pharmacy audit, Prime discovered that both pharmacies had received warning letters from the FDA detailing a number of issues such as the misbranding of drugs, unsubstantiated efficacy claims and marketing of unapproved medical devices. Another pharmacy was discovered to be dispensing an excessive quantity (540 5-ml bottles) of antimicrobial ophthalmic drops to be diluted with saline and administered intranasally three times daily for the treatment of recurrent upper respiratory infections. The total cost of one 30-day prescription of this unproven therapy was \$10,000.

What do the CMS regulations say?

Chapter 6 of the Medicare Prescription Drug Benefit Manual provides the following guidance on the coverage of “Extemporaneous Compounds”:

- Compounded prescription drug products can contain: (1) all Part D drug product components; (2) some Part D drug product components; or (3) no Part D drug product components.
- Only costs associated with those components that satisfy the definition of a Part D drug are allowable costs under Part D because the compounded products as a whole do not satisfy the definition of a Part D drug. As a consequence, claims for compounded prescriptions can consist only of National Drug Codes (NDC) for FDA-approved prescription drug products.

Traditional compounding powders are typically not FDA-approved drug products.

- The labor costs associated with mixing a compounded product that contains at least one Part D drug component can be included in the dispensing fee.

What are we asking providers to do?

Providers should discuss with their patients in detail whether the use of compounded medications in lieu of FDA-approved and clinically tested products is indeed the best option for their specific medical needs. Patients or practitioners who encounter problems such as adverse drug events with compounded products are asked to file a MedWatch report with the FDA at: 800-332-1088, fax 800-FDA-0178, MedWatch, 5600 Fishers Ln., Rockville, MD 20852-9787, or online at www.fda.gov/medwatch.

References

¹U.S. Food and Drug Administration. Limited FDA Survey of Compounded Drug products.

www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm155725.htm (accessed Jan. 12, 2010).

²U.S. Food and Drug Administration. The Special Risk of Pharmacy Compounding. www.fda.gov/ForConsumers/ConsumerUpdates/ucm107836.htm (accessed Jan. 12, 2010).

³U.S. Food and Drug Administration. FDA Takes Action Against Compounded Menopause Hormone Therapy Drugs.

www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2008/ucm116832.htm (accessed Jan. 12, 2010).

⁴Anon. FDA Takes Action Against Compounded Bioidentical Hormones. Pharmacist's Letter/Prescriber's Letter 2008. 24(2): 240209.

BCBSTX Special Investigations Department reviews allergy testing and treatment services

In recent months, the Blue Cross and Blue Shield of Texas (BCBSTX) Special Investigations Department (SID) has conducted several investigations focusing on the delivery of allergy testing and allergy treatment to BCBSTX members. SID reminds providers to submit claims for only covered services. Intentional misrepresentation of services to induce payment is considered health care fraud in violation of state and federal law.

Two forms of testing and treatment comprised the majority of the investigations:

SDET/SET

When performing allergy testing, providers should remember Serial Dilution Endpoint Titration/Serial Endpoint Titration (SDET/SET) is not a covered service. SDET/SET is a form of intradermal skin testing that uses increasing doses of antigen to determine the concentration at which the reaction changes from negative to positive (the "endpoint"). SDET/SET has been used to guide the initiation of immunotherapy, by using the endpoint dilution as the starting antigen dose. BCBSTX medical policy MED206.001 (Allergy Management) clearly specifies this type of allergy testing to be experimental, investigational and unproven and, as such, is a non-covered service. The CPT code most often used to bill for this non-covered service is 95028 (Intracutaneous [intradermal] tests with allergenic extracts). While 95028 is a valid code, when billed to

induce payment for a non-covered service, it is considered an intentional misrepresentation of the services provided and as such constitutes a fraudulent act.

SLIT

Sublingual Immunotherapy (SLIT) is a form of allergy treatment where antigen serum is administered (often self-administered by the patient) by placing a few drops of the serum under the patient's tongue. BCBSTX medical policy MED206.001 (Allergy Management) clearly specifies this type of allergy treatment to be experimental, investigational and unproven, and as such, is a non-covered service. The CPT code most often used to bill for this non-covered service is 95165 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy). CPT defines allergen immunotherapy as "the parenteral (administered in a manner other than through the digestive tract, as by intravenous or intramuscular injection) administration of allergenic extracts". While 95165 is a valid code, when billed to induce payment for SLIT or other non-covered service, it is considered an intentional misrepresentation of the services provided and as such constitutes a fraudulent act.

Additionally, the following are considered experimental, investigational and unproven, and as such are not covered services:

Non-covered Allergy Testing Methods

- Provocative tests for food or food additive allergies
- Neutralization testing
- Serial dilution endpoint titration (SDET), serial endpoint titration (SET), Rinkle/Rinkle method
- Nasal challenge tests
- Conjunctival challenge test (ophthalmic mucous membrane test)
- Cytotoxic food tests (Bryan's test)
- Leukocyte histamine release test (LHRT)
- Rebuck skin window test
- Passive transfer or P-X (Prausnitz-Kustner test)
- Antigen leukocyte cellular antibody test (ALCAT)
- Sublingual provocation food testing
- IgE concentration food allergy testing
- IgG food and environmental testing
- Any aspect of the Lifestyle Eating and Performance (LEAP) program, including the Mediator Release Test (MRT) used to identify "delayed food allergies" and treatments which include dietary manipulation and/or supplements or herbs

Non-covered Allergy Treatment Methods

- Provocative and neutralization therapy, using intradermal and subcutaneous routes
- Sublingual: oral application of natural or enzymatically altered antigens
- Topical: localized application of an allergen directly to the organ creating the allergy response, such as the nose for allergic rhinitis
- Urine auto-injections (autogenous urine immunization): freshly collected urine, having been sterilized and filtrated, injected to the donating patient
- Repository emulsion therapy - solutions of vegetable and mineral oils containing additional allergens, to produce slow releases of the allergens at the injection site

- Intracutaneous (intra-dermal) tests, sequential and incremental (Serial dilution endpoint titration [SDET] therapy [Rinkel/Rinkle Method]).

Should you have any questions regarding whether or not your services are covered by BCBSTX, go to www.bcbstx.com and access our medical policies under the Provider tab.

BCBSTX SID aggressively pursues cases of fraud for the protection of our members, groups, and assets. If you have knowledge of fraudulent activity, contact the BCBSTX Fraud Hotline at (800) 543-0867 or go to www.bcbstx.com/sid/reporting/. You may remain anonymous if you wish.

Reference

BCBSTX Medical Policy MED206.001, Allergy Management.

Attention specialty care physicians...Need to see if a referral has been issued to you?

Because primary care physicians (PCPs) are not required to furnish your office with written or verbal confirmation for referrals made to your specialist office, Blue Cross and Blue Shield of Texas (BCBSTX) is offering a tool to assist your office with real-time access to confirm both current and previous referral authorizations.

You can now access referral information in real-time and online using the iEXCHANGE® Web application, which allows you to view referrals issued from a PCP to your practice.

iEXCHANGE:

- Gives you real time, immediate access to status and details of referrals to specialist(s).
- Reduces time and expenses associated with paper, telephone and fax processes.
- Implements more efficient processes, freeing up additional time to focus on patient care.
- iEXCHANGE is FREE to providers.
- Upon approval and completion, BCBSTX will continue to mail referral notifications to Specialty Care Providers for your records.

The iEXCHANGE registration process is simple:

1. Designate a staff member to be your office's iEXCHANGE Administrator. They can set up and manage access for other staff members at your office.
2. The designated administrator should register for an iEXCHANGE Account ID by clicking on the iEXCHANGE logo on the BCBSTX Provider Web site at www.bcbstx.com/provider, and then "sign up now".
3. BCBSTX sends back a secured email containing the necessary information to access the iEXCHANGE system.
4. The administrator accesses iEXCHANGE and completes a short set up process.
5. BCBSTX confirms set up is correct for your iEXCHANGE provider account.

6. The administrator can immediately begin viewing and printing referrals to your office with a simple click of the mouse.*

*If you are unable to do a Treatment Search, contact the iEXCHANGE Support Desk at 800-441-9188 for assistance.

Electronic submission can help expedite secondary claim payments

PROFESSIONAL PROVIDERS Most Medicare Part B supplemental claims will crossover automatically to BCBSTX. Crossover is the most efficient and cost effective method of receiving payment for Medicare Supplemental claims because you do not have to submit a separate claim with the Medicare explanation of member benefits (EOMB) to BCBSTX.

Sometimes, such as when a patient has not updated their BCBSTX membership information, the claim may not automatically crossover. In these cases, you can file the supplemental portion electronically to BCBSTX. Refer to our Medicare B Supplemental Electronic Claim Submission Reference Guide for Professional providers, located in the Claim Pointers and Reference Guides sections of our online Provider Library at www.bcbstx.com/provider.

Professional providers may *not* submit electronic claims when BCBSTX is secondary to other commercial carriers. Professional providers may *only* submit electronic claims when BCBSTX is secondary to Medicare.

INSTITUTIONAL PROVIDERS

Electronic Data Interchange (EDI) requirements for electronic submission of **BCBSTX Institutional claims secondary to Medicare** are included in the 837I Companion Document, available in the Electronic Commerce section of our Provider Web site.

Institutional providers also may file electronic claims when **BCBSTX is secondary to other commercial carriers**. See below for the EDI specifications for submitting electronic secondary Institutional claims (ANSI 837I Format — Version 4010A1) when another commercial carrier is primary. Submission of the primary payer's explanation of benefits is not required.

PAYEE IDENTIFICATION LOOP – 2320:

Other Subscriber Information

- SBR01 Enter the Payer Responsibility Sequence Code: (P) -- Primary
- SBR02 Enter the Individual Relationship Code (Examples: 01=Spouse; 18=Self)
- SBR03 Enter the subscriber's Group or Policy Number

Payer Prior Payment

- AMT01 Enter the Amount Qualifier Code: C4
- AMT02 Enter the amount paid by the Primary Insurance Carrier

PAYEE IDENTIFICATION LOOP – 2330A:

Other Subscriber Information

- NM101 Enter the Entity Identifier Code: (IL) – Insured or Subscriber
- NM102 Enter the Entity Type Qualifier: (1) – Person
- NM103 Enter the other subscriber's last name
- NM104 Enter the other subscriber's first name
- NM105 Enter the other subscriber's middle initial, if applicable
- NM106 (Not Used)
- NM107 Enter the other subscriber's name suffix, if applicable
- NM108 Enter the Identification Code Qualifier: (MI) – Member ID Number
- NM109 Enter the other subscriber's primary insurance ID number

PAYEE IDENTIFICATION LOOP – 2330B:

Other Payer Name

- NM101 Enter the Entity Identifier Code: (PR) – Payer
- NM102 Enter the Entity Type Qualifier: (2) – Non-person Entity
- NM103 Enter the name of the Primary Insurance Carrier
- NM104 (Not Used)
- NM105 (Not Used)
- NM106 (Not Used)
- NM107 (Not Used)
- NM108 Enter the Identification Code Qualifier: (PI) – Payer Identification
- NM109 Enter the other payer's unique primary identifier

FOR MORE INFORMATION

- **Ask your software vendor...** Can your practice management software accommodate the electronic data elements for secondary claims? Make sure there are no preset defaults that may prevent submission.
- **Unsure of primary vs. secondary status for a claim?** Have questions regarding claim payment or need other claim information? Contact BCBSTX Provider Customer Service at (800) 451-0287.
- **Need Federal Employee Program (FEP) assistance?** Call (800) 442-4607, or call the number listed on the back of the member's ID card.

Questions regarding the electronic claim submission process? Contact our Electronic Commerce Center at (800) 746-4614.

Notices and announcements

BCBSTX moves into new headquarters building

Blue Cross and Blue Shield of Texas (BCBSTX) has moved its headquarters to a new location at 1001 E. Lookout Drive in Richardson, Texas. The new facility allows us to consolidate our North Texas area locations into one campus. Phone numbers and e-mail addresses for the Network Management staff will remain the same.

Evidence-based measures evaluation

BCBSTX has evaluated BlueChoice® network physicians in certain specialties annually over the past four years for performance on evidence-based measures (EBMs). With this year's evaluation currently under way, BCBSTX is mailing communication materials with the results of this year's evaluation to affected physicians, along with instructions for accessing individual EBM performance reports through a newly developed secure online portal if applicable. This year's evaluation will include all measures from last year's evaluation. For information on the current list of EBMs and the specialties measured, visit www.bcbstx.com/provider/ebi_2010.

New clotting factor management initiative

Patients with bleeding disorders such as hemophilia need immediate access to clotting factor and related products to manage bleeding episodes. Therefore, it is important that physicians who prescribe clotting factors prescribe amounts appropriate to the patient's clinical situation.

BCBSTX recommends the *Medical and Scientific Advisory Council Recommendation Concerning Prophylaxis* as a helpful resource in managing these patients. In addition, BCBSTX has implemented a review of prescription data to identify high utilization of clotting factors and related products. If high utilization is identified, a form requesting key clinical information and medical rationale may be sent to the prescribing physician. Completed forms are reviewed by a medical director, who will contact physicians with any questions or concerns. For additional information, visit www.bcbstx.com/provider/clotting_factor.htm.

After-hours access

Members/subscribers should be able to contact their physician (primary or specialty care physician), or on-call designee, for medical advice 24 hours a day, 7 days a week. Physicians 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 mechanisms for immediate response 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.

Providing after-hours accessibility increases members' satisfaction with their health care and improves the quality of service they receive from their physician. Please ensure that your practice has an acceptable mechanism in place for after-hours access. If you have any questions concerning after-hours accessibility requirements, contact your local BCBSTX Professional Provider Network Representative.

Failure to establish relationship between physician or other professional provider and patient

Under certain circumstances, a physician or other professional provider may terminate his or her professional relationship with a member as provided for and in accordance

with the provisions outlined in the HMO Blue Texas and BlueChoice® Provider Manuals. Guidelines and updated procedures are located in Section B of both provider manuals and are available for your review on the Blue Cross and Blue Shield of Texas Web site at www.bcbstx.com/providermanuals.

Change to claims run-out period for U.S. Virgin Islands Extended to April 16, 2010

Effective July 1, 2009, Triple-S assumed responsibility for processing U.S. Virgin Islands host claims. The claims run-out period has now been extended from July 1, 2009 to April 16, 2010. Services incurred in U.S. Virgin Islands on or before June 30, 2009 will be processed through BlueCard by Independence Blue Cross just as they are today. Services incurred in U.S. Virgin Islands on or after July 1, 2009 to April 16, 2010 will be processed through BlueCard by Triple-S.

Request for Duplicate 1099

To request a duplicate 1099, you can either e-mail or fax your request to the following:

E-mail address: 1099Inquiries@bcbstx.com

Fax #: 972-766-4360.

Your request must include the following information:

Physician Name/Group Name

Tax Identification Number

Correct Mailing address

Contact Name and Contact Number

Questions regarding your 1099 should be directed to our Finance Department at 972-766-6623.

Note: If you have less than \$600.00 in claims payment, the IRS does not require that we supply you with a 1099.

Clear Claim Connection (C3) Disclosure

Clear Claim Connection™ (C3), a web-based code auditing reference tool, is now available to all contracted Blue Cross and Blue Shield of Texas (BCBSTX) providers. You may access this tool through a secured provider portal at www.bcbstx.com. C3 mirrors the ClaimCheck® auditing rules that BCBSTX has adopted as part of its claim adjudication process. It provides easy access to ClaimCheck payment policies and rules, along with clinical rationales, clarifications and source information for ClaimCheck edits.

Certain claims, such as Medicare Primary and BlueCard claims, are exempt from ClaimCheck auditing. The BCBSTX ClaimCheck database is updated periodically and upgraded to a new version annually. This may result in certain edit combinations being modified. Appropriate notice of such modifications will be provided on our Web site and through this newsletter.

Effective on or about April 19, 2010, BCBSTX contracted providers will be able to access the C3 web link via Availity, in addition to RealMed. Log on to the BCBSTX Web site at www.bcbstx.com. Click on Providers; then in the General Reimbursement Information

section – under Bundling Information, click on Clear Claim Connection. You will need to register with RealMed or Availity the first time you access C3. Instructions for registering with RealMed or Availity are located with the link to the respective portal. Once your registration process is completed, you will have access to C3.

Note: ClaimCheck audit results obtained on the BCBSTX Web site are specific to BCBSTX. Another carrier who offers C3 may have different edits, which will produce different results. This information is confidential and proprietary, and is not to be shared. For more information, contact your local Professional Provider Network (PPN) office or Provider Customer Service at 800-451-0287.

Clear Claim Connection™ is a trademark of McKesson Information Solutions Inc. ClaimCheck® is a registered trademark of McKesson Information Solutions Inc.

In every issue

AIM RQI reminder

Physicians and professional providers must contact American Imaging Management (AIM) first to obtain an RQI number when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's office, a professional provider's office, the outpatient department of a hospital or a freestanding imaging center:

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

To obtain a PPO RQI number, log in to AIM's provider portal at www.americanimaging.net and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an RQI number. If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. *AIM's provider portal uses the term "Order" rather than "Preauth" or "RQI."*

Note: Facilities cannot obtain an RQI number from AIM on behalf of the ordering physician. Also, 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 commercial PPO/POS coverage are included in the program.

Outpatient Clinical Reference Laboratory for HMO Blue® Texas

Laboratory Corporation of America (LabCorp) is the exclusive outpatient clinical reference laboratory provider for HMO Blue Texas members through May 31, 2010 (see note below for exceptions). To find the closest LabCorp Patient Service Center, call LabCorp's automated phone system toll-free at 888-LABCORP or visit their Web site at www.labcorp.com. Both systems will prompt you for your Zip Code and will provide those service centers nearest that Zip Code location.

You may find a complete list of participating providers by using the Provider Finder® search tool at www.bcbstx.com/provider. For physicians located in certain 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 office for HMO Blue Texas members. **Note that all other lab services/tests performed in the physician's office will not be reimbursed.**

You may access the county listing and the revised Reimbursable Lab Services list to be effective June 1, 2010 at www.bcbstx.com/provider under the General Reimbursement section.

NOTE: Physicians who are contracted/affiliated with a capitated IPA/Medical Group, and physicians who are not part of a capitated IPA/Medical Group but who provide services to a member whose PCP is a member of a capitated IPA/Medical Group, must contact the applicable IPA/Medical Group for instructions regarding outpatient laboratory services.

BlueChoice® Solutions Large Employer Groups List

For your reference, the following is an alphabetical list of large employer groups currently enrolled in BlueChoice Solutions. Note that the employer groups listed below include insured and self-funded health plans. These employer groups may have chosen the BlueChoice Solutions network as an optional network for their employees. In addition, BlueChoice Solutions is offered to individual members.

BlueChoice Solutions Large Employer Group List As of January 2010	
A.H. Beck Foundation Co. Inc.	MHMR Services of Texoma
Air Force Villages Inc.	Naegeli Transportation Inc.
Alamo Iron Works Inc.	Odyssey Aerospace Components LLC
Blue Cross and Blue Shield of Texas	Reef Industries, Inc.
Centaurus Property Management LLC	Research Analysis & Maintenance Inc.
City of Sanger	San Antonio Food Bank Inc.
Community Hospice of Texas	Six Day Dental & Orthodontics-North TX P.A.
Crestview RV	Southwest Ford, Inc.
DCTA	SXSW, Inc.
Epic Medstaff Services Inc.	TEI & Associates, LLC
First Co.	The Care Group of Texas
Good Fulton & Farrell	The City of Glenn Heights
Health Services Management of Texas LLC	The CMI Group Inc.
Hi-Tech Plastics	United Graphics
Houk Air Conditioning Inc.	Universal Machining Industries Inc.
Mass Group Marketing Inc.	Yantis Company

Fee schedule updates

Reimbursement changes and updates for BlueChoice® and HMO Blue® Texas (Independent Provider Network only) practitioners will be posted under "Reimbursement

Changes/Updates" in the Professional Reimbursement Schedules section on the Blue Cross and Blue Shield of Texas Web site at www.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 posted.

To view this information, visit the General Reimbursement Information section on this Web site. Also, the Drug/Injectable Fee Schedule will be updated on the following dates: March 1, 2010 and June 1, 2010.

Improvements to the medical records process for BlueCard claims

BCBSTX is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records. As always, we will request that you submit your medical records to BCBSTX if needed for claims processing.

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

Pass-through billing

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

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

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

Contracted providers must file claims

Providers must file claims for any covered services rendered to a patient enrolled in a BCBSTXhealth 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.

Medical policy disclosure

New or revised medical policies, when approved, will be posted on our Provider Portal on the first or the fifteenth day of each month. Those policies requiring disclosure will become effective 90 days from the posting date. Policies that do not require disclosure

will become effective 15 days after the posting date. The specific effective date will be noted for each policy that is posted.

To view pending policies, go to the General Reimbursement section at www.bcbstx.com/provider and click on “Medical Policies”. After reading the disclaimer, click on “I Agree” to advance to the medical policy page. The policies can be accessed by clicking the “View Pending Policies” tab.

Draft medical policy review

In an effort to streamline the medical policy review process, you can view draft medical policies on our Provider Portal and provide your feedback online. The documents will be made available for your review around the first and the fifteenth of each month with a review period of approximately two weeks.

To view draft policies, go to the General Reimbursement Information section of our Provider Portal at www.bcbstx.com/provider and click on “Draft Medical Policies”. After reading the disclaimer, click on “I Agree” to advance to the Medical Policy page.

Urgent versus standard predeterminations

At times, a predetermination for services may need to be handled as priority. Urgent predetermination requests include, but are not limited to:

- Procedures and/or drugs needed to relieve pain.
- Acute medical conditions.
- Continuities of care in a chronic condition.
- Treatments that need to be given within one week of the date the request is received.

Cosmetic procedures and bariatric surgery would not be considered urgent.

In order for a predetermination request to be processed as priority, check the box marked “URGENT” located at the top of the completed predetermination form and indicate the anticipated date of service. Urgent predetermination requests only should be faxed to 888-579-7935.

Note that photographs will not be accepted via fax. They should be placed in a sealed envelope with the words “Request for Predetermination - Original Photos - Do Not Bend” written on both sides and sent to the appropriate address found on the form.

Remember, all predetermination requests are considered standard and should be mailed to the appropriate address found on the form if treatment is to be given later than one week.

No additional medical records needed

Physicians and professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from American Imaging Management (AIM) 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.

Importance of obtaining preauthorizations for initial stay and add-on days

Preauthorization is required for certain types of care and services. It is the responsibility of the insured person to confirm that their provider obtains preauthorizations for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

If an insured person does not obtain preauthorization for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced. Preauthorization does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

Avoidance of delay in claims pending COB information

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

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

- CMS-1500, box 11-d – if there is no secondary insurance carrier, mark the “No” box.
- Do not place anything in box 9, a thru 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.

Nonliability and hold harmless reminders: billing for non-covered services

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

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

In no event shall a contracted provider collect payment from the subscriber for identified hospital acquired conditions and/or never events.

QVT (quantity versus time) limits

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

The Blue Cross and Blue Shield of Texas Clinical Pharmacy Department is currently working on updating the QVT list for 2010. Visit www.bcbstx.com for an update and detailed list under the Pharmacy section.

Preferred drug list

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

The 2010 drug guide updates are posted at www.bcbstx.com under the Pharmacy section.

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. Our mission calls for us to respond to our customers with promptness, sensitivity, respect and dignity. In support of this mission, BCBSTX encourages appropriate utilization decisions; it does not allow or encourage decisions based on inappropriate compensation. Physicians, providers or BCBSTX staff do not receive compensation or anything of value based on the amount of adverse determinations, reductions or limitations of length of stay, benefits, services or charges. Any person(s) making utilization decisions must be especially aware of possible underutilization of services and the associated risks.

This topic has been addressed in the *Blue Review* provider newsletter and in previous BCBSTX employee communications, as a requirement of our Utilization Review Accreditation Commission accreditation. This serves as a reminder for all providers in the BCBSTX provider network.

Billing for Non-Covered Services

In the event that BCBSTX/HMO Blue Texas determines in advance that a proposed service is not a covered service, a Physician or other Professional Provider must inform the Subscriber/Member in writing in advance of the service rendered. The Subscriber/Member must acknowledge this disclosure in writing and agree to accept the stated service as a non-covered service billable directly to the Subscriber/Member.

To clarify what the above means - if you contact BCBSTX/HMO Blue Texas and find out that a proposed service is not a covered service - you have the responsibility to pass this along to your patient (our Subscriber/Member). This disclosure protects both you and the Subscriber/Member.

The Subscriber/Member is responsible for payment to you of the non-covered service if the Subscriber/Member elects to receive the service and has acknowledged the disclosure in writing.

Please note that services denied by BCBSTX/HMO Blue Texas due to bundling or other claim edits may not be billed to Member/Subscriber even if the Member/Subscriber has agreed in writing to be responsible for such services. Such services **are** Covered Services but are **not payable services** according to BCBSTX/HMO Blue Texas claim edits.

Change your information online

Click the Change Your Information icon at www.bcbstx.com/provider to electronically submit a change to your name, office or payee address, e-mail address, telephone number, tax ID, or other information. You should submit all changes at least 30 days in advance of the effective date of the change.

If your specialty, practice information/status or board certification is not correct on Blue Cross and Blue Shield of Texas (BCBSTX) Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the Other field or contact your local Professional Provider Network office.

Blue Review is published for BlueChoice®, ParPlan and HMO Blue® Texas contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; e-mail BlueReviewEditor@bcbstx.com.

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

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