

Issue 3, 2010

New administration of behavioral health program

Effective January 2011, Blue Cross and Blue Shield of Texas (BCBSTX) will manage behavioral health (behavioral/mental health and substance abuse/chemical dependency) services for all non-HMO members, replacing Magellan Health Services. Behavioral health care management will be more integrated with our medical care management, allowing our clinical staff to better identify members that could benefit from co-management earlier. This change may result in improved outcomes, enhanced continuity of care, clinical efficiency, and reduced costs over time.

BCBSTX will work with all behavioral health professionals to limit the possibility for disruptions in patient care coordination during this transition. You can use the same phone numbers on the back of the member's ID card for submitting treatment plans, requesting preauthorization and continuity of care, asking customer service inquiries, and more.

Outpatient Preauthorization Requirement Updates

Members may now receive authorization for up to 10 outpatient visits to any behavioral health provider(s) without the need to submit medical records/Outpatient Treatment Request (OTR) forms. Please note, however, either the member or the provider will still need to preauthorize with BCBSTX prior to the visits, and all outpatient behavioral health services must be deemed medically necessary as outlined in the member's benefit booklet.

All outpatient behavioral health visits scheduled after the 10th visit will require that you submit an OTR form. You can call BCBSTX with the OTR required information at any point prior to the 11th visit using the number on the back of the member's ID card.

Continue to watch the "What's New" and UM/QI/Medical Management sections of our website at bcbstx.com/provider and upcoming issues of the *Blue Review* for additional information.

All behavioral health benefits are subject to the terms and conditions as listed in the member's benefit plan.

Billing with National Drug Codes (NDCs)

Currently, Blue Cross and Blue Shield of Texas (BCBSTX) requires inclusion of the National Drug Code (NDC) in conjunction with the applicable Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT[®]) code(s) when unlisted or "Not Otherwise Classified" (NOC) physician-administered and home infusion therapy drugs are billed.

Please be advised that in the future, BCBSTX will be accepting use of the NDC for billing of all drugs. This will provide a more accurate pricing methodology for payment and will also facilitate better management of drug-associated costs. BCBSTX will be using a phased-in approach to

implement NDC pricing and will inform providers accordingly, based on their contractual notification provisions.

Here are some reminders to assist you with proper submission of valid NDCs and related information:

- Submit the NDC along with the applicable HCPCS procedure code(s).
- The NDC must be in the proper format (11 numeric characters, no spaces or special characters).
- The NDC must be active for the date of service.
- The appropriate qualifier, unit of measure, number of units, and price per unit also must be included, as indicated below.

ELECTRONIC CLAIM GUIDELINES

Field Name	Field Description	ANSI (Loop 2410) – Ref Desc
Product ID Qualifier	Enter N4 in this field.	LIN02
National Drug CD	Enter the 11-digit NDC (without hyphens) assigned to the drug administered.	LIN03
Drug Unit Price	Enter the price per unit of the product, service, commodity, etc.	CTP03
NDC Units	Enter the quantity (number of units) for the prescription drug.	CTP04
NDC Unit / MEAS	Enter the unit of measure of the prescription drug given. (Values: FR – international unit; GR – gram; ML – milliliter; UN – unit)	CTP05-1

If you have any questions regarding utilization of the NDC code on your **electronic** claims, contact our Electronic Commerce Center at (800) 746-4614.

PAPER CLAIM GUIDELINES

In the **shaded portion** of the line-item field 24A-24G on the CMS-1500, enter the qualifier **N4** (left-justified), immediately followed by **the NDC.*** Next, enter the appropriate qualifier for the correct dispensing unit (**FR** – international unit; **GR** – gram; **ML** – milliliter; **UN** – unit), followed by the quantity and the price per unit, as indicated in the example below. (*Note: The HCPCS/CPT code corresponding to the NDC is entered in field 24D.)

Example:

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. CPT/HCPCS	E. DIAGNOSIS POINTER	F. CHARGES	G. QTY OR UNITS	H. UNIT/FACTOR	I. ID. QUAL.	J. RENDERING PROVIDER ID.#				
From	To	From	To	EMG	MODIFIER										
MM	DD	YY	MM	DD	YY										
N449500267230 UN1 50.00															
10	01	05	10	01	05	11	J7603			1	50 00	2.5	N	1B	12345678901
															0123456789

For additional CMS-1500 details, refer to the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, available on the NUCC Web site at nucc.org. For more information, continue to visit the What's New and Electronic Commerce Alerts sections of our website, bcbstx.com/provider. Updates also will be included in upcoming issues of the *Blue Review*.

Current Procedural Terminology (CPT®), copyright 2008, by the American Medical Association (AMA). CPT is a registered trademark of the AMA.

Availity[®] CareProfile supports quality care delivery

The CareProfile is the latest offering from Availity and Blue Cross and Blue Shield of Texas (BCBSTX) to assist health care professionals deliver quality care to their patients. The CareProfile is a user-friendly, electronic health record (EHR), created with collaborative input by MEDecision[®], Availity and BCBSTX.

How it works

1. The CareProfile is created using claim-related data that BCBSTX collects from physicians, pharmacies, labs and other health care providers.
2. MEDecision applies robust clinical intelligence and analytics to the data and then summarizes it into a report that highlights treatment opportunities. This summary includes a health status measurement score to help identify a patient's likelihood for serious health complications.
3. Availity displays the information in a user-friendly EHR through its portal, which can be easily accessed by any authorized physician at the point of care.

Other information the CareProfile provides includes:

- Patient demographic information, including date of birth, address and phone number.
- Details about the patient's current primary care physician (if applicable) and other providers visited in the past 24 months.
- Diagnoses and procedures submitted and reflected in the claims records.
- Professional, hospital and emergency room services reflected in the claims records.
- Prescriptions filled, including the class of the drug, total fills, and last date filled.
- Radiological and laboratory services reflected in the claim records.

Available to physicians and provider organizations free of charge, the CareProfile can be accessed on the Availity portal, at availity.com. BCBSTX members can also access the same information under "My Care Profile," in their Personal Health Manager, via Blue Access[®] for Members.

Fast, secure access to the CareProfile information for patients, providers and BCBSTX gives all a common view of each patient, which promotes a collaborative approach to health management, and ensures BCBSTX members the best-possible outcomes.

*Availity is a registered trademark of Availity, L.L.C., an independent, third party vendor.

** MEDecision is an HCSC analytical and care management partner.

Enterprise Interactive Voice Response System enhancement now available

Recent enhancements to the Federal Employee Program (FEP) Enterprise Interactive Voice Response System (eIVR) make it better able to meet your needs. Prior to the 2010 benefit year, the FEP eIVR provided an automated process for obtaining benefit information. However, inquiries regarding visit accumulations and out-of-pocket maximums were not options provided to our customers through this automated system.

Now, the FEP eIVR is able to provide you with a more efficient resource for obtaining necessary information without the assistance of a customer advocate. This update not only allows you to obtain benefit descriptions, but also makes it possible to access out-of-pocket accumulations and visit limitations.

Because accumulations and visit limitations impact the benefits applied to the services you provide, Blue Cross and Blue Shield of Texas wants you to have the ability to access this information without intervention from an advocate. These additional options also allow you to obtain the latest information on file for your patient. This eIVR enhancement includes both individual and family calendar year amounts for Standard Option members, catastrophic out-of-pocket accumulations, and visit accumulations. The visit accumulations available through this system include chiropractic care, physical, speech and occupational therapies, nutritional counseling, and acupuncture.

We expect this system enhancement to eliminate the time spent you spend on the telephone, which will allow you more time to service your patients and our members.

Clear Claim Connection™ available to BCBSTX providers

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 the secure provider portal at 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 in addition to clinical rationales, clarifications and source information for ClaimCheck edits. Certain claims, such as Medicare Primary and BlueCard, are exempt from ClaimCheck auditing.

The BCBSTX ClaimCheck database is updated periodically and upgraded to a new version annually, which may result in certain edit combinations being modified. Appropriate notice of such modifications will be provided on our Web site and through this BlueReview newsletter.

As of April 19, 2010, BCBSTX contracted providers are able to access the C3 web link via Availity, in addition to RealMed. Registration with RealMed or Availity is required prior to 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.

To use C3, log on to the BCBSTX website at bcbstx.com and click on the "Providers" tab. You will find Clear Claim Connection in the "General Reimbursement Information" section under Bundling Information.

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.

If you need more information, please 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.

Easier access to pre-certification/pre-authorization information for out-of-area Blue members

Blue Cross and Blue Shield of Texas is pleased to offer enhancements to the BlueCard® Eligibility Line. These changes will improve your experience in verifying eligibility and obtaining pre-certification/pre-authorization information for your out-of-area Blue members.

As of April 1, 2010, when your pre-certifications/pre-authorizations for a specific member need to be handled separately from eligibility inquiries, your call to 800-676-BLUE (2583) will be routed directly to the area that handles pre-certification/pre-authorizations. You will choose from the four following options regarding the type of service you are requesting the pre-authorization/pre-certification for:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Durable medical equipment

Upon making your selection, you will be transferred to the appropriate area of the member's plan to service your specific request.

If you are calling 800-676-BLUE (2583) to obtain eligibility only or if you need both eligibility and pre-certification/pre-authorization information, the call process will not change. You will select the option to obtain eligibility and pre-certification/pre-authorization information, your eligibility inquiry will be determined and you will be transferred to the appropriate pre-certification/pre-authorization area.

BCBSTX offers a new solution for credentialing

Blue Cross and Blue Shield of Texas (BCBSTX) has chosen the CAQH®* Universal Provider Datasource (UPD)® to electronically collect the data we require to credential physicians or other professional providers contracted with our HMO Blue Texas and BlueChoice networks. The UPD utilizes an online credentialing application process that supports our administrative simplification and paper reduction efforts.

The credentialing and re-credentialing process entails significant paperwork and administrative time. The UPD will reduce the time required, while producing quality credentialing and demographic information that improves the accuracy and integrity of our provider database.

Physicians and other professional providers will complete one standardized application that will meet the needs of all participating healthcare organizations. UPD's database will collect vital information, such as:

- Education and training
- Experience
- Practice history
- Location
- Disclosure of any issues impacting the ability to provide care
- Other background information

All data submitted by physicians and other professional providers through the UPD service is maintained by CAQH in a state-of-the-art data center, located within the U.S. Only the health

care organization(s) authorized by the physician or other professional provider may have access to the provider's data.

Visit the CAQH website at upd.caqh.org/oas/ for more information about the application process. You may also contact your local Professional Provider Network office with any questions regarding this new procedure.

*CAQH is the Council for Affordable Quality Healthcare, Inc., a not-for-profit collaborative alliance of the nation's leading health plans and networks. The mission of the CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs.

Medicare Part D Pharmacy Update: Generic Drugs and Current Controversies

Several months ago, we started a discussion about generic medications by outlining a brief history of significant legislation that governs the generic approval process utilized by the Food and Drug Administration (FDA). That article was intended to provide a basic understanding of the concept of bio-equivalence, which allows the FDA to approve low-cost alternatives to expensive brand-name products once they have lost their patent protection.

This is an important discussion since generic drugs now account for 70 percent of all prescriptions in the United States. Health plans, third-party payors and pharmacy benefit managers promote these less costly, bioequivalent medications as a way to reduce health care costs and to facilitate patient access to important treatments. At the same time, generics represent only about 18-20 percent of the total health care expenditures for pharmaceuticals. Controversies, however, surround the utilization of these low-cost alternatives. Examples of current issues that require further discussion include: a) **Narrow-Therapeutic Index medications**, b) **'Pay for Delay'** settlements, and c) the search for a **generic approval process for high-tech bio-similar medications**.

Narrow-Therapeutic-Index Medications (NTI)

A medication is said to have a 'narrow therapeutic index' or 'therapeutic window' when the serum levels required to exert its desired clinical effect is also close to levels associated with toxic side effects. As a consequence, in order to utilize these medications in a safe and effective manner, physicians usually need to follow careful dose titration and regular patient monitoring.

Despite well-documented determinations of statistical bioequivalence, opponents of generic substitution for certain therapeutic drug classes (e.g. immunosuppressants, anticonvulsants, warfarin, digoxin, lithium, etc.) continue to raise questions about changes in efficacy and toxicity and have voiced the need for patients to receive consistent products with routine refills. In fact, most experts will warn that the real problem is the switching between generic products as opposed to switching between a generic and a brand since bio-equivalence testing is between the brand and a generic – not between generics.

Adding to the public fear of generic alternatives is a wave of anti-generic claims in consumer publications and television programs that feature patient complaints about significant adverse reactions to generic therapies. 'Carve-out' laws and regulations that limit generic substitution at the pharmacy (e.g. dispensing of AB-rated generic products for NTI branded drugs) vary widely by states. For example, in North Carolina, state law requires that the pharmacist dispense the same drug product from the same manufacturer for each refill of an NTI medication. Documented prescriber and patient consent must also be received prior to any switch in

products. California and Texas, on the other hand, have no special regulations when considering the substitution of brand name NTI products for a generic alternative.

'Pay for Delay' Settlements:

Another controversy regarding the approval of generic medications involves efforts by the pharmaceutical industry to either delay or undermine the generic medication approval process. One such effort is the use of 'authorized generics'. An authorized generic exists when a pharmaceutical manufacturer sells a drug under both a brand-name and a generic label. Since authorized generics are considered brand products by the FDA, the authorized generic does not have to go through the same rigorous Abbreviated New Drug Application (ANDA) approval process required by a true generic.

As noted in the previous article, the first generic competitor of a branded drug product is awarded a 180-day period of marketing exclusivity under the Hatch-Waxman Act in an effort to help 'first filers' recoup expensive legal fees. Unfortunately, it does not preclude competition from an authorized generic. Authorized generic entry during this time can substantially reduce the revenues of a first-filer generic firm by 47 to 51 percent as reported by a recent Federal Trade Commission (FTC) report. As a result, a generic firm may be willing to agree to defer its market entry in return for a brand manufacturer's promise not to launch a competing authorized generic during the 180-day marketing exclusivity period.

Such practices can harm consumers in two ways. First, generic drugs and the accompanying price discounts would not be available to consumers as soon as otherwise would have been the case. Secondly, consumers would lose the benefit of price discounts from the authorized generic competition during the 180 day exclusivity period. The FTC report also states that between fiscal years 2004 – 08, about 25 percent of the final patent settlements reviewed by the FTC contained provisions related to authorized generics and an agreement by the brand manufacturer not to launch an authorized generic to compete against the first-filer combined with an agreement by the first filer to defer entry past the settlement date by an average of 34.7 months. The FTC has gone to court to block delay settlements and congressional leaders may try and curb these deals through legislation (e.g. HR 573).

Battle over Bio-similars

With procedures for developing and marketing generic drugs well established, generic manufacturers are naturally looking for expansion in the manufacture of more complex dosage forms such as biologic agents, commonly known as 'bio-similars' or follow-on biologics (FOBs). Examples of this class of medications include REMICADE (infliximab) and ENBREL (entercept) which are used to treat rheumatoid arthritis. These agents include many important new therapies and constitute the fastest growing segment (25 percent of total pharmacy costs in 2008) of the pharmaceutical market. As promising as these therapies appear to be, their costs can be substantial, reaching \$200,000 or more annually for treatments such as imiglucerase (CEREZYME) which is used to treat Gaucher's Disease.

Consumer protection groups, health insurers, and prescription benefit managers (PBMs) have supported a five-year period of exclusivity promoted by Rep. Henry Waxman (D-CA). Manufacturers would argue that added protection from competition is fair, based on the fact that development costs for biologic products are so much higher than for other medications. Generic manufacturers and consumer groups argue that it would discourage development of generic biologics and reduce the incentive to develop new products. Even the FTC has weighed in on the debate with a study that states that introduction of bio-similars would lower costs to consumers without hampering drug innovation and development. Industry analysts say that if

the law changes to allow bio-similar drugs, the FDA can expect a lot of approval requests. Many biotech drug patents have either expired or will expire in the next five to 10 years. When that happens, experts expect bio-similars to cost 20 to 30 percent below the cost of brand name products. Ultimately, FOBs are a balancing act for lawmakers – balancing the need to control escalating specialty drug costs while making sure it doesn't come at the expense of future new drug research and development.

What can we expect from Health Care Reform

Recently, passage of the Health Care Reform bill in Congress resolved a number of related issues – at least for the foreseeable future. The Health Care and Education Reconciliation Act of 2010 (H.R. 4872) would authorize the FDA to create an approval pathway for FOB products that would guarantee manufacturers 12 years of market exclusivity before any bio-similar product could be approved, even in the absence of a valid patent. In addition, manufacturers could also obtain additional 12-year exclusivity by making minor changes to the structure of an approved product, such as those that could lead to changes in its administration schedule. It remains to be seen how the new law pertains to older products with expired patents.

On the other hand, efforts by consumer groups, senators, and even President Obama to add a 'Pay-for-Delay' provision to the Senate health care bill failed. The provision, which was based on a bill (S. 369) introduced by Sen. Herb Kohl (D-WI) in February 2009, would have prohibited payments from brand name to generic drug manufacturers with the purpose to prevent or delay the entry of competition from generic drugs.

Conclusion

Despite some continuing controversies outlined above, the utilization of generic drug products continues to grow as more products become available and as consumers, private health plans and government programs look for alternatives to increasingly expensive brand-name products. Generic drugs represent a valuable alternative for those patients with no insurance, or even those with insurance who face increasing financial co-sharing responsibility. Studies continue to show that drug costs can be a significant factor to determine a patient's adherence to therapy, even when the patient has health insurance. Lastly, because beneficiaries in the Medicare Part D program are currently liable for up to \$4,550 in out of pocket expenses before Catastrophic Coverage takes effect, seniors are increasingly turning to generic drugs in an attempt to lower their monthly drugs bills.

References:

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Medicare Part D formulary changes

A summary of recent Blue Cross Blue and Shield of Texas Medicare Part D formulary changes can be found in the chart below. This list is updated regularly by our pharmacy provider, Prime Therapeutics.

For a complete list, and for future changes, go to myrxassistant.com, and follow the directions below:

- 1) Type the drug name in the section 'Find Drugs' and click 'search'
- 2) Follow directions to a corresponding health plan
- 3) Under Forms and Related Information, select **Formulary Updates.pdf**

This Web site also offers access to the comprehensive formulary, as well as other useful informational sources including prior authorization criteria, filing a grievance, etc.

Generic name (TRADE NAME)	BRAND Generic Product	Effective Date	Nature of Change	Comments
Tadalafil (ADCIRCA) Tabs 20mg	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 4 • Prior Authorization applies
Azelastine (ASTEPRO) nasal 0.15%	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 2 • Quantity Limit applies
Brimonidine ophthalmic soln 0.15%	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for ALPHAGAN P
Buprenorphine SL tabs 2mg, 8mg	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for SUBETEX
COLCRYS (colchicine) tabs 0.6mg	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 3 • Only FDA approved colchicine product
Prasugrel (EFFIENT)	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 2
Paliperidone (INVEGA) Tabs 1.5mg Paliperidone (INVEGA SUSTENNA) 39mg/0.25ml	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 3 • Step Therapy and Quantity Limits apply
Ketorolac ophthalmic soln 0.4%	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for ACULAR LS
Ketorolac ophthalmic soln 0.5%	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for ACULAR
Lamotrigine starter kits (3) NOT taking carbamazepine	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for LAMICTAL STARTER KITS

TAKING carbamazepine – NOT taking valproate TAKING valproate				
Lansoprazole caps 15mg, 30mg	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for PREVACID • Quantity Limit applies
Melphalan injection 50mg	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 4 • First generic for ALKERAN
Dronedarone (MULTAQ) tabs 400mg	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 2
Nateglinide tabs 60mg, 120mg	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for STARLIX
Saxagliptin (ONGLYZA) tabs 2.5mg, 5mg	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 2 • Quantity Limit applies
Oxaliplatin injection 5mg/ml	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 4 • First generic for ELOXATIN
Piperacillin-tazobactam for inj 2/0.25gm, 3/0.375gm, 4/0.5gm	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 4 • First generic for ZOSYN
Vigabatrin (SABRIL) Tabs, powder pack 500mg	BRAND	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 3
Valacyclovir tabs 500mg, 1,000mg	Generic	1-1-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for VALTREX
Pramipexole tabs 0.125mg, 0.25mg, 0.5mg, 1mg, 1.5mg	Generic	1-4-10	Addition	<ul style="list-style-type: none"> • Tier 1 • First generic for MIRAPEX
Human papilloma virus bivalent (CERVARIX) inj.	BRAND	1-28-10	Addition	<ul style="list-style-type: none"> • Tier 3 (new vaccine)
Letrozole (FEMARA) tabs 2.5mg	BRAND	2-1-10	Cost Share Reduction	<ul style="list-style-type: none"> • Tier 2 (was Tier 3)
Tacrolimus caps 5mg	Generic	2-1-10	Cost Share Reduction	<ul style="list-style-type: none"> • Tier 1 (was Tier 4)
Pancrelipase (ZENPEP) caps 5,000 units, 10,000 units	BRAND	2-15-10	Addition	<ul style="list-style-type: none"> • Tier 3 • Second FDA approved pancreatic enzyme replacement therapy

15,000 units, 20,000 units				
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EFT, ERA and EPS Survey Results

In previous articles, we have outlined the definitions, advantages and enrollment process for Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS). We also posted an interactive EFT, ERA and EPS Overview tutorial on our Web site. This tutorial included a survey to help us gauge provider understanding while offering viewers the opportunity to submit questions or comments.

After viewing the tutorial, 74 percent of respondents reported that they were “Highly Likely” to enroll for EFT, ERA/EPS, while 24 percent of respondents fell into the “Somewhat Likely” to enroll category. Many “Somewhat Likely” providers also included comments in response to the following survey questions: *Do you have any questions that haven’t been addressed and that may have prevented you from enrolling? Tell us how we can assist you?*

Here is a sampling of the basic EFT, ERA and EPS questions we received, along with our answers:

1. **Is there a fee for enrolling and/or using the EFT, ERA or EPS?** BCBSTX does not charge any fees related to EFT, ERA/EPS. However, if you utilize a billing service, vendor or clearinghouse, you should ask if they charge any fees.
2. **Do I have to enroll in all three, or can I pick and choose?** We highly encourage you to enroll for all of these transactions to help synchronize payment and reporting processes in your office. You can choose to enroll in EFT alone; or you may enroll for ERA/EPS, without EFT. You must enroll for ERA to receive EPS.
3. **I file claims electronically. Can I still enroll for EFT, ER and EPS?** Yes! While electronic claim submission is strongly encouraged, it is not a prerequisite to EFT, ERA/EPS enrollment.
4. **What’s the difference between the ERA and EPS?** The purpose of the ERA file is to eliminate the need for manual posting – it enables you to complete automatic posting of your patient accounts. The EPS replaces your paper Provider Claim Summary (PCS) with an electronic file that is easy to archive and retrieve.

Most provider questions received from the online survey were related to ERA/EPS. Therefore, we will be including an ERA/EPS-focused feature article in the next three issues of Blue Review and posting additional ERA/EPS-focused articles on our provider Web site. The Electronic Options tutorial is available in the Electronic Commerce section of our Web site at bcbstx.com/provider, along with answers to frequently asked questions about EFT, ERA and EPS.

If you need additional assistance with the enrollment process, contact our Electronic Commerce Center at 800-746-4614. We look forward to helping you discover the benefits of participating in these electronic transactions.

Predetermination – important tips

Predetermination of benefits: a voluntary, written request for review of treatment or services; includes services that may be considered experimental, investigational or cosmetic. Predetermination approvals and denials are usually based on provisions in our medical policies. ***A predetermination of benefits is not a substitute for the precertification process.**

1. Always check benefits before submitting a predetermination; a predetermination is not available for all procedures.
2. Mail each patient separately to P.O. Box 660044, Dallas TX 75266-0044
3. Urgent requests can be faxed to 888-579-7935. Be sure to mark "urgent" on the request form and include the date the service is scheduled to be rendered.
4. When you fax or mail your documents, always place the predetermination request form on top.
5. If the request is over 10 pages or includes photos, they must be mailed.
6. Fill out the entire form.
7. Include provider address and fax number
8. Provide the contact's name, address and phone number
9. Always provide the procedure code(s) and the diagnosis code(s).
10. If applicable, provide left, right or bilateral.
11. For major diagnostic tests, include the patient's history, physical and any prior testing information. Refer to bcbstx.com/provider/pdf/med_pol_guidelines.pdf
12. A predetermination is not available for complete or partial bony impacted teeth. Please check the patient's benefits.
13. If the procedure is cosmetic in nature, please include original photos or digital color copies that clearly show the affected area of the body. This information must be mailed.

* Always place the Predetermination Request Form on top.

Predetermination instructions and form:

bcbstx.com/provider/pdf/predeterminationform_instruct.pdf

bcbstx.com/provider/pdf/predeterminationform.pdf

Medical Policy:

<http://medicalpolicy.hcsc.net/medicalpolicy/disclaimer.do?corpEntCd=TX1#hlink>

bcbstx.com/provider/pdf/med_pol_guidelines.pdf

Notices and Announcements

Multiple surgery pricing per session methodology

Effective July 1, 2010, Blue Cross and Blue Shield of Texas (BCBSTX) will implement a "per operative session" methodology for multiple surgery pricing. BCBSTX currently uses an "operative area" methodology.

The change to a "per operative session" Multiple Surgery pricing methodology means the primary surgical procedure will be adjudicated at 100 percent of the allowable amount, and each subsequent surgical procedure performed (regardless of anatomic area) will be adjudicated at 50 percent of the allowable amount. The procedure with the highest dollar allowance will be considered the primary procedure.

Add-on multiple codes and Modifier-51 exempt codes will continue to be exempt from Multiple Surgery pricing logic.

Electronic claims with NPI-related errors set to reject August 1, 2010

In June 2008, we published a complete listing of [electronic claim edits](#) that were implemented in support of an NPI-Only claims processing environment. This document provided the three-digit error code along with a defining message indicating the severity level of the error and the resulting impact on the claim – “W” for Warning and “R” for Rejection.

An updated NPI-only Electronic Claim Submission Edits listing has been posted in the Electronic Commerce “Alerts” section of our provider Web site at bcbstx.com/provider. ***Please be advised that most of the edits/error listings that were formerly set at the Warning level will be set to Reject as of August 1, 2010.*** The only two error types that will continue to remain at the Warning (“W”) level are as follows:

Error Code	Message	Status
BA6	Rendering NPI is not on file (Claim Level Error Message)	W
CA6	Rendering NPI is not on file (Service Line Level Error Message)	W

If you are currently receiving Warning message(s) on your electronic claim reports denoting a lack of NPI-related information, it is imperative that you make the necessary correction(s) immediately, as most of these claims will reject commencing August 1, 2010.

It is important to ensure that you and/or all of your electronic trading partners (billing services, clearinghouses and software vendors) are aware of and responsive to these messages. If you have any questions on these edits, please contact our Electronic Commerce Center at 800-746-4614.

If your office refers to a printed copy of the 2008 NPI-only Electronic Claim Submission Edits listing, please replace it with the updated version posted in the Electronic Commerce Alerts section of our provider website at bcbstx.com/provider.

Physical, occupational and speech therapy services billed with an Evaluation & Management Code (E&M)

It is not within the scope of practice for physical, occupational and/or speech therapy providers to bill for medical examinations (office visit) Common Procedural Terminology (CPT) codes. Such CPT codes are designed for evaluation and management of an injury or illness. If an evaluation is performed for physical, occupational or speech therapy, there are therapy evaluation CPT codes available for evaluation of therapy related injuries and/or illnesses. For a list of appropriate therapy evaluation CPT codes, please refer to the CPT Manual or contact the American Medical Association at 800-621-8335.

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 the prescribing physician with any questions or concerns. For additional information, visit bcbstx.com/provider/clotting_factor.htm.

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 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.

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

Effective June 1, 2010, Quest Diagnostics, Inc. is the **exclusive** outpatient clinical reference laboratory provider for HMO Blue[®] Texas members* and 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 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 bcbstx.com/provider under the General Reimbursement Information section.

Effective June 1, 2010, Laboratory Corporation of America (LabCorp) is no longer 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.*

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 April 2010	
A.H. Beck Foundation Co. Inc. Air Force Villages, Inc. Blue Cross and Blue Shield of Texas Centaurus Property Management, LLC City of Sanger Community Hospice of Texas DCTA Epic Medstaff Services Inc. First Co. Goodheart Specialty Meats Health Services Management of Texas, LLC	Naegeli Transportation Inc. Overland Mortgage Corporation Reef Industries Inc. Research Analysis & Maintenance Inc. Southwest Ford Inc. SXSU, Inc. TEI & Associates, LLC The Care Group of Texas The City of Glenn Heights The CMI Group Inc. United Graphics

Fee schedule updates

The ParPlan, BlueChoice® and HMO Blue® Texas (Independent Provider Network only) maximum allowable fees for practitioners will be updated to reflect 2010 CMS values effective July 1, 2010. Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality. HMO Blue Texas, BlueChoice and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility). A “per operative session” methodology for Multiple Surgery Pricing will be implemented for BlueChoice, HMO Blue Texas and ParPlan effective 7/1/2010. The Drug/Injectable Fee Schedule will be updated on the following dates: 6/1/2010, 9/1/2010, 12/1/2010, 3/1/2011 and 6/1/2011.

Blue Cross and Blue Shield of Texas provides general reimbursement information policies, request forms for allowable fees and fee schedule information at bcbstx.com/provider. To view this information, visit the General Reimbursement Information section on this website. If you would like to request a sample of maximum allowable fees or if you have any other questions, please contact your local Professional Provider Network office.

Reimbursement changes will be posted under "Reimbursement Changes/Updates" in the "Professional Reimbursement Schedules" section on the Web site. 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.

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 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.

Reminder — Contracted providers must file claims

As a reminder, 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 (ARRA) 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 event, you must comply with HIPAA and not file the claim to BCBSTX.

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Per recent revisions to HIPAA, the requirement to file claims does not apply if an enrollee chooses to self-pay a provider in full and directs the provider not to file a claim 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 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 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 through d – this area is reserved for member information for a secondary insurance payer.

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

Billing for non-covered services

As a reminder, contracted providers may collect payment from subscribers for supplemental charges, copayments, co-insurance 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 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 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.

