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BCBSTX automates claims processing for preventive colonoscopies

Processing for preventive colonoscopy claims with modifiers PT and 33 is now automated for Blue Cross and Blue Shield of Texas (BCBSTX). This new automated claims processing demonstrates BCBSTX's commitment to make changes to effectively implement the Affordable Care Act (ACA) Preventive Care Services provision.

The Current Procedural Terminology (CPT[®]) modifier 33 became effective Jan. 1, 2011. BCBSTX has manually processed claims submitted with this modifier while automation was being completed.

ACA requires that preventive services such as diagnostic colonoscopies be covered without member cost-sharing when the member is covered by a non-grandfathered health care plan. That means the preventive service must be covered with no coinsurance, deductible or copay when the patient covered under a non-grandfathered BCBSTX health plan uses health care professionals in the BCBSTX network.

Accurate claims billing is essential to receiving correct payment for a preventive care service like a diagnostic colonoscopy. The initial reason a procedure was performed determines whether it is covered without member cost-sharing. For example, when the initial reason for a colonoscopy is to screen for colorectal cancer, it is considered preventive under the United States Preventive Services Task Force (USPSTF) guidelines that drive ACA requirements. That procedure should be billed using the applicable new CPT modifier 33. However, CPT modifier 33 does not apply to non-preventive colonoscopies, such as those done to evaluate or follow up on signs, symptoms or pre-existing conditions.

Health care providers should already be using the new CPT modifier 33 that became effective Jan. 1, 2011. This modifier alerts us and others who pay health insurance claims that the service was provided as preventive care, and that deductibles, copays and coinsurance do not apply.

Tips on using modifiers for preventive services

Sometimes it can be difficult to know when to use which modifiers. Here are some tips that may help:

- If the purpose of the procedure is to screen for colorectal cancer and the service becomes diagnostic during the procedure, both modifier PT and 33 may be used.
- Modifier 33 can be used alone when the service remains preventive throughout the procedure.
- Modifier 33 is not used for non-preventive colonoscopies or other non-preventive procedures.
- At least one of the preventive modifiers must be used in order for the colonoscopy claim to pay as preventive.
- A colonoscopy procedure will pay at the no-cost sharing benefit level as long as modifier 33 is used alone or in combination with the PT modifier (PT + 33).

- Colonoscopies not billed with one of the preventive modifiers will *not* be paid as a preventive screening.

Frequently Asked Questions about preventive colonoscopies

1. *What colonoscopy procedures is BCBSTX defining as preventive?*

A service associated with a screening colonoscopy must pay at the preventive benefit level. If a procedure is billed as a screening, colonoscopy benefits will be applied as preventive based on the intent of the test and not on the findings. If a problem is found during the screening and a procedure is performed to address the problem (such as polyp removal), the claim will still be paid as preventive with no cost sharing – as long as it has been billed with modifier 33. If the procedure is not billed as preventive, it will not be paid as a preventive screening.

2. *What services are considered part of the screening colonoscopy?*

A service that is directly related to a screening colonoscopy is considered to be part of the screening colonoscopy:

- Colonoscopy screening procedure
- Pathology services
- Anesthesiology (if necessary)
- Outpatient facility fee

3. *What if a procedure has already been performed and improperly coded and the member has paid a share of the cost?*

If the member or provider calls or writes to ask why the procedure was not paid without cost sharing, the Customer Advocate will be authorized to make an adjustment and reimburse the provider, if appropriate. This will be done through the normal “Explanation of Benefits” process.

Note: BCBSTX is not retroactively reviewing colonoscopy screening claims unless a patient or provider requests the review.

4. *Will BCBSTX adjust a claim for a colonoscopy?*

There are a number of factors that could impact the way BCBSTX will reimburse for a colonoscopy procedure. Reasons that may lead to the claim being paid with member cost-sharing include number of visits; age limits; use of a non-network provider; procedure billed as diagnostic or medical; symptoms or history.

If a member advises that a colonoscopy was intended to be preventive, BCBSTX will research claims history and adjust the claim when it represents the first one on record for the member. The provider may be called if a claims search does not find a preventive diagnosis on the corresponding date of service.

5. *What if a problem is found during the colorectal screening? Does it change the way the claim is paid?*

If a procedure is billed as a preventive screening, BCBSTX will assume that colonoscopy benefits should be applied based on the intent of the test and not on the findings. If a problem is found during the screening and a procedure is performed to address the problem (such as polyp removal), the claim will still be paid as preventive with no member cost sharing – as long as it has been billed using the appropriate preventive modifiers. If the procedure is not billed as preventive, it will not be paid as a preventive screening.

For more information about the USPSTF recommendation on screening for colorectal cancer see <http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm>.

This material is for informational purposes only and is not the provision of legal advice. If you have any questions regarding the law, you should consult with your legal advisor.

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

On track with the Affordable Care Act: Women's preventive services

The Affordable Care Act (ACA), enacted on March 23, 2010, has created many opportunities for health care providers to deliver effective and efficient patient care. Preventive services are meant to improve patient outcomes and lower health care costs by reducing or eliminating the occurrence of certain illnesses and medical conditions.

Under ACA patients may have access to many preventive services with no cost-sharing. With the coverage provided by ACA, a number of new preventive services for women will be covered with no cost-sharing on or after Aug. 1, 2012, when using a provider in their plan/policy network.

Background

On Aug. 3, 2011, federal regulatory agencies published regulations requiring that certain preventive services for women be provided without cost-sharing as part of guidelines supported by the Health Resources and Services Administration (HRSA). For non-grandfathered plans, the new regulations expand the coverage of women's preventive services under ACA.

The guidelines supported by the HRSA include the following types of services:

- Well-woman visits
- Screening for gestational diabetes
- Testing for HPV in women at least 30 years old
- Counseling for sexually transmitted infections
- Screening and counseling for HIV
- FDA-approved contraception methods and counseling
- Breastfeeding support, supplies and counseling
- Interpersonal and domestic violence screening and counseling

Women's Preventive Coverage

Under ACA, certain preventive health services are covered with no patient cost-share – there is no copayment, coinsurance or deductible – when using a provider in the plan/policy network. Depending on the particular plan, coverage may be provided for the following types of services without cost-sharing when using a network provider:

- Chlamydia infection screening
- Gonorrhea and syphilis screening
- Counseling about genetic testing for breast cancer
- Counseling to help stop use of tobacco products
- Screening for diabetes for persons with high blood pressure
- Osteoporosis (bone density) screening
- Cholesterol screening based on age and individual risk factors
- Colorectal cancer screenings

- Screen and counseling for alcohol misuse
- Use of folic acid to promote health
- Use of aspirin to prevent heart disease
- Health counseling to include nutrition and weight management
- Immunizations
 - Hepatitis A and B
 - Human Papillomavirus (HPV)
 - Influenza (Flu)
 - Measles, mumps, rubella
 - Meningococcal (Meningitis)
 - Pneumococcal (Pneumonia)
 - Tetanus, Diphtheria, Pertussis
 - Varicella (Chickenpox)
 - Zoster

Pregnancies

Depending on a particular plan, coverage may also be provided for the following types of services without cost-sharing when using a network provider:

- Anemia screening for iron deficiency
- Syphilis screening
- Hepatitis B screening
- Blood testing for Rh incompatibility
- Urinary tract infection screening
- Breastfeeding education

Contraceptives

Depending on the particular plan, coverage without cost-sharing may expand to include contraceptive services when using a network provider:

- Prescription – One or more products within the categories approved by the FDA for use as a method of contraception
- Over-the-counter – Contraceptives available over-the-counter approved by the FDA for women (foam, sponge, female condoms) when prescribed by a physician
- The morning after pill
- Medical devices such as IUD, diaphragm, cervical cap and contraceptive implants
- Female sterilization*

*Certain restrictions may apply. Hysterectomies are not considered part of the women's preventive care benefit.

Breastfeeding

Coverage without cost-sharing may expand to include breastfeeding services when using a network provider, subject to terms and conditions of coverage:

- Breastfeeding support and counseling by a trained network provider while pregnant and/or during postpartum period
- Breastfeeding specialist/nurse practitioner with state-recognized certification who is in the plan/policy provider network
- Manual breast pump*

*Electronic and hospital-grade pumps will not be covered with no cost-sharing.

For more details on the coverage of preventive services without cost-sharing, visit the Affordable Care Act Resource Center on our website, bcbstx.com/affordable_care_act.

This information is for informational purposes only, does not constitute legal or other advice, and should not be relied upon to determine coverage.

An introduction to risk adjustment

What is Risk Adjustment?

Risk adjustment identifies the differences in health care risk among specific patients, which results in the ability to compare care and cost performance fairly. Risk adjustment is a critical element of the Affordable Care Act (ACA), which is slated to begin in 2014. It is intended to help assure the long-term success of the law's new health insurance exchanges.

Risk adjustment compensates insurers offering plans in the individual and small-group markets inside and outside the exchanges for the risks they accept related to the individuals they enroll. Risk adjustment makes it possible to understand the illness burden each provider is managing, enabling a fairer comparison of performance across health care providers.

The use of severity-of-illness measures, such as diagnoses, to estimate the health risk (measurable or predictable health care cost expenditures) to which a patient is subject is a consistent, scientific approach to quantifying and measuring risk. It also allows comparison of quality outcomes and cost performance in the context of the specific patient health risks managed across health care organizations (hospitals, insurers) and communities.

History of risk adjustment

Risk adjustment was initially introduced in 1997, when it was incorporated into Medicare policy via the Balanced Budget Act to pay Medicare Advantage Plans more accurately for the predicted health cost expenditures of members by adjusting payments to health plans based on demographics (age and gender), as well as health status.

In 2006, Medicare began offering an outpatient prescription drug benefit under the Part D program. Individual Medicare beneficiaries could sign up for benefits administered by private health plans offering either stand-alone drug benefits, i.e., Prescription Drug Plans (PDPs), or obtain prescription drugs through a Medicare Advantage Prescription Drug (MAPD) program. In either case, Medicare now pays private plans a prospective payment for each Part D beneficiary, adjusted for each enrollee's disease burden as determined by a risk score.

It was not until March 23, 2010, however, that risk adjustment was proposed for measuring illness burden in the non-Medicare population as part of the exchanges when the Patient Protection and Affordable Care Act (PPACA) was signed into law. The technical details of the law are slowly being released from the Department of Health and Human Services (HHS), beginning with the publishing of the Final Rule in March 2012.

What will risk adjustment mean to your practice?

It is business as usual. However, there is the need for a heightened awareness of the important role you play in ensuring that the increased specificity in medical record documentation exists and that it will support the coding on claim or encounter data that your practice submits. The reported diagnoses should follow industry-coding guidelines for conditions that are **M**onitored, **E**valuated, **A**ssessed or **T**reated ("MEAT").

Audits of medical records

Payer risk scores and the source data, as well as your submitted claims and encounter data will be audited to confirm accuracy. In turn, audits of medical records and your clinical documentation will be required to validate coding accuracy.

You can impact your risk scores

You can take the appropriate actions to evaluate the quality of your clinical documentation and accuracy of the reported translated codes, as follows:

- Clearly document the clinical details of your care including the underlying reason (diagnosis) for the care and/or medications, along with the date, time and your clinical credentials
- Record all clinically relevant diagnoses under evaluation and ongoing treatment: acute, acute on chronic and chronic conditions; a single diagnosis code may not reflect the complete clinical picture
- Ensure that diagnoses are clearly documented in the medical record; they should not be inferred from physician orders, nursing notes, lab or diagnostic test results
- Consider ongoing training and education to ensure accurate coding, whether you code the diagnoses yourself or your designee reads your documentation and codes for you

The other “Rs”

Reinsurance and risk corridors, two of the other programs that ACA has established, are also designed to help ensure that payers compete based on quality and service rather than risk selection. The goal of these programs is to reduce uncertainty that could increase premiums when Affordable Insurance Exchanges begin operating in 2014.

- **Reinsurance** is a transitional program established in each state to help stabilize premiums for individuals with higher cost needs who obtain insurance coverage during the first three years (2014 through 2016) of exchange operation. All health insurance payers, self-insured group health plans and third-party administrators on their behalf will make contributions to support reinsurance payments to individual market issuers that cover individuals with high medical costs.
- **Risk corridors** are designed to protect against the uncertainty in rate setting during the first three years of the exchanges by creating a mechanism for sharing risk between the federal government and qualified health plan payers. In general, the risk corridors are temporary financial “bumpers,” reducing the potential financial impact extremes an issuer may experience by providing a government subsidy if an issuer’s losses exceed a certain threshold and similarly limiting an insurer’s gains if gains exceed a certain threshold, by requiring issuers to pay the government.

Although risk adjustment guidelines are not yet finalized, providers should begin preparing for compliance with risk adjustment standards. Blue Cross and Blue Shield of Texas (BCBSTX) will work with independently contracted providers to help support the long-term success of health care reform. In keeping with this and to create an open communication channel with our providers, BCBSTX recently conducted a focus group on the topic of risk adjustment to solicit input and insight from our network providers. A sample provider risk adjustment score card was introduced to the focus group to review and provide feedback. Feedback obtained will be utilized to enhance prototype score cards and data sharing with our providers in support of the transition to the 2014 exchange environment and future risk adjustment based contracts.

Please watch the News and Updates section of the BCBSTX provider website at bcbstx.com/provider and the *Blue Review* for additional information, announcements and links to related resources.

Enhancements to ClaimsXten code auditing tool

Blue Cross and Blue Shield of Texas (BCBSTX) will implement a new version and new rules to the ClaimsXten™ code auditing tool into our claim processing system beginning on or after Dec. 10, 2012. [We've provided FAQs](#) to help explain the updates to the code auditing tool.

The ClaimsXten tool offers flexible, rules-based claims management with the capability of creating customized rules as well as the ability to read historical claims data. ClaimsXten can automate claim review, code auditing and payment administration, which we believe results in improved performance of overall claims management.

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

For updates on the ClaimsXten implementation and other BCBSTX news, programs and initiatives, refer to the BCBSTX provider website at bcbstx.com/provider. Additional information also may be included in upcoming issues of *Blue Review*.

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

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

Medicare Part D formulary updates

A summary of recent Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Part D formulary changes can be found below. The Blue MedicareRx formulary is updated monthly by our pharmacy provider, Prime Therapeutics. For a complete formulary listing and for future inquiries regarding **prior authorizations, step therapy, coverage determinations/RE-determinations, transition plan benefits, and appointment of representative** for your BCBSTX members, please follow the following instructions:

Utilize the following link (<https://www.myprime.com>) to access the Prime Therapeutics' Medicare Part D member website:

- a) Click on **'Find Drugs & Estimates'**,
- b) Follow directions to
 - 'Select your Health Plan' click on 'BCBS Texas,'
 - 'Medicare Part D Member?' Click **'YES'**,
 - 'Select Your Health plan type' and click **'Blue MedicareRx'**

c) From this page you will be able to determine the formulary status and applicable utilization management programs for individual drugs or access any of the important databases outlined above.

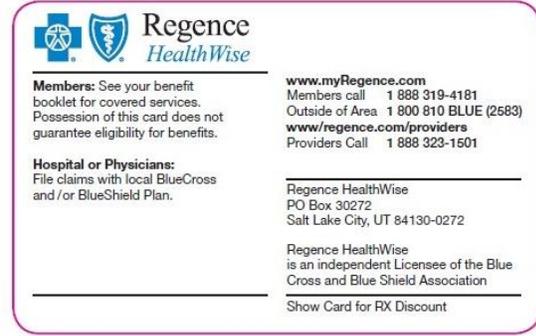
Generic name (TRADE NAME)	BRAND Generic Product	Effective Date	Description of Change	Comments
doxorubicin liposomal inj, 2 mg/mL	Generic	2/26/12	Addition	Tier 1. May be covered by Medicare Part B or Medicare Part D depending on circumstances.
AFINITOR (everolimus) tab, 7.5 mg	Brand	3/4/12	Addition	Tier 4. Prior authorization and quantity limits apply.
ziprasidone cap, 20 mg, 40 mg, 60 mg, 80 mg	Generic	3/4/12	Addition	Tier 1. Quantity limits apply. Generic for GEODON
ZYCLARA (imiquimod) pump cream, 3.75%	Brand	3/4/12	Addition	Tier 2. Prior authorization and quantity limits apply.
methotrexate for inj	Generic	3/25/12	Cost Share Reduction	Change to Tier 1 (was 3).
MENEST tab, 0.3 mg, 0.625 mg, 1.25 mg, 2.5 mg	Brand	3/30/12	Addition	Tier 3.
quetiapine tab, 25 mg, 50 mg, 100 mg, 200 mg, 300 mg, 400 mg	Generic	4/1/12	Addition	Tier 1. Quantity limits apply. First generic for Seroquel.
escitalopram oral soln, 5 mg/5 mL; tab, 5 mg, 10 mg, 20 mg	Generic	4/1/12	Addition	Tier 1. Quantity limits apply. First generic for Lexapro.
irbesartan tab, 75 mg, 150 mg, 300 mg	Generic	4/8/12	Addition	Tier 1. Quantity limits apply. First generic for Avapro.
irbesartan/ hydrochlorothiazide tab, 150-12.5 mg, 300-12.5 mg	Generic	4/8/12	Addition	Tier 1. Quantity limits apply. First generic for Avalide.
morphine sulfate oral soln, 10 mg/5 mL, 20 mg/5 mL	Generic	4/10/12	Cost Share Reduction	Change to Tier 1 (was 3).
REVLIMID (lenalidomide) cap, 2.5 mg	Brand	4/22/12	Addition	Tier 4. Quantity limits apply.
dextroamphetamine tab, 10 mg	Generic	4/22/12	Cost Share Reduction	Change to Tier 1 (was 3). Quantity Limits continue to apply.

ibandronate sodium tab, 150 mg	Generic	4/22/12	Addition	Tier 1. Quantity limits apply. May be covered by Medicare Part B or Medicare Part D depending on circumstances. First generic for Boniva.
vancomycin cap, 125 mg, 250 mg	Generic	4/29/12	Addition	Tier 4. First generic for Vancocin.
VIIBRYD (vilazodone) tab, starter kit containing 10 mg, 20 mg, and 40 mg	Brand	4/29/12	Addition	Tier 2. Step therapy and quantity limits apply.
JANUMET XR (sitagliptin- metformin) extended- release tab, 50-500 mg, 50-1000 mg, 100-1000 mg	Brand	5/1/12	Addition	Tier 2. Step therapy and quantity limits apply.
JENTADUETO (linagliptin- metformin) tab, 2.5-500 mg, 2.5-850 mg, 2.5-1000 mg	Brand	5/1/12	Addition	Tier 3. Step therapy and quantity limits apply.
KALYDECO (ivacaftor) tab, 150 mg	Brand	5/1/12	Addition	Tier 4. Prior authorization and quantity limits apply.
PROLIA (denosumab) inj, 60 mg/mL	Brand	5/1/12	Addition	Tier 4. Prior authorization applies.
TRADJENTA (linagliptin) tab, 5 mg	Brand	5/1/12	Addition	Tier 3. Step therapy and quantity limits apply.
INTELENCE (etravirine) tab, 25 mg	Brand	5/6/12	Addition	Tier 3.
clopidogrel tab, 75 mg	Generic	5/20/12	Addition	Tier 1. First generic for Plavix.

Notices and Announcements

Blue coverage for Regence HealthWise members terminates on Sept. 9

Effective **Sept. 9, 2012**, Blue health insurance coverage for members with Regence HealthWise will terminate. These members will carry ID cards with Alpha Prefix **HWZ** or **ZHO**.



Remember, to ensure eligibility and benefits, always verify patient coverage prior to rendering services by using one of your electronic technologies, or by calling 800-676-BLUE.

Please note the following:

- You should not accept ID cards with Alpha Prefix **HWZ** or **ZHO** after **Sept. 9, 2012**. Claims for services rendered after this date will not be reimbursed.
- For services rendered on or before **Sept. 9, 2012**, submit all claims to BCBSTX by **Sept. 1, 2014**.
- Original claims and adjustments submitted after **Sept. 30, 2014**, for services provided on or before **Sept. 9, 2012**, will not be reimbursed through BlueCard.

Synagis predetermination process for 2012-2013

The Respiratory Syncytial Virus (RSV) season is upon us. BCBSTX would like to take this opportunity to review the predetermination process for the RSV Prophylaxis program.

STEP 1 – BCBSTX Health Plan Predetermination/Authorization Process

- Complete the BCBSTX Synagis Request Form. Two types of forms (online and hard-copy) are posted at bcbstx.com/provider/forms/index.html.
- Submit the completed online version of the form; or fax the completed hard-copy version to Allan J. Chernov, M.D. (Medical Director, Health Care Quality & Policy) at 972-766-5559.

STEP 2 – Ordering Process for Prime Specialty Pharmacy

- Fax the Synagis Request Form, along with written authorization from BCBSTX, to Prime Specialty Pharmacy at: 877-828-3939.

* If the request form is incomplete or does not include BCBSTX written authorization, Prime Specialty Pharmacy will not process the order. The request form will be returned to the prescribing physician to supply the missing information.

* An approved predetermination will cover a maximum of five monthly injections for the patient for the 2012-2013 RSV season, which runs from Oct. 1, 2012, to March 15, 2013. No additional reviews will be needed.

* For out-of-state members, contact the member's Home Plan for eligibility and benefit information. You can find the Home Plan's phone number on the back of the member's ID card.

In the Know: New series of ICD-10 webinars

This month, Blue Cross and Blue Shield of Texas (BCBSTX) is continuing its series of ICD-10 webinars for providers. These complimentary online sessions offer you an opportunity to learn more about preparing for ICD-10, with a focus on the steps required for transitioning your practice or organization.

Our September webinars will introduce you to the selection process you should follow to build your project team and will review the various project phases to be completed for successful implementation. Click here to [view session dates and times and register online now](#).

Additional information is available in the Standards and Requirements/ICD-10 section – this includes our [ICD-10 Provider Readiness Assessment Survey](#).

2012 AIM clinical guideline changes

Periodically, AIM Specialty HealthSM (AIM[®]) (formerly American Imaging Management) will update its diagnostic imaging guidelines to better assist in preventing unnecessary utilization of radiology and diagnostic services.

AIM is increasing the value of its existing program to ensure members are receiving the most appropriate care. AIM has completed its 2012 guideline review and will be integrating the updates into its systems effective on Nov. 1, 2012. Physicians and other professional providers can review complete details and updates of the new guidelines on AIM's website at www.aimspecialtyhealth.com.

AIM is a registered trademark of AIM Specialty Health, an independent, third-party vendor that is solely responsible for its products and services. Blue Cross and Blue Shield of Texas (BCBSTX) makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions, you should contact the vendors directly.

In Every Issue

Medical record requests: Include our letter as your cover sheet

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

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

Thank you for your cooperation!

Technical and professional components

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

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

Surgical procedures performed in the physician's office

When performing surgical procedures in a non-facility setting, the physician and other professional provider reimbursement is all-inclusive.

Our payment covers all of the services, supplies and equipment needed to perform the surgical procedure when a member receives these services in the physician's or other professional provider's office. Please note the physician and other professional provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied based on the fact that the global physician reimbursement includes staff, supplies and equipment.

AIM RQI reminder

Physicians and professional providers must contact AIM Specialty HealthSM, formerly 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 aimspecialtyhealth.com 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 *ProviderPortal*_{SM} 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 BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program.*

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

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

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 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 195 patient service locations.
- 24/7 access to electronic lab orders, results, and other office solutions through Care360®™ Labs and Meds.

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

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

** **Note:** Physicians & 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.*

Fee schedule updates

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

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. Also, the Drug/Injectable Fee Schedule will be updated on Dec. 1, 2012, and on March 1 and June 1 in 2013.

Improvements to the medical records process for BlueCard® claims

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

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

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

Pass-through billing

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

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

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

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

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

Contracted physicians and other professional providers must file claims

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

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full

and directs a physician or other professional provider to not file a claim with the patient's insurer, the physician or other professional provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

Medical policy disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX provider website portal on the 1st or 15th 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 active and pending policies go to bcbstx.com/provider, click on the Policies link toward the bottom of the page and then click on the Medical Policies link. After reading and agreeing to the disclaimer, you will have access to active and pending medical policies.

Draft medical policy review

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

To view draft policies go to bcbstx.com/provider, click on the Policies link toward the bottom of the page and then click on the Draft Medical Policies link.

No additional medical records needed

Physicians and other 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 AIM Specialty Health, formerly American Imaging Management, need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

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

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

Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and other professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or other professional 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

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

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

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

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

Billing for non-covered services

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

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

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

Dispensing QVT (quantity versus time) limits

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

Visit the BCBSTX provider website at bcbstx.com/provider to access the [2012 QVT list](#).

Preferred drug list

Throughout the year, the BCBSTX 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.

For the 2012 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html.

Are utilization management decisions financially influenced?

BCBSTX is dedicated to serving its 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, other professional 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 physicians and other professional providers in the BCBSTX provider network.

Contact us

Click [here](#) for a quick directory of contacts at BCBSTX.

Update your contact information online

To update your contact information, go to bcbstx.com/provider, click on the Network Participation tab and follow the directions under Update Your Contact Information. This process allows you to electronically submit a change to your name, office or payee address, email 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 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; email BlueReviewEditor@bcbstx.com.

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

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

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