A closer look: Documentation and coding for pulmonary diagnoses

On Oct. 1, 2014, all HIPAA-covered entities must transition from ICD-9-CM to the ICD-10-CM/PCS code sets. At that time, claims with ICD-9-CM codes will not be accepted unless they are for service dates or discharge dates prior to Oct. 1, 2013.

As we draw closer to the 2014 ICD-10 implementation date, it is essential to take note of the key differences to coding in the ICD-10-CM code set. The goal of this article is to take a closer look at documentation and diagnosis coding for these chronic pulmonary conditions to successfully achieve accurate and compliant practices.

Asthma

The ICD-9-CM code structure classifies asthma into a single code category, 493. Accurate code assignment involves determination of specific fourth and fifth-digit subclassifications. The fourth-digit identifies the asthma type, while the fifth-digit identifies the presence of an acute exacerbation, status asthmaticus or an unspecified episode as follows:

Fourth-digit subclassification: 0 = Extrinsic Asthma 493.0X  
1 = Intrinsic Asthma 493.1X  
2 = Chronic Obstructive Asthma 493.2X

Fifth-digit subclassification: 0 = Unspecified 493.X0  
1 = with status asthmaticus 493.X1  
2 = with (acute) exacerbation 493.X2

When selecting the appropriate ICD-9-CM fifth-digit subclassification, an important consideration is to distinguish between an acute asthma exacerbation versus a status asthmaticus episode. The ICD-9-CM coding guidelines define status asthmaticus as a “severe, intractable episode of asthma unresponsive to normal therapeutic measures.”

An acute asthma exacerbation, on the other hand, is an increase in severity of asthma symptoms such as shortness of breath, wheezing, coughing and chest tightness. When a status asthmaticus episode occurs, documentation should be concise and include specific terms such as intractable asthma attack; severe, intractable wheezing; and severe prolonged asthma attack. Concise documentation will allow for unambiguous interpretation and code assignment.

Chronic Obstructive Pulmonary Disease (COPD) and Chronic Bronchitis
Over time, asthma may develop into COPD and one diagnosis may exacerbate the other. As such, clinical documentation for these pulmonary diagnoses is key to accurate code assignment. The ICD-9-CM code structure represents a relationship between COPD and Chronic Bronchitis. When both of these conditions occur together, the two diagnoses are grouped into a single code category, 491.\(^1\) These conditions represent instances when an individual may have a combination of pulmonary disorders that fall within the COPD category. For example, the fifth-digit assignment identifies obstructive chronic bronchitis with the presence of an acute exacerbation, acute bronchitis or obstructive chronic bronchitis with no exacerbation as follows:

Fifth-digit subclassification:
- 0 = without exacerbation \(491.20\)
- 1 = with (acute) exacerbation \(491.21\)
- 2 = with (acute) bronchitis \(491.22\)

Code 491.20, obstructive chronic bronchitis without exacerbation, is reported for a diagnosis of COPD with bronchitis without acute bronchitis or an acute exacerbation.\(^1\) This is commonly documented as chronic obstructive bronchitis. Conversely, code 491.21, obstructive chronic bronchitis with (acute) exacerbation is reported to capture a diagnosis of acute bronchitis with chronic obstructive bronchitis. From an ICD-9-CM coding perspective, this is considered an acute exacerbation and is often documented as COPD with acute exacerbation.\(^1\,^2\,^3\)

Over the coming months, Blue Cross and Blue Shield of Texas (BCBSTX) will be providing more information about impacts of coding and documentation that may help your practice with the transition to ICD-10, Risk Adjustment and more.


**Code correctly – Avoid ICD-10 coding pitfalls!**

Blue Cross and Blue Shield of Texas (BCBSTX) conducted preliminary ICD-10 testing with a subset of providers in 2012 and 2013. Although we are planning a larger scale testing phase in second quarter 2014, we wanted to share some of the common issues identified in our initial testing. Submitting claims with the following errors after Oct. 1, 2014, may delay or negatively impact reimbursement.

**Use of Invalid Diagnosis Codes**

Invalid diagnosis codes were common for three reasons, all of which would cause a claim to get rejected. Providers who use billing services or practice management systems that have claims scrubbers may avoid these problems; however, they should serve as test conditions for any provider.

1. **Confusion between letters and numbers.** We saw several examples where numbers were used in place of letters or vice versa. This confusion happened most frequently with the following commonly used numbers and letters in ICD-10:
Examples:

- A pediatrician used diagnosis code 301.80XA - Unspecified open wound of other part of head, initial encounter, and should have used diagnosis code S01.80XA. The "S" was incorrectly sent as a "3."

- A hospital trying to send a procedure code for a C-section - Extraction of products of conception, low cervical, open approach conception, low cervical, open approach – sent a procedure code of I0DO0Z1 when they were trying to send 10D00Z1. The letter "I" was used in place of the number "1," the letter "O" was used twice rather than the number "0," and the number "2" was used in place of the letter "Z."

2. Transposed digits and typographical errors.

- For example, a hospital used diagnosis code K45.909 when they should have used diagnosis code J45.909 for unspecified asthma, uncomplicated. A "K" was used in place of a "J" in error.

3. Truncated and incomplete diagnosis codes.
These types of errors are primarily received from physicians’ offices. They are not as common with submissions from hospitals.

- For example, a physician’s office used diagnosis code R50 – Fever, when only diagnosis codes R50.2, R50.81-R50.84, and R50.9 are valid for that use.

Inappropriate Use of ICD-10 Diagnosis Codes
Many providers struggled with the combination diagnosis codes available in ICD-10 and continued to bill conditions separately in error. In some cases, they used two diagnosis codes that are mutually exclusive, as in this example:

- A hospital sent a claim with diagnosis code I25.10 - Atherosclerotic heart disease of native coronary artery without angina pectoris, along with a second diagnosis of I20.9 – Angina pectoris, unspecified. However, they should have used a single diagnosis code of I25.119 – Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris.

Lack of Trimester or Encounter Sequence When Needed
Some ICD-10 diagnosis codes require identification of the encounter or trimester sequence. There were numerous claims received that did not specify or provided incorrect trimester /encounter information. Consider the following two examples:

- Trimesters: A hospital sent a series of obstetrical claims that involved the treatment of a patient who had low weight gain during her pregnancy. The
diagnosis codes for the trimesters were submitted out of sequence. The hospital used a diagnosis code of O26.12 – Low weight gain in pregnancy, second trimester, then on a later date of service used a diagnosis code of O26.11 - Low weight gain in pregnancy, first trimester.

- **Encounters:** The injuries section (S00.00XA-S99.929S) in ICD-10-CM and poisonings/external causes section (T07-T88.9XXS) is full of diagnosis codes that contain encounter sequence information. We saw many of these miscoded, such as billing the subsequent encounter diagnosis code T23.161D - Burn of first degree of back of right hand, subsequent encounter without billing the initial encounter with diagnosis code T23.161A – Burn of first degree of back of right hand, initial encounter.

**Use of “Unspecified” Diagnosis Codes**
Some providers were using unspecified diagnosis codes when a more specific diagnosis was available.

For example, a general practitioner billed diagnosis code J20.9 – Acute bronchitis, when a more specific diagnosis code J21.0 - Acute bronchiolitis due to respiratory syncytial virus, was available. The practitioner coded the same claim in ICD-9 with the additional diagnosis of respiratory syncytial virus, so the underlying virus was most likely documented in the patient’s chart. Coding guidelines dictate that diagnosis code assignment should fully identify the diagnostic condition including specificity in describing causal conditions, secondary processes, manifestations and complications.

Whether you are conducting testing with BCBSTX or other Payers/Clearinghouses, the ICD-10 coding issues identified above are essential. Good documentation practices and accurately coding with ICD-10 upon the Oct. 1, 2014 transition date will help avoid delayed, rejected and incorrect claims.

**GuidedHealth® helps identify drug therapy opportunities**
Medication therapy can be an essential part of a member’s overall treatment plan. That’s why Blue Cross and Blue Shield of Texas (BCBSTX) uses the GuidedHealth clinical rules platform to conduct periodic reviews to help identify opportunities that can positively impact members’ medication therapy. This platform drives our Retrospective Drug Utilization Review (RDUR) program, which integrates medical and pharmacy claims data for generating evidence-based, medication-related recommendations for physicians and members.

The GuidedHealth program targets drug therapy issues in modules such as overutilization, safety and cost. The table below lists the programs that were implemented during the fourth quarter of 2013. If your patient is identified via one or more of these categories, you may receive a letter from BCBSTX that references GuidedHealth.

**We Invite Your Comments**
In support of your treatment plan for our member, a drug therapy opportunity summary will be included with your letter for your consideration, along with a medication claims profile for the identified member. We hope you find this information helpful and we want to thank you in advance for taking the time to review all medication-related
recommendations. If you receive a letter, we would appreciate your taking the time to fill out the enclosed feedback survey so we can continue to improve the service we provide.

**Fourth Quarter 2013 Programs**

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<th>Module</th>
<th>Objective</th>
<th>Program Examples</th>
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| Overutilization | Identify potential misuse and/or abuse, as well as drug conflict and off-label use | • Off-Label Use (requires medical claim)  
• Trinity  
• Stimulant Polypharmacy |
| Safety        | Identify and recommend discontinuation of potentially unsafe medication use | • High Dose Acetaminophen |
| Cost Savings  | Promote the awareness of generic drug alternatives in place of non-formulary brand products. | • Generic Opportunity  
  o Proton Pump Inhibitors  
  o Statins |

*The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.*

*GuidedHealth is a registered trademark of Prime Therapeutics LLC (Prime), a pharmacy benefit management company. Blue Cross and Blue Shield of Texas (BCBSTX) contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSTX, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. BCBSTX makes no endorsement, representations or warranties regarding GuidedHealth. If you have any questions about this product or services, you should contact Prime Therapeutics LLC directly.*

**Self-administered specialty drug claim processing reminder**

As a reminder, beginning Jan. 1, 2014, Blue Cross and Blue Shield of Texas (BCBSTX) expanded its claims processing system edit to redirect professional electronic (837P) and paper (CMS-1500) claims for fertility, oral oncology and various other select self-administered specialty drugs.* Specialty drugs approved by the U.S. Food and Drug Administration (FDA) for self-administration must be billed under the member’s pharmacy benefit for members to receive coverage consideration.

Members impacted by the recent claim system edit expansion were advised through letters sent in late October. These member letters included a sample list of self-administered specialty medications, along with instructions on how to obtain these specialty medications and whom to call for assistance, if needed.
To help providers determine the correct path for medication fulfillment and ensure that the correct benefit is applied, a Specialty Pharmacy Program Drug List is available in the Pharmacy Program/Specialty Drug Programs/Prime Specialty Pharmacy section of the BCBSTX provider website at bcbstx.com/provider.

- This list identifies medications that require administration by a health care professional, and are often covered under a member's medical benefit.
- This list also identifies specialty drugs that are approved by the U.S. FDA for self-administration, and are usually covered under the member's pharmacy benefit. For these self-administered drugs, the member's physician must write or call in the prescription to a pharmacy provider that is contracted to provide specialty services.

A specialty pharmacy program drug list is also available as a reference for your patients on our website, at bcbstx.com/member. In accordance with their benefits, members may be required to use a preferred specialty pharmacy. Providers and members may call the number on the member's ID card to verify coverage or obtain clarification on the member's benefits.

*The various other select specialty drugs of this system edit expansion include: Actimmune, Apokyn, Firazyr, Fuzeon, Leuprolide Acetate, Octreotide Acetate and Stelara.

Third-party brand names are the property of their respective owners. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions.

**Notices and Announcements**

**Networks offered on the Texas Health Insurance Marketplace**
Open enrollment for the new Health Insurance Marketplace began Oct. 1, 2013. BCBSTX is offering two networks on the Texas Health Insurance Marketplace to be effective Jan. 1, 2014, for all enrollees:

- Blue Advantage HMO<sup>SM</sup>
- Blue Choice PPO<sup>SM</sup>

Both networks are available in all 254 Texas counties and will be offered on and off the Texas Health Insurance Marketplace.

Product names currently offered on the Texas Health Insurance Marketplace are listed below.
If you have questions, please contact the Provider Relations department.

**BCBSTX uses CAQH for health care practitioner demographic data**

BCBSTX uses the Council for Affordable Quality Healthcare (CAQH) Universal Provider DataSource (UPD) for gathering data for physicians and other health care professionals. BCBSTX encourages physicians and other health care professionals to review and update their demographic data every four months, within their CAQH profile at [http://www.caqh.org/oas](http://www.caqh.org/oas) or by calling the CAQH Help Desk at 888-599-1771. You can make changes to your record anytime by phone or online. When updating your UPD application, please ensure that BCBSTX is authorized to access your data.

**Learn what’s new on iEXCHANGE for 2014**

Beginning Jan. 1, 2014, BCBSTX is enhancing iEXCHANGE®, our web-based preauthorization tool, to support requests for additional Behavioral Health, Pharmacy and Medical/Surgical Treatment services.

With the iEXCHANGE portal you can submit initial and extension requests for approval prior to services being rendered, once eligibility, benefits and preauthorization requirements have been confirmed through your current process. This flexible tool provides you with real-time response for direct submission of inpatient admissions and select outpatient medical services, and enables you to send preauthorization submissions after hours and on weekends.

We have scheduled 90-minute webinars throughout the month of January to provide iEXCHANGE users with an overview of what’s new and improved for 2014. To register for a January webinar, visit the [iExchange Overview](http://www.bcbstx.com/provider) page on our provider website at [bcbstx.com/provider](http://www.bcbstx.com/provider) by clicking on Provider Tools under the Education & Reference tab.
BCBSTX claim letters get a new look
BCBSTX is continually working to improve the customer experience, including correspondence related to the claim process. We know that you and your patients appreciate information that is easy to understand. That’s why we recently updated the format, tone and readability of many of our standard claim letters.

In addition to redesigning the letter format, the content was updated to provide a friendly, but professional and concise message. The letters are written in plain language. New sections explain the next steps in the claim process, to help the reader take action, if needed. For contracted providers, the new letters will specify if we need additional information from you, helping to ensure that you get paid as quickly as possible.

Your patients can view their letters electronically on our secure member website, Blue Access for MembersSM. See a sample of a revised provider letter.

Notice regarding annual benefit updates
BCBSTX is processing annual benefit changes for 2014. Beginning January 2014, if you are using an online Web vendor to obtain patient eligibility and benefits, you may be instructed to contact BCBSTX Provider Customer Service. Please be aware, BCBSTX expects a substantial increase of calls due to the large number of policy changes underway.

To avoid lengthy hold times, providers are encouraged to limit their general eligibility and benefit calls to patients who are scheduled for an upcoming appointment. If your patient has a scheduled appointment, please contact the appropriate provider customer service number listed on their identification card. We appreciate your patience while we update our files.

Quick tip: Check your records for outdated drug codes
When billing with National Drug Codes (NDCs) on medical professional/ancillary electronic (837P) or paper (CMS-1500) claims, it is important to ensure that the NDC used is valid for the date of service. This is because NDCs can expire or change.

An NDC’s inactive status is determined based on a drug’s market availability in nationally recognized drug information databases. Additionally, an NDC is considered to be obsolete two years after its inactive date. It is a good idea to conduct a periodic check of records or automated systems where NDCs may be stored in your office for billing purposes.
To help ensure that correct reimbursement is applied, the NDC on your claim should match the active NDC on the medication’s current label or packaging. Inactive products will continue to be reimbursed until they become obsolete.

For more quick tips to assist you with billing for drugs on medical claims, view the NDC Billing Guidelines and answers to Frequently Asked Questions in the Claims and Eligibility/Claim Filing Tips section of our provider website at bcbstx.com/provider.

**Blue Advantage HMO routine vision benefits**

Blue Advantage HMO members under age 19 will receive their annual eye exam and eye wear from Davis Vision providers. Blue Advantage HMO members will continue to use Blue Advantage HMO physicians for medical eye care. Please include all appropriate diagnosis codes on your claims in order to accurately represent the services provided. To request network participation with Davis Vision, please call 800-584-3140.

**In Every Issue**

**After-hours access is required**

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

**Acceptable after-hours access mechanisms may include:**

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

For more detail, please refer to the provider manuals for Blue Choice PPO℠ Physician and Other Professional Provider (Section B) and HMO Blue Texas℠ Physician and Other Professional Provider (Section B) available on our provider website at bcbstx.com/provider. Click on the "Education & Reference" tab, then click on "Manuals" and enter the password.

**BCBS Medicare Advantage PPO network sharing**

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

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.
What does the BCBS MA PPO network sharing mean to me?
If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX) and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

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

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?
You can recognize a BCBS MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

![Medicare Advantage PPO Logo]

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

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

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

What if my practice is closed to new local BCBS MA PPO members?
If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.
**How do I verify benefits and eligibility?**

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

You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:
- Log in to the Availity Portal, the Availity Revenue Cycle Management Portal or your preferred vendor
- Enter required data elements
- Submit your request

**Where do I submit the claim?**

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

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

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

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

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

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

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

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

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

**What if I disagree with the reimbursement amount I received?**

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

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

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Medicare Advantage Customer Service at 877-774-8592.
**Medical record requests: Include our letter as your cover sheet**

When you receive a letter from 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 covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the physician's or other professional provider's office.

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

Please note the physician 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 and equipment.

**AIM RQI/Preauthorization/Order number reminder**

Physicians and professional providers must contact AIM Specialty Health® (AIM), first to obtain a Radiology Quality Initiative (RQI) number (for BlueChoice members), a Preauthorization (for HMO Blue Texas members) or an Order number (for Blue Advantage HMO members) 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 Blue Choice RQI number, an HMO Blue Texas Preauthorization or a Blue Advantage HMO Order 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 a RQI number, a Preauthorization or an Order number (whichever is applicable). 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 ProviderPortalSM uses the term “Order” rather than “Preauth” or “RQI.”

Note: Facilities cannot obtain an RQI number, a Preauthorization or an Order number from AIM on behalf of the ordering physician. Also, the RQI, Preauthorization or Order number program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO or HMO 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 clinical reference lab provider
Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for HMO Blue TexasSM and Blue Advantage HMO℠ members* and the preferred statewide outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO℠ 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 Blue Choice and HMO Blue Texas (Independent Provider Network only) and Blue Advantage HMO 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 March 1, 2014 and June 1, 2014.

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 on the 1st or 15th day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted.

To view active and pending medical policies go to bcbstx.com/provider and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to active and pending medical policies.
Draft medical policy review
In an effort to streamline the medical policy review process, you can view draft medical policies on the BCBSTX provider website and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

To view draft medical policies go to bcbstx.com/provider and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

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 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 preauthorization 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 preauthorization for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

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

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

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 serious reportable 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 2013 Drug Dispensing Limits 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 2014 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html and click on the Preferred Drug Guide offering in the left-side navigation list.
Are utilization management decisions financially influenced?
BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

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

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 the BCBSTX Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the “Other” field or contact your Provider Relations office.

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