July 2014

(Electronic distribution July 2, 2014)

The Affordable Care Act and the Multi-state Plan Program

Blue Cross and Blue Shield of Texas (BCBSTX) is participating, along with other Blues Plans, in the Multi-state Plan Program (MSPP). The Affordable Care Act (ACA) created the MSPP to provide consumers with additional health care choices on the Health Insurance Marketplaces.

What is the MSPP?
The MSPP is operated by the U.S. Office of Personnel Management (OPM) and is designed to increase consumer options on the exchanges. Payers participating in the MSPP are contracted with the OPM. Plans that are approved by the OPM qualify to be sold on the Health Insurance Marketplaces. MSPP eligibility requirements are similar to that of a qualified health plan (QHP) and plans with standard levels of coverage must be offered.

Are there different steps providers must follow for patients with multi-state plans?
Before rendering services for patients with multi-state plans, you should complete the same steps you follow for any other patients, such as:

- Ensuring the patient’s plan is in the network for which you are contracted;
- Checking the patient’s BCBSTX ID card;
- Checking the patient’s eligibility and benefits online through Availity™, or if unable to check online, by calling the number on the back of member’s ID card; and
- Helping to ensure patients are referred to in-network providers by using the BCBSTX Provider Finder®.

Product names currently offered on the Texas Health Insurance Marketplace are listed below.

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<td>Blue Cross Blue Shield Basic 5, a Multi-State Plan (PPO)</td>
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Blue Review will continue to be a source of information about BCBSTX products and networks. You may also visit the OPM’s MSPP web page. To monitor the latest announcements, check the News and Updates section of the BCBSTX provider website at bcbstx.com/provider.

Availity is a registered trademark of Availity, LLC. Availity is a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions about the products or services offered by such vendors, you should contact the vendors directly.

**ClaimsXten™ third-quarter 2014 updates**

Blue Cross and Blue Shield of Texas (BCBSTX) reviews new and revised Current Procedural Terminology (CPT®) and HCPCS codes on a quarterly basis. Codes are periodically added to or deleted from the ClaimsXten software by McKesson and are not considered changes to the software version.

BCBSTX will normally load this additional data to its claim processing system within 60 to 90 days after receipt from McKesson and will confirm the effective date on the BCBSTX provider website, bcbstx.com/provider. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) will continue to be posted on the BCBSTX provider website.

Beginning on or after Sept. 29, 2014, BCBSTX will enhance the ClaimsXten code auditing tool by adding two new rules into our claim processing system.

The first new rule is Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure (CPAP/BiPAP) Supply Frequency. This rule identifies supply codes, submitted from all providers for the same member, associated with CPAP/BiPAP therapy that are being submitted at a frequency that exceeds Centers for Medicare & Medicaid Services (CMS) Local Coverage Determination (LCD) policy for CPAP Supplies. Quantities of supplies greater than those described in a CMS LCD policy will be denied.

The second new rule is Obstetrics Package Rule. This rule audits claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services) were submitted with another global OB care code or a component code during the average length of time of the typical pregnancy of 280 days and/or pregnancy plus postpartum period of 322 days.

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.

BCBSTX will continue with the modifier 59 exempt program through ClaimsXten. This program is based on the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI).
NCCI guidelines state, "Each NCCI edit has an assigned modifier indicator. A modifier indicator of '0' indicates that NCCI associated modifiers cannot be used to bypass the edit." BCBSTX will continue to use ClaimsXten as the code pair default. NCCI edits (either Incidental or Mutually Exclusive) that are currently not part of the ClaimsXten database will NOT be added.

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 ClaimsXten, watch the News and Updates on our provider website, as well as upcoming issues of Blue Review.

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

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

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Networks offered on the Texas Health Insurance Marketplace
Open enrollment for the new Health Insurance Marketplace began Oct. 1, 2013. Blue Cross and Blue Shield of Texas (BCBSTX) is offering two networks on the Texas Health Insurance Marketplace effective Jan. 1, 2014 for all enrollees:

- Blue Advantage HMO℠
- Blue Choice PPO℠

Both networks are available in all 254 Texas counties and will be offered on and off the Texas Health Insurance Marketplace. As a reminder, the terms of your Blue Advantage HMO and Blue Choice PPO agreements apply to plans offered on and off the Texas Health Insurance Marketplace. The agreement terms also prevent you from refusing to provide services to a BCBSTX member, regardless of where they purchased their coverage.

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

**Reminder: Introducing electronic provider access for out-of-area members**

Effective July 19, 2014, Electronic Provider Access (EPA) will be available to Blue Cross and Blue Shield of Texas (BCBSTX) independently contracted providers who are registered Availity™ Web Portal users. EPA will enable you to initiate online pre-service reviews for out-of-area Blue Plan members, just as you do now for our local members.

The term “pre-service review,” as used with EPA, refers to benefit preauthorization, precertification, pre-notification and prior approval functions. Conducting a pre-service review is not a substitute for checking eligibility and benefits.

You will be able to initiate online pre-service reviews via the Authorizations link under the “Auths and Referrals” menu on the Availity Web Portal. Upon entering the three-character prefix from the member’s ID, you will be securely routed from Availity to the EPA landing page on the member’s Home Plan portal.

**Attend a webinar to learn more**

BCBSTX is hosting webinars in July and August to provide you with an overview of EPA. You will also learn how to help maximize EPA functionality, such as enabling online medical/surgical and behavioral health benefit preauthorizations by enrolling for single sign-on from Availity to a tool called Aerial™ iExchange® (iExchange).

To register now, select your preferred date and time from the list below:

- July 8, 2014 -
For details on registration with Availity, visit availity.com. Additional information on iExchange is available in the Education and Reference/Provider Tools section of the BCBSTX provider website, bcbtx.com/provider. Also watch the News and Updates section of the provider website, as well as upcoming issues of Blue Review, for announcements and related resources.

Depending on differing implementation schedules, EPA may not be available for some Blue Plans.

Please note that verification of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, 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.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. Aerial, iExchange and Medecision® are trademarks of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity or Medecision. The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

NOTICES AND ANNOUNCEMENTS

IVIG drug program
Please note that the article below includes a revised list of codes as of June 19, 2014.

Effective Oct. 1, 2014, Blue Cross and Blue Shield of Texas (BCBSTX) is offering a program through Coram Alternate Site Services dba Coram Specialty Infusion Services to provide the following intravenous immune globulin (IVIG) medications to BCBSTX members at a lower price and allow shipment of this IVIG drug to a physician’s or Home Infusion Therapy provider’s office.
IVIG Products:

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To Order through Coram Specialty Infusion Services
Call 877-267-2679 or fax 877-513-7847 and a Coram Specialty Infusion Services patient care coordinator will contact you to arrange delivery of the medication.

Member/subscriber ID card
BCBSTX offers a wide variety of health care products. Each member’s/subscriber’s identification (ID) card displays important information required for billing and determining benefits. When filing a BCBSTX claim, two of the most important elements are the member’s/subscriber’s ID number and group number.
Member/subscriber ID cards (sample below) may list coinsurance and/or copay amounts. Some products have a percentage value associated with the benefit instead of a copay. When you see an ID card that has a percentage only i.e., 100% - the member/subscriber typically will have a deductible to meet first before their coinsurance applies.

**Coinsurance**: The percentage of a covered service that is the member’s/subscriber’s responsibility to pay after the deductible is met.

**Copay**: Fixed dollar amount the member/subscriber pays for covered services at the time they receive care. As a provider, you may log into iEXCHANGE, Availity™ or call the number on the back of the member’s/subscriber’s ID card to learn more.

*Please check benefits for all members/subscribers prior to rendering services; even if several visits have already been authorized.*

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**Fight fraud: Upcoding practices on claims**

The BCBSTX Special Investigations Department (SID) occasionally reviews claims for possible upcoding. Upcoding occurs when a provider submits a claim for payment to the insurance company for a higher paying service than is supported by the medical records documentation. Intentional upcoding is illegal and fraudulent.

The SID has identified that a small percentage of providers may be billing high complexity Current Procedural Terminology (CPT)® Evaluation and Management (E/M) codes solely based upon the amount of time spent with a patient. Per CPT coding guidelines, selecting a level of E/M service based upon time is only appropriate when counseling and/or coordination of care dominates (greater than 50 percent) the encounter with the patient and/or family. This includes face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility.
The extent of counseling and/or coordination of care must be documented in the medical record when time is considered as the key or controlling factor in determining a particular level of E/M service. It is important to note that selecting the appropriate level of E/M service, in any other instance, is based upon meeting the required key component criteria including history, examination and medical decision making for each respective E/M category and subcategory.

Appropriate clinical documentation must be present in the medical record to support code assignment. Anyone who is aware of a provider or organization that may be defrauding insurance companies by committing upcoding offenses, or any other alleged fraudulent practice, may contact the BCBSTX Fraud Hotline at 800-543-0867.

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**Supporting appropriate use of prescribed controlled substance medications**
The BCBSTX pharmacy program includes initiatives to help educate members on the importance of taking medications as prescribed. Members are advised to follow their physicians’ instructions, in accordance with the individualized treatment plan that is developed for each member. BCBSTX recognizes that additional support may be needed to help monitor appropriate use, particularly for patients with prescribed drug therapy regimens that include controlled substances.

Effective June 30, 2014, our Controlled Substance Program will be enhanced to include new criteria aimed at identifying members with controlled substance utilization patterns that may indicate potential abuse, misuse or improper utilization. As part of this program, BCBSTX care management teams will work together and also involve providers to help develop action plans that support our members’ care. For example, a plan of action may include applying quantity limits for identified members. Additionally, BCBSTX may assist with coordination of care for complex cases where members may be receiving care from multiple physicians.

**Second quarter 2014 pharmacy optimization initiative highlights**
In the second quarter of 2014, BCBSTX focused on the expansion of several clinical pharmacy programs with an emphasis on identifying patients with potential drug therapy concerns related to the safe and effective use of medications.

As part of the BCBSTX pharmacy optimization initiative, we are posting a summary of recent enhancements on our Provider website at the end of each quarter. Topics for the 2nd quarter summary are as follows:

- GuidedHealth® program updates
- Medication adherence program expansion and move to new platform
- Controlled substance program enhancement
- Pharmacy program reminders and helpful resources

Watch for the pharmacy optimization initiative in the second quarter in the *Highlights in the News and Updates* section of our website at bcbstx.com/provider. A link to the
second quarter highlights is also available on the home page of this our provider website.

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

New on Availity™: Option to contact BCBSTX
We'd like to take this opportunity to thank you for making electronic options your first choice when conducting business with BCBSTX.

We know that sometimes, however, personal assistance is needed. That's why we're pleased to introduce a convenient new service for registered users of the Availity Web Portal when eligibility and benefits inquiries are initiated but cannot be completed online.

Now, if the benefit information you need is not available upon selecting View Details*, you'll see a new option called Speak to an Agent. This option enables priority access to the next available BCBSTX customer advocate, during normal service hours.

Here's how it works:
- You will see an orange Speak to an Agent button, when this option is available
- You will be prompted to contact BCBSTX and enter your transaction number
- Once we identify the patient, you will be routed to the next available customer advocate, bypassing our standard automated phone system

*As a reminder, View Details should be used for every transaction to obtain important information on the benefit requested. This option is available at the top and bottom of the Eligibility and Benefits Summary Results page on the Availity Web Portal.

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, any claims received during the interim period and the terms of the member’s certificate of coverage applicable on the date services were rendered.

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**Assistant surgeons**
Licensed Assistant Surgeons should bill with their own rendering NPI. Per ANCI 5010 guidelines, all providers are required to file claims uniformly for all payors. CMS requires these services to be billed with the appropriate rendering provider NPI.

A supervising physician should use the AS modifier when billing on behalf of a physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant 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.

**Billing with National Drug Codes**
BCBSTX reimburses claims submitted with National Drug Code (NDC) in accordance with the NDC Fee Schedule posted on the BCBSTX provider website, bcbstx.com/provider, under "Drugs." To locate this information, click the Standards & Requirements tab, then select General Reimbursement Information, enter password, then scroll down to the Reimbursement Schedules and Related Information area, then go to Professional and select the BlueChoice PPO and HMO Blue Texas Schedules offering, then select 2014 Schedules effective July 1, 2014, then scroll down to Drugs. The NDC Fee Schedule is updated monthly on the first of each month.

Lower-cost generic medications may be reimbursed with a larger margin compared to higher-cost generic and brand medications. Effective June 1, 2014, BCBSTX revised the methodology utilized for determining the allowables for Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes associated with multiple NDCs, including vaccines. The HCPCS or CPT code allowable generally will be equivalent to the lowest NDC allowable associated with the HCPCS or CPT code.

When drugs are billed under the medical benefit on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims, it is important to include NDCs and related data. Using NDCs on medical claims facilitates more accurate payment and better management of drug costs based on what was dispensed. Physicians and ancillary providers are encouraged to include NDC information on claims.

BCBSTX requires inclusion of the NDC along with the applicable HCPCS or CPT code(s) on claim submissions for unlisted or “Not Otherwise Classified” (NOC) physician or ancillary provider administered and supplied drugs. BCBSTX will continue to accept the HCPCS or CPT code elements without NDC information (excluding unlisted or "Not Otherwise Classified" drugs).

As a reminder, when submitting NDCs on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims to BCBSTX, you must also include the following related information:

- The applicable HCPCS or CPT code
- Number of HCPCS/CPT units
- NDC qualifier (N4)
- NDC unit of measure (UN – Unit, ML – Milliliter, GR – Gram, F2 – International Unit)
- Number of NDC units (up to three decimal places)
Your billable charge/price per unit

Attention electronic claim submitters: If you have converted to ANSI 5010, there should be no additional software requirements when NDCs are included on electronic claims. However, please verify with your software vendor to confirm that your Practice Management System accepts and transmits the NDC data fields appropriately. If you use a billing service or clearinghouse to submit electronic claims on your behalf, please check with them to ensure that NDC data is not manipulated or dropped inadvertently.

For additional information to assist you with using NDCs on medical claims, please refer to the Billing with National Drug Codes (NDC) information in the Claims and Eligibility/Submitting Claims section of our website at bcbstx.com/provider. You will also find other NDC-related resources on our website, such as answers to Frequently Asked Questions, an interactive online tutorial and the NDC Units Calculator Tool.

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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 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 PPOSM Physician and Professional Provider (Section B) and HMO Blue TexasSM / Blue Advantage HMO™ Physician and 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:

![MA PPO Logo](https://example.com/logo)

**MEDICARE ADVANTAGE**

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 Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

**Who do I contact if I have a question about BCBS MA PPO network sharing?**
If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.
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 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 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 professional provider's office.

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician's or professional provider's office. To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind 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 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 reminder
Physicians and professional providers must contact AIM Specialty Health® (AIM), first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPO members and Blue Advantage HMO members or a Preauthorization for HMO Blue Texas 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 PPO/Blue Advantage HMO RQI or an HMO Blue Texas Preauthorization, 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 or Preauthorization (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 or a Preauthorization from AIM on behalf of the ordering physician. Also, the RQI or Preauthorization 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 Health (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 Texas℠ 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 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 professional provider’s office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician’s or 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 & 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 PPO 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. The CPT/HCPCS Fee Schedule will be updated quarterly on June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule will be updated monthly.

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 professional provider requests and bills for a service, but the service is not performed by the ordering physician or professional provider.

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

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

- **AS modifier:** A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used **ONLY** if they assist at surgery.)

- **SA modifier:** A supervising physician should use this modifier when billing on behalf of a PA, APN or CRNFA for non-surgical services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that **DOES NOT** include surgery.)

**Contracted physicians and professional providers must file claims**
As a reminder, physicians and 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 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 professional provider to not file a claim with the patient's insurer, the physician or 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](http://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 professional providers who have received an approved predetermination
(which establishes medical necessity of a service) or have obtained a radiology quality
initiative (RQI) from AIM Specialty Health need not submit additional medical records to
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 professional providers are required to obtain the
preauthorization, it is the responsibility of the insured person to confirm that their
physician or professional provider obtains preauthorization for services requiring
preauthorization. Preauthorization must be obtained for any initial stay in a facility and
any additional days or services added on.

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

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

**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 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 professional providers may collect payment from subscribers for copayments, co-insurance and deductible amounts. The physician or 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 professional provider must inform the subscriber in writing in advance. This will allow the physician or professional provider to bill the subscriber for the non-covered service rendered.

In no event shall a contracted physician or 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 2014 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.

Blue Review, July 2014
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 bcbtx.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 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.

Blue Review is published for Blue Choice PPO™, HMO Blue Texas™, Blue Cross Medicare Advantage (PPO)™, Blue Advantage HMO™ and ParPlan 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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