Participate as a provider in the new STAR Kids Medicaid HMO

Blue Cross and Blue Shield of Texas (BCBSTX) would like to extend the opportunity for participation as a provider in the new “STAR Kids” Medicaid Managed Care Program. STAR Kids will be the first Medicaid managed care program specifically serving youth and children who get disability related Medicaid.

Beginning Sept. 1, 2016, children and youth age 20 or younger who either receive Supplemental Security Income (SSI) Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive services through a STAR Kids health plan. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids.

Children, youth and their families will have the choice of at least two STAR Kids health plans and will have the option to change plans. BCBSTX intends to bid to provide STAR Kids services on behalf of the Health and Human Services Commission (HHSC).

Currently these children and young adults are in the fee-for-service HHSC program. The operational start date of the new program is Sept. 1, 2016, but we are required to submit our participating provider list to HHSC by mid-October 2014. If HHSC awards a bid to BCBSTX to provide managed care services for the STAR Kids Program, it will include, but is not limited to, network development, provider contracting and education, and coordination with provider and treatment facilities. Your network participation will ensure the success of this new important program.

In order to participate in STAR KIDS Medicaid HMO physicians/professional providers:

- Must be an attested/enrolled provider in Texas Medicaid Health Partnership (TMHP) with a TPI;

- Must have privileges at a participating STAR Kids HMO hospital (unless inpatient admissions are uncommon or not required for the physician's/professional provider's specialty). If you do not have active admitting privileges at a participating STAR Kids HMO hospital, you may sign and return a Hospital Coverage Letter to indicate that you will refer STAR Kids HMO members to a participating physician or hospitalist who has active admitting privileges at a participating STAR Kids HMO hospital;

- Must have a valid National Provider Identifier (NPI) Number; and

- Cannot have opted-out of Medicaid or have any sanctions or reprimands by any licensing authority or review organizations.
To learn more about participation in the BCBSTX STAR Kids program, go to bcbstx.com/provider/medicaid/index.html or contact Provider Relations at 855-547-1388.

Talking with BCBSTX medical management staff about pre-authorization requests
Blue Cross and Blue Shield of Texas (BCBSTX) medical management staff members are available to receive incoming calls and discuss care management issues, questions or specific requests with providers from 6 a.m. to 6 p.m. Central Time (CT), Monday through Friday and non-legal* holidays.

On Saturday, Sunday and legal holidays, staff are available from 9 a.m. to noon CT. You can reach staff during these business hours by calling the preauthorization/pre-notify toll−free number listed on the back of the member's identification card. After business hours, callers may leave a message in a confidential voicemail box. Calls are returned within 24 hours and staff members will provide you with their name, title and company name.

To help our members with special communication needs and those whose first language is not English, we offer several services. Members may ask to speak to a bilingual (English-Spanish) representative when they call the Customer Service number on the back of their member ID cards. Our staff members also have access to a telephone-based translation service to help with other languages. Our deaf, hard-of-hearing and speech disabled members can communicate with a representative through the Texas Relay Network. By dialing 711 or 800-RELAY-TX (800-735-2989), the caller is connected to the state transfer relay service for TTY and voice carryover calls.


Blue Advantage HMO℠ versus Blue Cross Medicare Advantage (PPO)℠
Blue Cross and Blue Shield of Texas (BCBSTX) would like to remind the provider community that Blue Advantage HMO and Blue Cross Medicare Advantage (PPO) are two distinct products. Only Blue Cross Medicare Advantage (PPO) is a Medicare product.

- Blue Advantage HMO is the new HMO product that individuals can purchase on or off the Health Insurance Marketplace.

- Blue Cross Medicare Advantage (PPO) is a product for individuals who are eligible for Medicare Part A and B. Please note the use and placement of “Medicare” both in the name and on the card. “Medicare Advantage” will always be included on the face of a Blue Cross Medicare Advantage (PPO) card.

Providers may or may not be contracted with both products, so it is important to make sure you know which product the patient has. Remember to always get a copy of your patient's ID card for your records and to determine the product.
Blue Advantage HMO ID card sample:
- The network identifier **BAV** (in red font) will be on the front of the ID card and “HMO” on top of the ID card.

![Blue Advantage HMO ID card sample](image)

Blue Cross Medicare Advantage (PPO) ID card sample:
- The alpha prefix will be **ZGD** and will have “Blue Cross Medicare Advantage (PPO)” on top of the ID card.

![Blue Cross Medicare Advantage (PPO) ID card sample](image)

**ClaimsXten™ November 2014 update**
Beginning on or after Nov. 3, 2014, Blue Cross and Blue Shield of Texas (BCBSTX) will enhance the ClaimsXten code auditing tool by adding two new rules into our claims processing system.

The first rule is Medically Unlikely Edit (MUE) of Durable Medical Equipment (DME). This rule identifies claim lines where the MUE value has been exceeded for a Current Procedural Terminology (CPT®) or HCPCS code, reported by the same or multiple providers, for the same member, on the same date of service. This rule audits professional claims utilizing the DME Supplier Services MUE table data published quarterly by the Centers for Medicare & Medicaid Services (CMS). The DME Supplier Services MUE table contains assigned MUE values for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

The second rule is Durable Medical Equipment (DME) Maximum Payment Rule. This rule calculates the total payments for the DME item being rented to own or for the DME
item being purchased new or used and determines if the total payments exceed the plan DME maximum allowance.

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 our provider website at bcbstx.com/provider for additional information on gaining access to C3.

For updates on ClaimsXten, watch the News and Updates on the 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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Medicare Part D formulary updates first quarter 2014
A summary of recent Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Part D formulary changes can be found below. The Blue Cross MedicareRx formulary is updated monthly by our pharmacy provider, Prime Therapeutics. For a complete formulary listing and for future inquiries regarding prior authorizations, step therapy, coverage determinations/RE-determinations, transition plan benefits, and appointment of representative for your BCBSTX members, please refer to the following instructions:

Once you have accessed the Prime Therapeutics’ Medicare Part D member website:
a) Click on ‘Continue without sign in’,

b) Follow directions to
- ‘Select your Health Plan’ click on ‘BCBS Texas’,
- ‘Medicare Part D Member?’ Select ‘YES’,
- ‘Select Your Health plan type’ ‘Blue Cross MedicareRx Value’
- Select ‘Continue to MyPrime’
- Select ‘Find Medicines’

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

<table>
<thead>
<tr>
<th>TRADE NAME (generic name)</th>
<th>Brand/Generic Product</th>
<th>Effective Date</th>
<th>Description of Change</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>abacavir/lamivudine/zidovudine tabs, 300-150-300 mg</td>
<td>Generic</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 1. Quantity limits apply. First generic for TRIZIVIR.</td>
</tr>
<tr>
<td>acyclovir sodium IV soln, 50 mg/mL</td>
<td>Generic</td>
<td>2/23/14</td>
<td>Cost Share Reduction</td>
<td>Change to Tier 2 (was 4). May be covered by Medicare Part B or Medicare Part D depending on circumstances.</td>
</tr>
<tr>
<td>CINRYZE (C1 esterase inhibitor (human)) for IV inj, 500 units</td>
<td>Brand</td>
<td>2/1/14</td>
<td>Addition</td>
<td>Tier 5. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>cimetidine inj, 150 mg/mL</td>
<td>Generic</td>
<td>4/27/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>COPAXONE (glatiramer) inj, 40 mg/mL</td>
<td>Brand</td>
<td>2/2/14</td>
<td>Addition</td>
<td>Tier 5. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>diclofenac sodium gel, 3%</td>
<td>Generic</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 5. First generic for SOLARAZE. (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>Duloxetine caps, 20 mg, 30 mg, 60 mg</td>
<td>Generic</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for CYMBALTA.</td>
</tr>
<tr>
<td>DYNACIRC (isradipine) CR tabs, 5 mg, 10 mg</td>
<td>Brand</td>
<td>1/1/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>TRADE NAME (generic name)</td>
<td>Brand/Generic Product</td>
<td>Effective Date</td>
<td>Description of Change</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------</td>
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<td>----------</td>
</tr>
<tr>
<td>ELSPAR (asparaginase) for inj, 10,000 units</td>
<td>Brand</td>
<td>4/27/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>esomeprazole for IV, 20 mg, 40 mg</td>
<td>Generic</td>
<td>1/19/14</td>
<td>Addition</td>
<td>Tier 2. First generic for NEXIUM IV.</td>
</tr>
<tr>
<td>fenofibrate DR caps, 45 mg, 135 mg</td>
<td>Generic</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for TRILIPIX. (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>FETZIMA (levomilnacipran) caps, 20 mg, 40 mg, 80 mg, 120 mg, titration pack</td>
<td>Brand</td>
<td>2/1/14</td>
<td>Addition</td>
<td>Tier 4. Step therapy and quantity limits apply.</td>
</tr>
<tr>
<td>FOLOTYN (pralatrexate) inj, 20 mg/mL, 40 mg/2 mL</td>
<td>Brand</td>
<td>2/10/14</td>
<td>Addition</td>
<td>Tier 5.</td>
</tr>
<tr>
<td>FYCOMPA (perampanel) tabs, 2 mg, 4 mg, 6 mg, 8 mg</td>
<td>Brand</td>
<td>2/1/14</td>
<td>Addition</td>
<td>Tier 4.</td>
</tr>
<tr>
<td>FYCOMPA (perampanel) tabs, 10 mg, 12 mg</td>
<td>Brand</td>
<td>2/2/14</td>
<td>Addition</td>
<td>Tier 4.</td>
</tr>
<tr>
<td>HUMULIN 70/30 KWIKPEN (insulin isophane (human)/regular (human)) inj, 100 units/mL</td>
<td>Brand</td>
<td>1/26/14</td>
<td>Addition</td>
<td>Tier 3. (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>HUMULIN N KWIKPEN (insulin isophane (human)) inj, 100 units/mL</td>
<td>Brand</td>
<td>1/26/14</td>
<td>Addition</td>
<td>Tier 3. (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>lamivudine tabs, 100 mg</td>
<td>Generic</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 2. First generic for EPIVIR HBV tabs.</td>
</tr>
<tr>
<td>LEUKINE (sargramostim) inj, 500 mcg/mL</td>
<td>Brand</td>
<td>4/27/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>LOMUSTINE caps, 100 mg</td>
<td>BRAND</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 4.</td>
</tr>
<tr>
<td>TRADE NAME (generic name)</td>
<td>Brand/Generic Product</td>
<td>Effective Date</td>
<td>Description of Change</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>-----------------------</td>
<td>----------</td>
</tr>
<tr>
<td>moxifloxacin tabs, 400 mg</td>
<td>Generic</td>
<td>2/23/14</td>
<td>Addition</td>
<td>Tier 2. First generic for AVELOX tabs. (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>mycophenolic acid DR tabs, 180 mg, 360 mg</td>
<td>Generic</td>
<td>1/12/14</td>
<td>Addition</td>
<td>Tier 2. May be covered by Medicare Part B or Medicare Part D depending on circumstances. First generic for Myfortic (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>NUVIGIL (armodafinil) tabs, 200 mg</td>
<td>Brand</td>
<td>2/23/14</td>
<td>Addition</td>
<td>Tier 4. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>nystatin/triamcinolone oint, 100000 units/g-0.1%</td>
<td>Generic</td>
<td>1/1/14</td>
<td>Cost Share Reduction</td>
<td>Change to Tier 2 (was 4). (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>ONTAK (denileukin diftitox) IV soln, 150 mcg/mL</td>
<td>Brand</td>
<td>5/25/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>OPSUMIT (macitentan) tabs, 10 mg</td>
<td>Brand</td>
<td>2/1/14</td>
<td>Addition</td>
<td>Tier 5. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>PREDNISONE dose-pack, 5 mg, 10 mg</td>
<td>BRAND</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 1.</td>
</tr>
<tr>
<td>PREZISTA (darunavir) tabs, 400 mg</td>
<td>Brand</td>
<td>4/27/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>sirolimus tabs, 0.5 mg</td>
<td>Generic</td>
<td>1/12/14</td>
<td>Addition</td>
<td>Tier 2. May be covered by Medicare Part B or Medicare Part D depending on circumstances. First generic for Rapamune tabs, 0.5 mg.</td>
</tr>
<tr>
<td>tolterodine ER caps, 2 mg, 4 mg</td>
<td>Generic</td>
<td>1/12/14</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for DETROL LA.</td>
</tr>
</tbody>
</table>
### TRADE NAME (generic name) | Brand/Generic Product | Effective Date | Description of Change | Comments
--- | --- | --- | --- | ---
Tyzine (tetrahydrozoline) nasal soln, 0.1% | Brand | 4/27/14 | Removal | Manufacturer has discontinued marketing this drug.
Vancomycin for inj, 10 g | Generic | 1/1/14 | Addition | Tier 2.
Versacloz (clozapine) susp, 50 mg/mL | Brand | 1/1/14 | Addition | Tier 5. Quantity limits apply.

### NOTICES AND ANNOUNCEMENTS

**Benefits Value Advisor available to members**

Blue Cross and Blue Shield of Texas (BCBSTX) Benefits Value Advisor (BVA) service, launched on Jan. 1, 2014, is available to BCBSTX members to help maximize their health insurance benefits.

BVAs can provide cost comparisons on:
- Imaging services
- Maternity services
- Joint replacement services
- Back surgery
- And many more procedures

BVAs can also help members:
- Understand their benefits
- Find in-network providers
- Schedule appointments
- Request preauthorization
- Access online educational tools

Providing members with more information may help them make better decisions about their health care. Look for more information about BVAs and the services they provide in future issues of *Blue Review*.

**Revised: ClaimsXten™ third-quarter 2014 updates**

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 the BCBSTX claim processing system within 60 to 90 days after receipt from McKesson and will confirm the effective date on the BCBSTX Provider website. 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 Oct. 28, 2014, BCBSTX will enhance the ClaimsXten code auditing tool by adding two new rules into our claim processing system, as follows:

**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.

**Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure (CPAP/BiPAP) Supply Frequency Rule**
This rule audits maximum frequency of PAP supplies based on the recommended replacement schedule from the Centers for Medicare & Medicaid Services (CMS). Specifically, this rule identifies supply codes associated with CPAP/BiPAP therapy that are being submitted by all providers for the same member at a frequency that exceeds the CMS Local Coverage Determination (LCD) policy for PAP supplies. Accessories used with a CPAP device are covered when the coverage criteria for the device are met. If the coverage criteria are met, the accessories billed that exceed the maximum number of supplies for the CPAP/BiPAP item will be disallowed. See below for maximum allowable quantity/frequency guidelines, as determined by CMS:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Quantity</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4604</td>
<td>1</td>
<td>90</td>
</tr>
<tr>
<td>A7027</td>
<td>1</td>
<td>90</td>
</tr>
<tr>
<td>A7028</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>A7029</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>A7030</td>
<td>1</td>
<td>90</td>
</tr>
<tr>
<td>A7031</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>A7032</td>
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<tr>
<td>A7033</td>
<td>2</td>
<td>30</td>
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<tr>
<td>A7034</td>
<td>1</td>
<td>90</td>
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<td>A7035</td>
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<td>180</td>
</tr>
<tr>
<td>A7036</td>
<td>1</td>
<td>180</td>
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<tr>
<td>A7037</td>
<td>1</td>
<td>90</td>
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<tr>
<td>A7038</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>A7039</td>
<td>1</td>
<td>180</td>
</tr>
<tr>
<td>A7046</td>
<td>1</td>
<td>180</td>
</tr>
</tbody>
</table>
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).

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**Implantable device versus medical supply/material**

National Uniform Billing Committee (NUBC) definition of an implant
- Revenue Code 274 – Prosthetic/orthotic devices
- Revenue Code 275 – Pacemaker
- Revenue Code 278 – Other Implants

An implantable device is that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Also included is an object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.
Examples of other implants reported under revenue code 278 include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds (not an all-inclusive list).

Supplies that are not implantable should be submitted as supply charges. In conjunction, a device is not a “material or supply furnished incident to a service.” Items used as routine supplies should not be submitted as an implant.

Guide wires, catheters and clips that are used during surgery but do not remain in the body are used the same way as an instrument and are not “implanted” should not be submitted as an implant.

Additional reference and definition of implantable devices, supplies and material can be located in the UB04 Editor and the website of the implantable device’s manufacturer.

**What is an independent review?**

A decision based on medical necessity or experimental/investigational status may be appealed to an Independent Review Organization (IRO) after the BCBSTX internal appeal process has been completed. If the member’s condition is life threatening, an immediate review by an IRO may be requested.

Once an eligible request for external review is received, it will be sent to an IRO. The assigned IRO is an independent, unbiased randomly selected company that receives no financial benefit based on the outcome of any review. There will be no charge to you for the IRO review. The IRO is not bound by BCBSTX’s decision.

The decision of the IRO is binding, but there may be additional state or federal dispute resolution measures available. Please refer to your provider manual for more information.

**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 Blue Choice 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 PPO℠ Physician and Professional Provider (Section B) and HMO Blue Texas℠ / 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](image)

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 Availability Portal, the Availability 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)SM 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 bcbtx.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 ProviderPortal℠ 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](http://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](http://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](http://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.

*Blue Review, August 2014*
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 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.

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 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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