BlueCross BlueShield of Texas
Blue Review
A Provider Publication

Issue 10, 2012
(Electronic distribution October 3, 2012)

Triessent Specialty Pharmacy name change

If you have patients on specialty medications administered through our specialty pharmacy program, Triessent®, please take note of the following change:

Effective Nov. 1, 2012, Triessent will become Prime Therapeutics Specialty Pharmacy, LLC (Prime Specialty Pharmacy). New fax and phone numbers are listed below.

Prime Specialty Pharmacy
Phone: 877-627-MEDS (877-627-6337)
Fax: 877-828-3939

Prime Specialty Pharmacy will provide specialty pharmacy services to your Blue Cross and Blue Shield of Texas (BCBSTX) patients formerly served by Triessent. Letters have been sent to notify our members who may be affected by this change. Benefit coverage will not be affected by the transition to Prime Specialty Pharmacy.

For additional information, such as updated forms, visit the Pharmacy Program/Specialty Pharmacy section of the BCBSTX provider website at bcbstx.com/provider.

Note: Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Triessent is a registered trademark of Prime Therapeutics, LLC. Prime Therapeutics, LLC is an independent company providing pharmacy benefit management and specialty pharmacy services for BCBSTX members. Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy) is a wholly owned subsidiary of Prime Therapeutics, LLC.

Medicare claims administration switching from TrailBlazer to Novitas in November!

On Nov. 19, 2012, you will start sending your traditional fee for service Medicare paper or electronic claims to Novitas Solutions. Novitas will replace TrailBlazer Health as the new Medicare Administrative Contractor (MAC) for the state of Texas. (Read the flyer.)

Very important
In the later part of July, Novitas sent a letter to all physicians who currently do electronic fund transfer (EFT) with TrailBlazer Health. The letter informed physicians of the change in Medicare MACs and also included a new EFT Agreement form to complete since Novitas has a different bank than TrailBlazer Health. It is imperative that any information (mail, email, and fax) that comes to you from Novitas Solutions be treated as priority and be reviewed as soon as possible. Please be sure to advise all your office staff members. Failure to complete and submit the EFT Agreement will result in a delay or interruption of your Medicare payments.

If you have not received the EFT form, either; 1) you are not set up with TrailBlazer Health to receive payments straight to the bank; or 2) you did not receive the letter. If you did not receive the letter, go to the Harris County Medical Society (HCMS) website, www.hcms.org/template.aspx?id=2245, click on the Novitas Solutions website and click the May alert. Follow the instructions on what to do to file a new EFT form. The Centers for Medicare and Medicaid Services (CMS) requires an original signature, so the form must be mailed.

It will be highly important that all Medicare claims sent to Novitas contain complete and/or valid information. Each electronic and paper claim must follow specific format requirements in order to submit your claims for adjudication and payment. Any claim that contains incorrect or invalid information is your responsibility to correct and return promptly. Otherwise, you will not meet your legal obligation for submitting a Medicare claim. If you are a non-participating provider and currently bill Medicare patients (beneficiaries) prior to submitting a claim, you may continue to follow your current procedure.

Make sure you are checking the Novitas website transition homepage located on the HCMS website http://www.hcms.org/template.aspx?id=2245 frequently. The site is a repository of information about the transition. In addition, confirm with vendors (billing services/clearinghouses) and staff managing billing directly that they: 1) are aware of the transition; 2) know about the Novitas Solutions website, and 3) are positioned to receive Listserv notifications.

Novitas has become aware that there is some inconsistency between certain Local Coverage Determination (LCDs). Novitas will NOT implement specific LCDs that did not go through the process of being analyzed side by side.

For more information check the HCMS website at
http://www.hcms.org/template.aspx?id=2245.

Source: Novitas

Pertussis – a vaccine-preventable disease – is killing vulnerable infants

Pertussis (“whooping cough”) outbreaks are occurring all over the country, including Texas. Newborns and infants are especially hard hit by this disease. While disease can occur in all ages, infants younger than 12 months are at highest risk for severe disease and death.

The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) has made significant changes on the use of the adolescent and adult pertussis vaccine to increase vaccine coverage and protect vulnerable infants. These changes were made after review of safety and immunogenicity data, especially in age groups for which Tdap is not licensed.

Considering the urgency of helping to prevent further outbreak of pertussis, a consortium of health care professionals has issued a letter and call for the health care industry to take action. Please take the time to read the letter and to visit the American Academy of Pediatrics website dedicated to understanding and preventing pertussis.

BlueAdvantage HMO℠

Blue Cross and Blue Shield of Texas (BCBSTX) is pleased to announce the development of a new cost-effective network designed to provide affordable quality health care services to the uninsured and underinsured. BlueAdvantage HMO affords members medical benefits at a lower cost whenever they access care through a participating BlueAdvantage HMO network provider.

BCBSTX extends an invitation for you to participate as a provider in BlueAdvantage HMO as your participation helps ensure the program's success. Our long-standing history in providing affordable health care coverage to the people of Texas and our strong brand recognition make BCBSTX an excellent choice for members seeking cost-effective health care.

Please note that additional credentialing is not required for those providers already credentialed in the BlueChoice PPO or HMO Blue Texas networks and whose credentialing is current.

Below are answers to frequently asked questions regarding BlueAdvantage HMO.

Please feel free to contact your local Professional Provider Network office if you have any further questions regarding BlueAdvantage HMO.

Q: What is BlueAdvantage HMO?

A: Blue Cross and Blue Shield of Texas (BCBSTX) is developing a new cost-effective network to make quality health care services affordable to the uninsured and underinsured, and would like to extend the opportunity for you to participate as a provider in the network. BlueAdvantage HMO affords benefits at a lower cost for members whenever they access care through a participating network provider. We believe that our long standing history in providing affordable health care coverage to the people of Texas and our strong brand recognition make BCBSTX an excellent choice for members seeking new cost effective health coverage opportunities. We need your network participation for this program to be successful.

Q: ***If I choose not to participate in BlueAdvantage HMO, will this affect my participation in other BCBSTX provider networks?***

A: No. Participation in BlueAdvantage HMO is optional. Accepting or declining the invitation in no way impacts a provider's participation in any other BCBSTX networks.

Q: ***Why should I participate in BlueAdvantage HMO?***

A: As the health care environment continues to evolve, a large number of people will become insured or seek new products that are more cost effective. We feel it is critical to offer new alternatives as an opportunity to build and retain customers that will stay with BCBSTX in the future. It is an opportunity for you to attract patients for the long-term, retaining them as patients as their health needs change. You may see reimbursement opportunities for serving those patients who were uninsured or underinsured in the past and were seen on a "no cost" basis.

Q: *Will the same claims and membership system used for our other commercial plans be used for administering the BlueAdvantage HMO plan?*
A: Yes.

Q: *If I am already participating in the BlueChoice PPO and/or HMO Blue Texas network, is any additional credentialing required?*
A: Additional credentialing is not required if you are already credentialed in the BlueChoice PPO or HMO Blue Texas networks and if your credentialing is current.

Q: Who are the target markets for BCBSTX's BlueAdvantage HMO network?
A: **Employees/Individuals**

- Employees who cannot afford their employer sponsored plans for themselves and/or their dependents
- Employees whose employers are not offering an employer-sponsored plan
- Employees of small businesses
- Individuals

Employers

- Small businesses with 2-50 employees

Q: *Why did BCBSTX decide to create a new network?*
A: We expect to attract a new population – many who were formally uninsured or enrolled in Medicaid – and to retain existing business. In order to keep costs low, we have to develop a new cost effective network.

Q: How can I learn more about this program?
A: Please contact your local Professional Provider Network department.

Quality Improvement Program available to providers

Blue Cross and Blue Shield of Texas (BCBSTX) has a **Quality Improvement Program** to better serve our members. The program focuses on preventive health, behavioral health, patient safety, condition management and health service delivery.

Member care and service are evaluated on a regular basis to determine whether members are receiving appropriate care and service and are satisfied with the health plan. Quality Improvement initiatives may include satisfaction surveys, condition management programs and wellness programs. As part of the program, birthday cards as well as targeted mailings are distributed and outbound calls are conducted to encourage preventive services such as immunizations, breast cancer screenings and cervical cancer screenings.

Information regarding the Quality Improvement Program is available in BCBSTX provider manuals. These manuals are available online at our provider website, bcbstx.com/provider. To find them, click on the Education & Reference tab, then View Manuals and enter the password 'manual' when prompted. Or, click on the following links for the BlueChoice Physician & other Professional Provider manual and the HMO Blue Texas Physician & other Professional Provider manual.

To receive a written summary of the Quality Improvement Program, which includes outcomes, please call the Quality Improvement Programs Department at 800-863-9798.

Blue Medicare Advantage (PPO) network participation

Blue Cross and Blue Shield of Texas (BCBSTX) has been approved to offer a Medicare Advantage preferred provider plan that offers improved health benefits for Medicare beneficiaries. BCBSTX would like to extend the opportunity for you to participate in this plan.

Blue Medicare Advantage affords more comprehensive benefits at a lower cost for Medicare beneficiaries, whenever they access care through a participating provider. Effective Jan. 1, 2013, BCBSTX will be offering the Blue Medicare Advantage plan to residents in the in the following counties: Bastrop, Burnet, Caldwell, Collin, Dallas, Denton, Ellis, Fayette, Fort Bend, Grayson, Harris, Hays, Johnson, Kaufman, Lee, Montgomery, Rockwall, Tarrant, Travis and Williamson.

BCBSTX believes that our long standing history in providing affordable health care coverage to the people of Texas, our strong brand recognition, and our historical relationship with Medicare makes BCBSTX an excellent choice for seniors seeking new health coverage opportunities. BCBSTX needs your network participation for this program to be successful.

In order to participate in the Blue Medicare Advantage, physicians and other professional providers:

- Must be a participating BlueChoice physician or other professional provider;
- Must have privileges at one of the Blue Medicare Advantage participating hospitals (unless inpatient admissions are uncommon or not required for the physician's or professional provider's specialty);
- Must have a valid National Provider Identifier (NPI) number;
- Must sign a Blue Medicare Advantage amendment to his/her BlueChoice agreement; and;
- Cannot have opted-out of Medicare or have any sanctions or reprimands by any licensing authority or review organizations.

Additional credentialing will not be required for those physicians or other professional providers already credentialed in the BlueChoice network and whose recredentialing is current.

If you have any further questions regarding this program and are interested in participating, please feel free to contact your local Professional Network Provider Network office:

- Austin - 512-349-4847

- Dallas - 800-749-0966 or 972-766-8900
- Houston - 800-637-0171, press 3 or 713-663-1149

BCBSTX appreciates your network participation.

Opioid-induced hyperalgesia

Introduction

Pain is one of the main reasons that people seek medical attention, and it is estimated to affect tens of millions of Americans. Chronic pain management commonly includes the use of opioid type medications. This is in spite of that fact that this class of drugs has well known adverse effects including the development of dependence, tolerance, and addiction.

Recently, however, a troubling clinical phenomenon known as opioid-induced hyperalgesia (OIH) is gaining more and more attention with medical providers. As a consequence, there has been a noted increase in the number of clinical studies exploring the mechanisms of action and clinical significance of OIH, although prevalence has yet to be determined.

For example, one small prospective study of six opioid-naïve chronic pain patients developed hyperalgesia to cold pressor pain within four weeks of starting moderate doses of morphine. In another study, OIH was described in multiple patients following acute opioid exposure in a peri-operative setting. Despite the debates on clinical relevance, it is clear that OIH presents a clinical challenge in acute, chronic, and cancer pain treatment settings.

Diagnosis and presentation

OIH is characterized by a significant intolerance to pain, often among patients that are receiving repeated doses of opioids. It can present as allodynia or hyperesthesia, and is often times mistaken for opioid tolerance. It differs from opioid tolerance in that the pain intensity is stronger than initially reported, occurs relatively quicker, and worsens with an increased opioid dose.

Common characteristics of OIH include nociceptive sensitization, the area of pain is more diffuse, has lesser quality, and is harder to pinpoint. It has been reported that pain can manifest beyond the original region of injury. A major concern with this condition is that a prescriber may often times continue to increase the dosages of opioids in an effort to control the patient's pain symptoms. However, this can be extremely dangerous as it can result in drug overdose or death.

Etiology

Although the exact mechanism is unknown, several mechanisms have been proposed and are currently being studies. OIH can occur under a number of varying treatment situations involving opioid medications (e.g. cancer patients, and with both acute and chronic exposure).

It has been reported with different types of opioids and with all different routes of administration such as oral, intravenous, intrathecal, and epidural. Therefore, it is likely that there are multiple mechanisms involved. One of the most commonly proposed mechanisms is the activation of the NMDA receptor. This causes an influx of calcium

and increases excitability of the neuron, therefore causing the neurons to be more active and to readily transmit painful impulses. Another proposed mechanism is the increased production of the endogenous opioid peptide, dynorphin, which activates the kappa and NMDA receptors and has been shown to be increased with prolonged opioid use.

Treatment options: The following are examples of some suggested treatment strategies:

- Referral of the patient to a pain management specialist.

- Discontinuation of the offending opioid using a gradual tapering method. This strategy is usually complicated by the fact that underlying pain issues persist and still require an effective treatment plan. To complicate matters further, opioid withdrawal can sometimes paradoxically produce hyperalgesia.

- Reducing the current opioid dose has been shown to reduce hyperalgesia while also improving the analgesic effects in some patients.

- Switching from one structural class of opioids to another has also been an effective strategy in some studies. Switching to methadone has been one of the most popular treatment alternatives thus far. (Phenanthrene opioids have shown a higher association with OIH, so try non-phenanthrene opioid such as buprenorphine, fentanyl, tramadol, or methadone).

- Supplementing opioid therapy with a non-opioid pain reliever such as acetaminophen or a COX-2 inhibitor/NSAID is another tactic that has gained some support.

Conclusion: Future directions

In order to better understand the clinical relevance of OIH, a number of important questions remain to be answered. For example; what patient population is at highest risk to develop OIH? Which opioids are or are not associated with the development of OIH? What is the typical duration of OIH? What is the prevalence of OIH? What is the root cause of OIH? Further research is clearly needed to determine the answers to these questions. Until that time, timely and accurate diagnosis of this condition and development of an effective treatment cannot be fully established.

References:

Bottemiller S. Opioid-Induced Hyperalgesia: An Emerging Treatment Challenge. US Pharm. 2012; 37(5): HS-2-HS-7. Available at www.uspharmacist.com/content/d/health_systems/c/34014/.

Chu LF, Clark DJ, Angst MS. Opioid tolerance and hyperalgesia in chronic pain patients after one month of oral morphine therapy: a preliminary prospective study. J Pain 2006; 7:43-8.

Colvin LA, Fallon MT. Opioid-induced hyperalgesia: A clinical challenge. Br J Anaesth 2010; 104:125-7. Available at www.ncbi.nlm.nih.gov/pubmed/ 20086062.

Low Y, Clarke CF, Huh1 BK. Opioid-induced hyperalgesia: a review of

epidemiology, mechanisms and management. Singapore Med J 2012; 53(5): 357–360. Available at www.ncbi.nlm.nih.gov/pubmed/22584979.

Parselis Kelly J, Cook SF, Kaufman DW, et al. Prevalence and characteristics of opioid use in the US adult population. Pain. 2008; 138:507-513.

West Nile virus cases causing concern in Texas

Blue Cross and Blue Shield of Texas (BCBSTX) continually monitors events that could impact the health and wellness of your patients.

The Centers for Disease Control and Prevention (CDC) reports the highest number of cases documented through the end of July since 2004. The high count is attributed in large part to the much greater than average number of infested mosquitoes, brought on by the mild winter, early spring and very hot summer we have experienced this year.

In Texas, more than 100 people are confirmed to have fallen ill with the West Nile infection, more than double the 10-year average for cases reported before August. Of that total, the majority were in Dallas, Tarrant, Collin and Denton counties of North Texas. Some deaths also have been connected to the illness, according to Texas Department of State Health Services.

We encourage you to communicate with your patients the preventive measures they can take to reduce their risk for contracting West Nile, including:

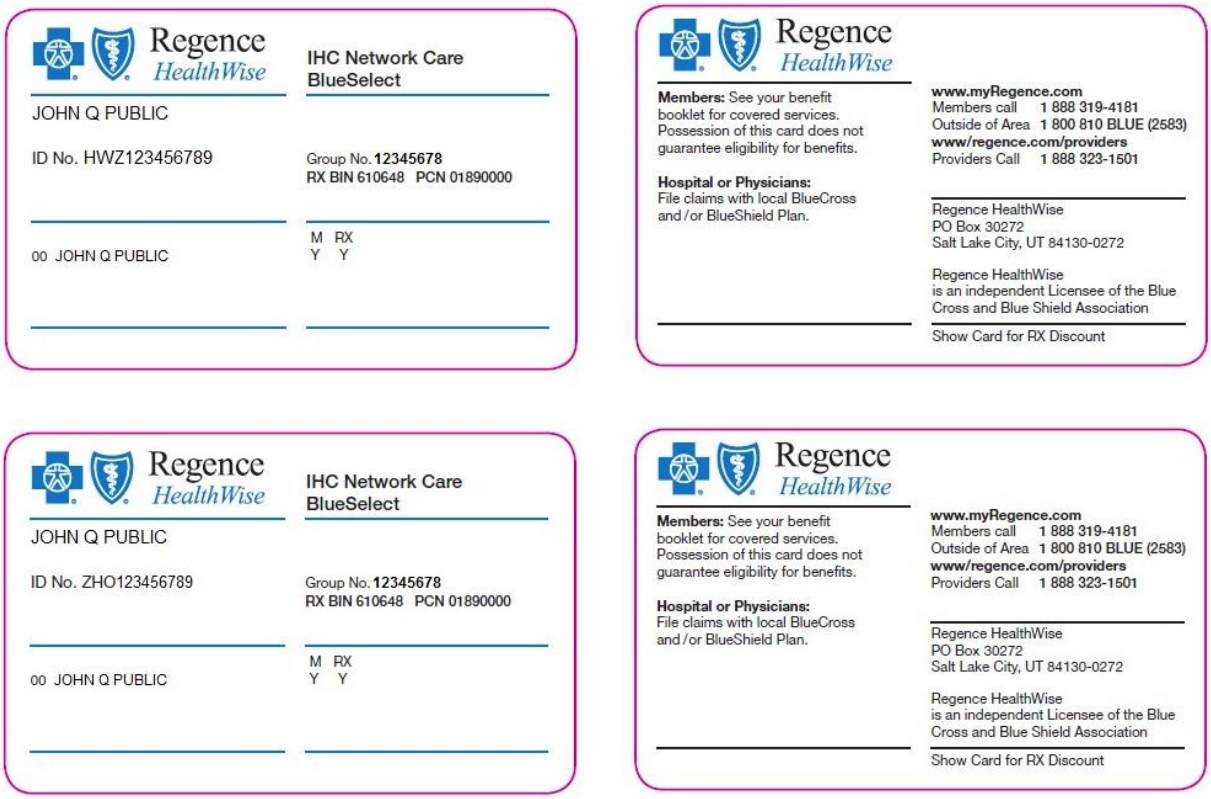
- Wear an insect repellent, preferably one with DEET, when outdoors
- Avoid being outdoors between dusk and dawn, when mosquitoes are biting.
- Install or repair screens to keep mosquitoes outside
- Drain standing water to eliminate breeding habitats
- Keep pools, saunas and hot tubs chlorinated
- Wear light-colored clothes when outdoors, and dress in long sleeves and long pants if possible.

The CDC also provides a fact sheet with more information about West Nile on its website: cdc.gov/ncidod/dvbid/westnile/wnv_factsheet.htm.

Notices and Announcements

Blue coverage for Regence HealthWise Members will NOT terminate effective Sept. 9, 2012

Blue health insurance coverage for members with Regence HealthWise ID cards **will *not*** terminate effective Sept. 9, 2012, as previously communicated. Coverage for members carrying the following ID cards will continue until further notice.



Remember, to ensure eligibility and benefits, always verify patient coverage prior to rendering services by using one of your electronic technologies, or by calling **800-676-BLUE** (800-676-2583).

If you have any questions, please contact Blue Cross and Blue Shield of Texas (BCBSTX) at 800-451-0287.

Electronic Remittance Advice (ERA) enrollment process change

The Electronic Remittance Advice (ERA) is a HIPAA-compliant electronic data file that can be used for automatic posting of payments to your patient accounts. The advantage of the ERA is that the payment information is received in your office the pay cycle after claim finalization. Also, when you enroll for ERA, you will automatically receive the Electronic Payment Summary (EPS) – a convenient alternative to your paper Provider Claim Summary (PCS).*

Beginning on Sept. 3, 2012, BCBSTX began processing ERA enrollment requests. Instead of faxing enrollment forms to Availity®, as instructed in the past, the ERA Enrollment Form should now be faxed to our Electronic Commerce Services Department at 312-946-3500.

Providers/receivers requesting ERA setup are still required to first register with Availity in order to obtain an Availity Customer ID. The Customer ID is needed to activate the ERA request.

For more detailed information and to get started with ERA and other electronic transactions, visit the Claims and Eligibility/Electronic Commerce section of our Provider website at bcbstx.com/provider. You may also call our Electronic Commerce Center at 800-746-4614 for enrollment assistance.

**Note:* *BCBSTX does not charge for setup or delivery of the ERA to your mailbox on the Availity portal. However, you may incur fees for translation software, or, if you have designated a billing agent to receive the ERA on your behalf, they may charge a fee to deliver your files to you. If you utilize a software vendor, billing service or clearinghouse, it is very important to contact them so that you are aware of any fees for products or services they provide.*

Availity is a registered trademark of Availity, L.L.C., an independent, third-party vendor. Availity is solely responsible for all of its products and services, including CareProfile.

Administrative Simplification: Past, present and future

Administrative Simplification was introduced as a component of the Health Insurance Portability and Accountability Act (HIPAA) to streamline administrative processes while increasing security of protected health information by standardizing electronic health care transactions between HIPAA-covered entities. Covered entities include all health benefit plans, health information technology vendors, physicians, facilities and other health care professionals.

Administrative Simplification is continuing as a provision of the Affordable Care Act (ACA). While HIPAA set the standard for electronic data interchange (EDI) transactions, new operating rules are being established under ACA to help promote greater uniformity in how electronic health care data is exchanged.

The Committee for Operating Rules on Information Exchange (CORE)[1] has designated a phased approach for health plans to implement operating rules for each EDI transaction. Implementation dates are tentative, pending publication of the final rules. The proposed deadlines are as follows:

- Eligibility and Benefits (ANSI 270/271) and Claim Status (ANSI 276/277) – Jan. 1, 2013
- Claims payment and remittance, which includes Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) – Jan. 1, 2014
- Referrals, preauthorizations, claim attachments – Jan. 1, 2016

BCBSTX will be making several enhancements prior to the first scheduled implementation deadline. Specifically, these enhancements will provide:

- Extended hours of online availability
- Ability to access past and future dates of service for eligibility and benefits
- More flexible parameters when searching by name to allow users a more comprehensive return of data meeting the search criteria
- A new notification process which will ensure that users are aware of any scheduled downtime or unscheduled outages

While you may see differences in the way information is returned – such as minimal screen changes – there is nothing you need to do at this time. Administrative Simplification under ACA can contribute to cost savings and help improve operational efficiencies for your office in the following ways:

- Reduced paperwork
- Streamlined daily operations resulting in less manual entry
- Less time spent on phone calls with health plans

For additional announcements related to this important initiative, please continue to watch the *Blue Review*, as well as the News and Updates section on our website at bcbstx.com/provider. We also encourage you to visit the Centers for Medicare & Medicaid Services (CMS) website at cms.gov, where you will find additional information in the Regulations and Guidance section, under HIPAA Administrative Simplification.

[1]CORE is part of the Council for Affordable Quality Healthcare (CAQH) initiative. Providers may refer to the CORE section on the CAQH website at http://www.caqh.org/benefits.php for detailed information and related resources.

Synagis predetermination process for 2012-2013

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

STEP 1 – BCBSTX Health Plan Predetermination/Authorization Process

- Complete the BCBSTX Synagis Request Form. Two types of forms (online and hard-copy) are posted at bcbstx.com/provider/forms/index.html.

- Submit the completed online version of the form; or fax the completed hard-copy version to Allan J. Chernov, M.D. (Medical Director, Health Care Quality & Policy) at 972-766-5559.

STEP 2 – Ordering Process for Prime Specialty Pharmacy

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

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

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

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

In Every Issue

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:

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 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 (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 Availty, or RealMed or your preferred vendor
- Enter required data elements
- Submit your request

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

What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?
If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

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

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

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

What if I disagree with the reimbursement amount I received?
If there is a question concerning the reimbursement amount, contact Blue Medicare Advantage Customer Service at 877-774-8592.

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

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Medicare Advantage Customer Service at 877-774-8592.

Medical record requests: Include our letter as your cover sheet

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

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

Thank you for your cooperation!

Technical and professional components

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

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

Surgical procedures performed in the physician's office

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

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

AIM RQI reminder

Physicians and professional providers must contact AIM Specialty Health℠, formerly American Imaging Management® (AIM®), first to obtain an RQI number when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician’s office, a professional provider’s office, the outpatient department of a hospital or a freestanding imaging center:

- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study

- PET scan

To obtain a PPO RQI number, log in to AIM's provider portal at aimspecialtyhealth.com and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an RQI number. If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM's ***Provider****Portal*$_{SM}$ uses the term "Order" rather than "Preauth" or "RQI."

Note*: Facilities cannot obtain an RQI number from AIM on behalf of the ordering physician. Also, the RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program.*

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

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

Quest Diagnostics, Inc., is the **exclusive** outpatient clinical reference laboratory provider for HMO Blue® Texas members* and the **preferred statewide** outpatient clinical reference laboratory provider for BCBSTX BlueChoice (PPO/POS) members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

Quest Diagnostics Offers:

- On-line scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto QuestDiagnostics.com/patient or call **888-277-8772**.
- Convenient patient access to more than 195 patient service locations.
- 24/7 access to electronic lab orders, results, and other office solutions through *Care360®™ Labs and Meds*.

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

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

* ***Note****: Physicians & other professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians & professional providers who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated*

IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.

Fee schedule updates

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

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

Improvements to the medical records process for BlueCard® claims

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

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

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

Pass-through billing

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

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

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

- The service is provided by an employee of a physician or other professional provider (physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or other professional provider) and the service is billed by the ordering physician or other professional provider.

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

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

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

Contracted physicians and other professional providers must file claims

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

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full and directs a physician or other professional provider to not file a claim with the patient's insurer, the physician or other professional provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

Medical policy disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX provider website portal on the 1st or 15th day of each month. Those policies requiring disclosure will become effective 90 days from the posting date. Policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each policy that is posted.

To view active and pending policies go to bcbstx.com/provider, click on the Policies link toward the bottom of the page and then click on the Medical Policies link. After reading and agreeing to the disclaimer, you will have access to active and pending medical policies.

Draft medical policy review

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

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

No additional medical records needed

Physicians and other professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from AIM Specialty Health, formerly American Imaging Management, need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

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

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

Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and other professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or other professional provider obtains preauthorizations for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

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

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

Avoidance of delay in claims pending COB information

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

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

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

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

Billing for non-covered services

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

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

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

Dispensing QVT (quantity versus time) limits

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

Visit the BCBSTX provider website at bcbstx.com/provider to access the 2012 QVT list.

Preferred drug list

Throughout the year, the BCBSTX Clinical Pharmacy Department team frequently reviews the preferred drug list. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

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

Are utilization management decisions financially influenced?

BCBSTX is dedicated to serving its customers through the provision of health care coverage and related benefit services. Our mission calls for us to respond to our customers with promptness, sensitivity, respect and dignity.

In support of this mission, BCBSTX encourages appropriate utilization decisions; it does not allow or encourage decisions based on inappropriate compensation. Physicians, other professional providers or BCBSTX staff do not receive compensation or anything of value based on the amount of adverse determinations, reductions or limitations of length of stay, benefits, services or charges. Any person(s) making utilization decisions must be especially aware of possible underutilization of services and the associated risks.

This topic has been addressed in the *Blue Review* provider newsletter and in previous BCBSTX employee communications as a requirement of our Utilization Review

Accreditation Commission accreditation. This serves as a reminder for all physicians and other professional providers in the BCBSTX provider network.

Contact us

Click here for a quick directory of contacts at BCBSTX.

Update your contact information online

To update your contact information, go to bcbstx.com/provider, click on the Network Participation tab and follow the directions under Update Your Contact Information. This process allows you to electronically submit a change to your name, office or payee address, email address, telephone number, tax ID or other information. You should submit all changes at least 30 days in advance of the effective date of the change.

If your specialty, practice information/status or board certification is not correct on Blue Cross and Blue Shield of Texas Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the "Other" field or contact your local Professional Provider Network office.

Blue Review is published for BlueChoice®, ParPlan and HMO Blue® Texas contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; email BlueReviewEditor@bcbstx.com.

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

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