November 2014

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Open enrollment: Helping your patients shop with confidence
For more than 75 years, Blue Cross and Blue Shield of Texas (BCBSTX) has demonstrated a firm commitment to providing excellent customer service as well as expanding access to cost-effective, quality health care for our members. As a recognized leader in the health insurance industry, our portfolio of product offerings continues to grow and change in response to market innovations and customer demands.

While the majority of our membership comes from employer groups, our retail and government program member population is growing as well. The number of new BCBSTX members increased significantly after the first open enrollment period under the Affordable Care Act (ACA) last year, but there still are millions of uninsured people to reach.

Open enrollment on the Health Insurance Marketplace begins Nov. 15, 2014, and BCBSTX is ready. In addition to first-time shoppers, many of our current members will be renewing for the first time. Where applicable, some members may be migrating from their current policies to new ACA-compliant plans. This means that some of your current patients may be shopping for a new plan and will need to know if they can still see you as an in-network provider. Or, you may receive calls from prospective patients who are doing preliminary research before they make a decision.

Educating consumers is critical, particularly during open enrollment. Our October 2014 Blue Review included updates on the Be Covered Texas and Know Your Network educational campaigns, each of which offers a library of online resources and printed materials for you to share with your patients.

We would also like to call your attention to a new brochure that may be helpful if your patients come to you with questions. The brochure is titled, Understanding Health Insurance – Your Guide to the Affordable Care Act. It is available in English and Spanish and offers quick tips and sample scenarios to help your patients understand the basics, such as:

- Why health insurance is necessary
- When and how to purchase a health insurance plan
- Financial considerations, special programs and exceptions
- Description of the four plan levels (Bronze, Silver, Gold, Platinum)
- Guaranteed coverage overview (essential health benefits and preventive services)
• Definitions of key terms, such as **premium**, **deductible**, **copayment**, **out-of-pocket maximum** and **in-network provider**

The brochure also includes a list of questions to help the newly insured prepare for next steps, once they've decided on a health care plan. The information is organized to call the reader’s attention to important details, such as how to make premium payments, what’s on the member ID card, how to find a primary care physician and the importance of confirming in-network provider status.

To view the *Understanding Health Insurance – Your Guide to the Affordable Care Act* brochure, visit the Standards and Requirements/Affordable Care Act/Patient Perspective section of the [BCBSTX provider website](http://www.bcbstx.com). If you would like to order printed copies of this brochure and other materials you can share with your patients, please contact your assigned Provider Relations Representative.

For additional information on open enrollment and ACA-related resources, please watch upcoming issues of *Blue Review*, as well as the News and Updates section of our provider website.

**BCBSTX behavioral health enhancements help reach more members**

Blue Cross and Blue Shield of Texas (BCBSTX) frequently monitors and evaluates our Behavioral Health Case Management program. This program is designed to help members with complex mental health and substance abuse issues manage the unique challenges of their condition. The program also increases awareness and provides education to members about their behavioral health condition, benefits and treatment options.

For members who require more frequent interaction, case managers also monitor medication adherence, coordinate crisis interventions and arrange individual support as needed. They also can assist members with transitions between levels of care and treatment settings.

Other benefits of the program include assisting members with locating specialists who are conveniently accessible, helping members understand how to utilize their behavioral health benefits and helping coordinate referrals between the physicians and other health care providers.

With the goal of increasing member engagement rates, the Behavioral Health team has implemented a number of enhancements to target specific barriers that may have prevented our members from participating in the program:

• Because case managers were often unable to reach members during the workday, case managers have begun contacting members during nonstandard business hours.
• Additional training has been provided for case managers on motivational interviewing, identification of co-morbid behavioral health and medical conditions, and procedures to make real-time referrals. This additional training has helped case managers capitalize on opportunities to integrate care between providers and the BCBSTX medical team.
Behavioral health case managers have been placed on-site at specific facilities to encourage members to engage in case management during acute admissions.

As a result of these program enhancements, member engagement in the BCBSTX Behavioral Health Case Management program increased from 86.1 percent in December 2011 to 90.8 percent by March 2014.*

Learn more about the Behavioral Health Care Management and Quality Improvement Programs.

The Case Management program is not meant to replace the independent opinion of the member’s doctors. The final decision about treatment is made between the treating provider and the member. If you have a BCBSTX member who you believe may benefit from the Behavioral Health Case Management program, please call the number on the back of the member’s ID card.

*Figures from quarter ending Dec. 31, 2011, compared to quarter ending March 31, 2014.

BCBSTX simplifies preauthorization requirements for psychological and neuropsychological testing
To support member access and decrease the administrative burden for providers, Blue Cross and Blue Shield of Texas (BCBSTX) is currently developing an alternative care management program for psychological and neuropsychological testing procedures.

With the introduction of this new program, effective immediately, except for the situations described below, routine preauthorization of psychological and neuropsychological testing will no longer be required.

As part of the new program, preauthorization of psychological and neuropsychological testing may be required if BCBSTX determines a provider’s pattern of testing varies significantly from their provider peer group. Additionally, periodic auditing will be conducted by BCBSTX to evaluate that testing is consistent with the presenting clinical issue, medical policy and benefit plan design. If preauthorization is required or testing is not consistent with the presenting clinical issue, medical policy and benefit plan design, BCBSTX will contact the provider to obtain additional information.

Additional details regarding the new care management program for psychological and neuropsychological testing will be announced in upcoming months.

Please note that the fact that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered.

The Choosing Wisely® campaign: Improving communication in health care
Can improved communication in health care be a key component to improved use of finite clinical resources? A current initiative of the American Board of Internal Medicine (ABIM) concludes, yes.
Choosing Wisely is an ABIM program designed to foster the appropriate and cost-effective use of health care resources by conveying to all physicians and their patients key insights from 50 clinical specialty groups. In recognition of the considerable waste in the U.S. health care system, ABIM has compiled those insights in the form of five recommendations from each specialty group that identify tests or treatments whose appropriateness should be critically assessed by doctor and patient rather than assumed.

While recognizing that there are situations in which the identified services are appropriate, Choosing Wisely seeks to limit their use to medically necessary situations, thereby promoting medical professionalism, physician-patient dialogue and care that is best suited to the individual. The medical practices in question include the use of antibiotics to treat apparently viral respiratory infections (the American Academy of Pediatrics), electroencephalography (EEG) to diagnose headaches (the American Academy of Neurology) and induced labor or cesarean section delivery before 39 weeks of gestation when not medically indicated (the American College of Obstetricians and Gynecologists).

Choosing Wisely is an outgrowth of a pilot project conducted by the National Physicians Alliance (NPA), working through a grant by the ABIM, in which NPA members in the fields of family medicine, internal medicine and pediatrics identified and field tested a dozen of the most common clinical activities in their fields that could be used more judiciously.

The non-profit organization, Consumer Reports, is supporting the Choosing Wisely campaign by coordinating the efforts of other consumer organizations to inform the public of the need for patients to engage in conversations with their physicians about the most safe, effective and efficient care.

Information about Choosing Wisely, including the specialty society Lists of Five Things Physicians and Patients Should Question, is available at choosingwisely.org.

Choosing Wisely is an initiative sponsored by the ABIM Foundation that is solely responsible for the program. Blue Cross and Blue Shield of Texas (BCBSTX) makes no representations or warranties regarding the Choosing Wisely program or any of its components.

**Choosing Wisely® campaign: Imaging tests for low back pain**

Most people experience low back pain at some time. Back pain can be severe, and imaging tests (MRI, CT, and/or conventional X-rays) are often performed in an attempt to identify the source of the pain.

However, medical specialty groups, including the American Academy of Family Physicians and the American Society of Anesthesiologists – Pain Medicine, recommend not performing imaging tests for low back pain for at least six weeks, unless red flags are present.

These specialty recommendations were issued through a national program called Choosing Wisely®. There are several reasons for the recommendations. Most people
with low back pain respond to conservative treatment such as exercise, heat and over-the-counter pain medications. Use of imaging tests in the first six weeks has not been shown to reduce the length of time for pain to subside. However, the tests sometimes reveal incidental findings that divert attention and increase the risk of having unhelpful surgery. The radiation from x-rays and CT scans may increase the risk of cancer.

*Choosing Wisely* does note that imaging studies should be performed promptly in some situations, such as when there are signs or symptoms of severe or worsening nerve damage (loss of bowel or bladder control, loss of muscle strength or feeling in the legs) or an underlying problem such as cancer or osteomyelitis. Other red flags suggesting that imaging should be considered include a history of trauma, unexplained weight loss, fever, known aortic aneurysm and recent infection.

*Choosing Wisely* is sponsored by the American Board of Internal Medicine Foundation. *Choosing Wisely* aims to promote conversations between providers and patients in order to help patients choose care that is supported by evidence, truly necessary, free from harm and not duplicative of other tests or procedures. Physicians and other practitioners may find that it is helpful to refer patients to *Choosing Wisely* at choosingwisely.org for additional information about low back pain. The website also contains information about many other tests and procedures that are not recommended in specific situations.

*The information from Choosing Wisely is provided to promote discussions between patients and their doctors, and is not a substitute for professional medical advice, diagnosis or treatment.*

**Provider-based billing**

Provider-based billing means the method of split billing allowed by Medicare for clinic or physician practices owned, controlled or affiliated with the Hospital and the clinic/practice can be designated with provider based status by The Centers for Medicare & Medicaid (CMS).

Currently, Blue Cross and Blue Shield of Texas (BCBSTX) allows hospitals that operate Medicare approved provider-based clinics to split bill for services performed in the provider-based clinics. Under split billing the hospital submits a bill for the technical component of the service on a UB04 Hospital Claim form (usually using rev code 510 for a clinic visit or 761 for a treatment room) while the physician services are billed separately on a CMS-1500 Professional Claim form.

As we renegotiate hospital agreements, we will no longer compensate for facility services billed on a UB04 billed as a provider-based clinic claim*. The facility services not compensated will not be considered patient responsibility. Currently, BCBSTX does not compensate clinic charges (defined as revenue codes 0510-0529) submitted on a UB04 form.

Going forward, BCBSTX will not compensate any charges for services performed in the provider-based clinic submitted on a UB04. This new policy will be discussed during the hospital’s contract renewal.
We recommend that hospitals operating provider-based clinics submit a global bill for all services on a CMS-1500 form in order to obtain appropriate payment. Clinics will be compensated according to their applicable professional fee schedules for these services.

Any services referred to or rendered by the hospital, such as lab and radiology, should be billed separately on a UB04 by the hospital as appropriate and that will not change.

BCBSTX governmental programs such as Medicare Advantage, Medicaid, Medicare crossover, and non-participating Indian Health Service claims are exempt from this provider-based billing contract policy change.

*Provider Based Billing Claim* means the claim submitted with at least one service including but not limited to surgery, lab, radiology, drugs and supplies billed with National Uniform Billing Committee (NUBC) revenue codes 0510 – 0529 or with revenue codes 0760 – 0761 and E&M Office Visit CPT/HCPCS codes (including but not limited to 99201-99205, 99211-99245, 99354, 99355, 99381-99387, 99391-99397, 99401-99411-99412, 99429, 99450, 99455-99456, 99487-99489, 99499).

For more information, please refer to the Blue Choice PPO℠ Facility Manual and/or to the HMO Facility Manual on the BCBSTX provider website. If you have any questions, please contact your Facility Provider Contracting Representative.

**Reminder: Register for a remittance viewer webinar**

Blue Cross and Blue Shield of Texas (BCBSTX) is offering complimentary webinars for our independently contracted providers to learn about the new remittance viewer tool. Remittance viewer is an online tool that offers providers and billing services a convenient way to view claim detail information from the 835 Electronic Remittance Advice (835 ERA).

Our webinars are designed to help new users learn how to gain or grant access, conduct a search, view general and payer-specific information, and save or print results. Register for either the Nov. 19 or Dec. 10 webinars.

To register for an upcoming webinar, visit the BCBSTX provider website, where you will find upcoming webinar dates, times and other helpful resources in the Education and Reference/Provider Tools section.

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

**Medicare Part D formulary updates for the second quarter**

We have provided a summary of Blue Cross and Blue Shield of Texas (BCBSTX) recent Medicare Part D formulary changes. The 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 patients, please refer to the following instructions:

Use MyPrime to access 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’ – This includes the current comprehensive formulary and formulary search function

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>ADASUVE (loxapine) inhal powder, 10 mg</td>
<td>Brand</td>
<td>4/25/14</td>
<td>Addition</td>
<td>Tier 4</td>
</tr>
<tr>
<td>allopurinol for inj 500 mg</td>
<td>generic</td>
<td>6/23/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>ALOPRIM (allopurinol) for inj 500 mg</td>
<td>BRAND</td>
<td>4/14/14</td>
<td>Addition</td>
<td>Tier 4 (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>ANORO ELLIPTA (umeclidinium/vilanterol) inhal powder, 62.5-25 mcg</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 3. Quantity limits apply.</td>
</tr>
<tr>
<td>atovaquone susp, 750 mg/5 mL</td>
<td>Generic</td>
<td>3/23/14</td>
<td>Addition</td>
<td>Tier 5. First generic for Mepron.</td>
</tr>
<tr>
<td>AZATHIOPRINE for inj, 100 mg</td>
<td>Brand</td>
<td>6/23/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
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<td>azelastine nasal spray, 0.15% (205.5 mcg/spray)</td>
<td>Generic</td>
<td>5/11/14</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for Astepro.</td>
</tr>
<tr>
<td>BREO ELLIPTA (fluticasone furoate/vilanterol) inhal powder, 100-25 mcg</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 3. Quantity limits apply.</td>
</tr>
<tr>
<td>TRADE NAME (generic name)</td>
<td>Brand/Generic Product</td>
<td>Effective Date</td>
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<tr>
<td>Cholestyramine/Light powder packets (4gm),</td>
<td>Generic</td>
<td>4/8/14</td>
<td>Addition</td>
<td>Tier 2 – BASIC formulary</td>
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<tr>
<td>COUMADIN (warfarin) tabs, 1 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg, 10 mg</td>
<td>Brand</td>
<td>4/1/14</td>
<td>Addition</td>
<td>Tier 4 (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>CYRAMZA (ramucirumab) inj, 100mg/10ml, 500mg/50ml</td>
<td>BRAND</td>
<td>5/4/14</td>
<td>Addition</td>
<td>Tier 5</td>
</tr>
<tr>
<td>ERWINAZE (asparaginase Erwinia chrysanthemi) for inj, 10,000 units</td>
<td>Brand</td>
<td>3/1/14</td>
<td>Addition</td>
<td>Tier 5.</td>
</tr>
<tr>
<td>EXELON (rivastigmine) oral soln, 2 mg/mL</td>
<td>Brand</td>
<td>8/21/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
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<tr>
<td>GRANIX (tbo-filgrastim) inj, 300 mcg/0.5 mL, 480 mcg/0.8 mL</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 5.</td>
</tr>
<tr>
<td>griseofulvin microsize tabs, 500 mg</td>
<td>Generic</td>
<td>1/1/14</td>
<td>Addition</td>
<td>Tier 2 (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>ibandronate inj, 3 mg/3 mL</td>
<td>Generic</td>
<td>3/16/14</td>
<td>Addition</td>
<td>Tier 2. First generic for Boniva inj.</td>
</tr>
<tr>
<td>KUVAN (sapropterin) oral powder, 100 mg</td>
<td>Brand</td>
<td>3/9/14</td>
<td>Addition</td>
<td>Tier 5. Prior authorization applies.</td>
</tr>
<tr>
<td>LEVEMIR FLEXTOUCH (insulin detemir) inj, 100 units/mL</td>
<td>Brand</td>
<td>5/25/14</td>
<td>Addition</td>
<td>Tier 3 (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>MYRBETRIQ (mirabegron) tabs, 25 mg, 50 mg</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 3. Quantity limits apply.</td>
</tr>
<tr>
<td>naloxone inj, 0.4 mg/mL</td>
<td>Generic</td>
<td>3/16/14</td>
<td>Cost Share Reduction</td>
<td>Change to Tier 2 (was 4). (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>NAMENDA (memantine) XR caps, 7 mg, 14 mg, 21 mg, 28 mg, titration pack</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>N/A</td>
</tr>
<tr>
<td>TRADE NAME (generic name)</td>
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<td>Description of Change</td>
<td>Comments</td>
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<tr>
<td>nevirapine ER tabs, 400 mg</td>
<td>Generic</td>
<td>4/20/14</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. <strong>First generic for Viramune XR 400 mg.</strong></td>
</tr>
<tr>
<td>OLYSIO (simeprevir) caps, 150 mg</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 5. Prior authorization applies</td>
</tr>
<tr>
<td>omega-3-acid ethyl esters caps, 1 gm</td>
<td>Generic</td>
<td>4/13/14</td>
<td>Addition</td>
<td>Tier 2. <strong>First generic for Lovaza.</strong></td>
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<tr>
<td>PILOPINE (pilocarpine) HS eye gel, 4%</td>
<td>Brand</td>
<td>8/21/14</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>pindolol tabs, 5 mg, 10 mg</td>
<td>Generic</td>
<td>4/6/14</td>
<td>Cost Share Reduction</td>
<td>Change to Tier 2 (was 4).</td>
</tr>
<tr>
<td>raloxifene tabs, 60 mg</td>
<td>Generic</td>
<td>4/6/14</td>
<td>Addition</td>
<td>Tier 2. <strong>First generic for EVISTA.</strong></td>
</tr>
<tr>
<td>rifabutin caps, 150 mg</td>
<td>Generic</td>
<td>3/30/14</td>
<td>Addition</td>
<td>Tier 2. <strong>First generic for MYCOBUTIN.</strong> (Tier 4 for BASIC formulary)</td>
</tr>
<tr>
<td>SILENOR (doxepin) tabs, 3 mg, 6 mg</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 3. Quantity limits apply.</td>
</tr>
<tr>
<td>SIMBRINZA (brinzolamide/brimonidine) eye susp, 1-0.2%</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 3 (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>Sodium polystyrene sulfonate rectal susp, 30gm/120ml</td>
<td>Generic</td>
<td>4/8/14</td>
<td>Addition</td>
<td>Tier 2 – BASIC formulary</td>
</tr>
<tr>
<td>SOVALDI (sofosbuvir) tabs, 400 mg</td>
<td>Brand</td>
<td>5/1/14</td>
<td>Addition</td>
<td>Tier 5. Prior authorization applies.</td>
</tr>
<tr>
<td>SYNTHEROID (levothyroxine) tabs, 25 mcg, 50 mcg, 75 mcg, 88 mcg, 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 300 mcg</td>
<td>Brand</td>
<td>4/1/14</td>
<td>Addition</td>
<td>Tier 4 (NOT available on the BASIC formulary)</td>
</tr>
<tr>
<td>Telmisartan/hydrochlorothiazide tabs, 40-12.5 mg, 80-12.5 mg, 80-25 mg</td>
<td>Generic</td>
<td>3/9/14</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. <strong>First generic for</strong></td>
</tr>
</tbody>
</table>
NOTICES AND ANNOUNCEMENTS

Benefits Value Advisor program adds member outreach component
As announced in previous issues of Blue Review, the Benefits Value Advisor (BVA) program was launched on Jan. 1, 2014. BVAs are Blue Cross and Blue Shield of Texas (BCBSTX) representatives who are available to assist most BCBSTX members with understanding their health care benefits, potential savings opportunities, clinical educational support, and appointment scheduling, among other services.

In October 2014, we introduced a pilot program for enhanced BVA services involving outreach calls to members for whom certain non-emergency, high-tech radiology imaging services were scheduled, such as MRIs and CT/CTA scans. Beginning Jan. 1, 2015, this enhancement will be expanded to additional members.

- The BVA may suggest options for lower cost, in-network imaging services.
- If the member accepts the recommended change, the BVA will coordinate all details, such as scheduling the service and notifying AIM Specialty Health® (AIM).
- AIM will notify the ordering physician via email regarding the change in servicing facility and related Radiology Quality Initiative (RQI) information.

Please note that, while enhancements are ongoing, there is nothing you need to do differently when submitting RQI requests through AIM for high-tech imaging services. Our BVAs are available to help provide members with more information that may help them make better decisions concerning their health care.

For more information on the BCBSTX RQI program, refer to the Clinical Resources/Radiology Quality Initiative/Preauth Program section of the BCBSTX provider website at bcbstx.com/provider.

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 is an operating subsidiary of WellPoint, Inc., an independent third party vendor that is solely responsible for its products and services. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions about the products or services offered by such vendors, you should contact the vendors directly.

Please note that the fact that a guideline is available for any given treatment, or that a service has been pre-certified or an RQI number has been issued is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage, including, but not limited to, exclusions and limitations applicable on the date services were rendered. Certain employer groups may require pre-certification for imaging services from other vendors. If you have any questions, please call the number on the back of the member's ID card.

**Diagnostic imaging management program change notice**

Effective Jan. 1, 2015, all high-tech outpatient diagnostic MRI/MRA scans, CT/CTA scans, PET scans and SPECT/Nuclear Cardiology studies for HMO Blue Texas members will no longer require preauthorization by the HMO Blue Texas radiology vendor, AIM Specialty Health® (AIM).

Effective Jan. 1, 2015, AIM will manage a statewide Radiology Quality Initiative (RQI) for outpatient high-tech diagnostic imaging services for HMO Blue Texas members. For procedures that are scheduled on or after Jan. 1, 2015, all HMO Blue Texas physicians and professional providers (excluding HMO Blue Texas physicians and professional providers who are contracted/affiliated with a capitated IPA/Medical Group) will be required to contact AIM first to obtain a Radiology Quality Initiative (RQI) when ordering or scheduling the outpatient high-tech diagnostic radiology procedures listed above when performed in a physician’s or professional provider’s office, or the outpatient department of a hospital, or a freestanding imaging center.

To view the list of high-tech outpatient diagnostic radiology procedures and CPT codes affected by this program, go to bcbstx.com/provider, then go to the Clinical Resources tab, then select Radiology Quality Initiative Program, then scroll down to the offering titled View the CPT Codes.

If you would like additional information pertaining to AIM, please visit AIM’s website at aimspecialtyhealth.com.

**NOTE:** HMO Blue Texas physicians or professional providers who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group regarding outpatient high-tech diagnostic imaging services.

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

**Networks offered on the Texas Health Insurance Marketplace**

Blue Cross and Blue Shield of Texas (BCBSTX) is offering two networks on the Texas Health Insurance Marketplace for all enrollees:

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

Product names that will be offered on the Texas Health Insurance Marketplace in 2015 are listed below.

<table>
<thead>
<tr>
<th>PPO</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Choice Bronze PPO 005</td>
<td>Blue Advantage Bronze HMO 005</td>
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If you have questions, please contact the BCBSTX Provider Relations department.

**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 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 or Ancillary (as appropriate) and select the Blue Choice PPO℠ and HMO Blue Texas Schedules offering, then select 2014 Schedules effective July 1, 2014, then select 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 Availity Portal, the Availity Revenue Cycle Management Portal or your preferred vendor
- Enter required data elements
Submit your request

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

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

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

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

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

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

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

**Medical record requests: Include our letter as your cover sheet**
When you receive a letter from BCBSTX requesting additional information such as medical records or certificates of medical necessity, please utilize the letter as a cover sheet when sending the requested information to us.

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

**Technical and professional components**

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

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

**Surgical procedures performed in the physician's office**

When performing surgical procedures in a non-facility setting, the physician and professional provider reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the physician's or professional provider's office.

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

Please note the physician and professional provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied based on the fact that the global physician reimbursement includes staff and equipment.

**AIM RQI/Preauthorization reminder**

Physicians and professional providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPO members and Blue Advantage HMO members or a Preauthorization for HMO Blue Texas members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician’s office, a professional provider’s office, the outpatient department of a hospital or a freestanding imaging center:

- CT/CTA scans
- MRI/MRA scans
- SPECT/Nuclear Cardiology studies
- PET scans

To obtain a Blue Choice PPO/Blue Advantage HMO RQI or an HMO Blue Texas Preauthorization, log in to AIM’s provider portal at amspecialtyhealth.com and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are
met, you will receive a RQI or Preauthorization (whichever is applicable). If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM’s ProviderPortalSM uses the term “Order” rather than “Preauth” or “RQI.”

**Note:** Facilities cannot obtain an RQI or a Preauthorization from AIM on behalf of the ordering physician or professional provider. 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 TexasSM and Blue Advantage HMOSM members* and the preferred statewide outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPOSM members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and freestanding 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://www.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 Care360SM 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://www.bcbstx.com/provider) under the General Reimbursement Information section located under the Standards and Requirements tab.

* **Note:** Physicians and professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians and professional providers who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.
Fee schedule updates
Reimbursement changes and updates for Blue Choice PPO and HMO Blue Texas (Independent Provider Network only) and Blue Advantage HMO practitioners will be posted under Standards and Requirements / General Reimbursement Information / Reimbursement Schedules and Related Information / Professional Schedules section on the BCBSTX provider website at bcbstx.com/provider.

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule will be updated monthly.

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

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

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

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

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

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

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

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

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

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

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

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

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

To view active and pending medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to active and pending medical policies.

**Draft medical policy review**
In an effort to streamline the medical policy review process, you can view draft medical policies on the BCBSTX provider website and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

To view draft medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to 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 bcbtx.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: bcbtx.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 PPOSM, HMO Blue TexasSM, Blue Cross Medicare Advantage (PPO)SM, Blue Advantage HMO_SM 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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