December 2014

(Electronic distribution December 3, 2014)

Making networks work
The dynamic, multi-dimensional landscape of health care reform requires a fresh perspective to help transform challenges into opportunities. With this viewpoint in mind, Blue Cross and Blue Shield of Texas (BCBSTX) has introduced many new health benefit products or plans (collectively called ‘plans’), on and off the Health Insurance Marketplace.

As we have noted in previous articles, BCBSTX is conducting extensive educational campaigns for new and prospective members, with particular emphasis on individuals who may be new to health care insurance. In addition to helping members navigate our broad menu of coverage options, educational materials also emphasize that, when choosing a health care plan, members are also choosing an independently contracted provider network. With the exception of emergencies, members are advised that using in-network providers and hospitals is essential to helping keep their out-of-pocket costs down.

We hope that our members will do their homework and “know their network” before seeking your services. However, it may take time for some of your patients, particularly if they are new to health care insurance, to become accustomed with how things work. For this reason, we want to stress the importance of confirming for each patient that you are an in-network provider for that patient’s plan, before rendering services. If you are out-of-network for the member’s particular benefit plan, you will need to inform the member that, if they choose to proceed as your patient, they may be responsible for all or part of the cost of care.

From a provider perspective, we acknowledge that the increased number of plans can seem daunting, particularly when each plan has a corresponding network that may be different from what you might expect. Please know that, while we must continue to make changes in support of our goal of providing the best services to our members, we also remain committed to helping providers conduct business with us easily and efficiently.

The following list includes some key reminders for you and your staff:

- Your network details are defined in your contractual agreement(s) with BCBSTX.
- We encourage you and your staff to view our online Provider Finder® to review and confirm the plans for which you may be considered an in-network provider.
- Also use the Provider Finder to confirm network status of other providers before directing your patients to those providers.
- As always, before providing care and services, it is critical to check eligibility and benefits to determine membership and coverage information.
If you have any questions, or if you would like to order educational materials for distribution to your patients or to display in your office, please contact your Provider Relations Representative for assistance.

*Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility, any claims received during the interim period and the terms of the member’s certificate of coverage applicable on the date services were rendered.*

**Open enrollment: Welcoming new and renewing members**
The 2015 Annual Open Enrollment period for individual and family coverage began Nov. 15, 2014, and will close Feb. 15, 2015. During open enrollment, a shopper has the opportunity to select a new plan or renew their current policy for 2015.

**New Process**
Effective with 2015 Open Enrollment, most members can be re-enrolled automatically into the same plan they selected for coverage in 2014. Current Blue Cross and Blue Shield of Texas (BCBSTX) members have received information explaining how to renew their existing coverage or select a new plan. BCBSTX members who take no action will be automatically enrolled in the same plan they had for 2014.

**Member ID Cards**
Renewing members who keep their same plan will retain the member ID cards they were issued when they signed up for their 2014 policy. New enrollees and BCBSTX members who change their plan selection for 2015 will receive new member ID cards. While the new member ID cards will have a slightly different look in 2015, one key component – the network code – will remain on the front of all cards. *Checking the network code is critical as it identifies in-network providers according to each member’s plan or product.*

**Eligibility and Benefits**
As always, it is important to check eligibility and benefits prior to rendering services for BCBSTX members. This step will help you identify the member’s product/plan, network, preauthorization requirements and other important details.

Please watch the News and Updates section of the BCBSTX provider website at bcbstx.com/provider for additional information and related resources.

*Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility, any claims received during the interim period and the terms of the member’s certificate of coverage applicable on the date services were rendered.*

**Bulk powder compounds: Claim processing change, effective Feb. 1, 2015**
Blue Cross and Blue Shield of Texas (BCBSTX) periodically conducts claim reviews to help ensure that we are paying only for services that are covered benefits under our members’ and groups’ benefit plans, as well as within our claims guidelines and Medical Policies. An increasing number of claims for compounded drug products have been identified that are not covered benefits as they do not meet the limited exception criteria..
for coverage of compounded drug products formulated from bulk powders under BCBSTX medical policy.

Please be advised that, for dates of service on or after Feb. 1, 2015, claims submitted to BCBSTX for compounded drug products using bulk powders will be denied, in accordance with our Medical Policy. As of this effective date, independently contracted BCBSTX providers will receive a message on their Electronic Payment Summary (EPS) or Provider Claim Summary (PCS), as follows:

“Services for Bulk Powder or Compound Drugs are considered experimental, investigational, or unproven and not covered under the member's benefit plan. This is a contracted provider, the member is not responsible for payment of these charges.”

For additional information, such as limited exceptions, please refer to the article in our October 2014 Blue Review titled, “Compound Medications May Warrant Dose of Caution.” Also refer to the BCBSTX Compounded Drug Products Medical Policy (RX501.063), which is available in the Standards and Requirements/Medical Policy section.

ClaimsXten™ second quarter 2014 updates
Blue Cross and Blue Shield of Texas (BCBSTX) reviews new and revised Current Procedural Terminology (CPT®) and HCPCS codes on a quarterly basis. Codes are periodically added to or deleted from the ClaimsXten software by McKesson and are not considered changes to the software version.

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

Beginning on or after Dec. 9, 2014, BCBSTX will enhance the ClaimsXten code auditing tool by adding the fourth quarter 2014 codes and bundling logic into our claim processing system.

The ClaimsXten tool offers flexible, rules-based claims management with the capability of creating customized rules, as well as the ability to read historical claims data. ClaimsXten can automate claim review, code auditing and payment administration, which we believe results in improved performance of overall claims management. BCBSTX will continue with the modifier 59 exempt program through ClaimsXten. This program is based on the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI).

NCCI guidelines state, "Each NCCI edit has an assigned modifier indicator. A modifier indicator of '0' indicates that NCCI associated modifiers cannot be used to bypass the edit." BCBSTX will continue to use ClaimsXten as the code pair default. NCCI edits (either Incidental or Mutually Exclusive) that are currently not part of the ClaimsXten database will NOT be added.
To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to our provider website for additional information on gaining access to C3.

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

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

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

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NOTICES AND ANNOUNCEMENTS

Fourth quarter 2014 pharmacy optimization initiative highlights
As part of the Blue Cross and Blue Shield of Texas (BCBSTX) pharmacy optimization initiative, we are posting a quarterly summary of news and announcements on the BCBSTX provider website. Our fourth quarter summary spotlights recent pharmacy program enhancements, such as GuidedHealth® program updates. Also included are helpful reminders, links to related resources and a quick review of upcoming initiatives.

Watch for the Pharmacy Optimization Initiative 4th Quarter Highlights in the News and Updates section of our website at bcbsxtx.com/provider. The quarterly highlights may also be accessed using the feature link on the Home page of our Provider website.

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

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](http://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](http://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.

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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**<sup>SM</sup> **Physician and Professional Provider** (Section B) and **HMO Blue Texas**<sup>SM</sup> / **Blue Advantage HMO**<sup>SM</sup> **Physician and Professional Provider** (Section B) available on our provider website at [bcbstx.com/provider](http://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:
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)SM Customer Service at 877-774-8592.

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

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

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

Thank you for your cooperation!

**Technical and professional components**

**Modifiers 26 and TC:** Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only.
**Note:** When a physician or professional provider performs both the technical and professional service for a lab or radiological procedure, he/she must submit the total service, not each service individually.

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

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician’s or professional provider’s office. To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX’s code-auditing software. Refer to the BCBSTX provider website at 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 aimspecialtyhealth.com and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive a RQI or Preauthorization (whichever is applicable). If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM’s **ProviderPortalSM** uses the term “Order” rather than “Preauth” or “RQI.”

**Note:** Facilities cannot obtain an RQI or a Preauthorization from AIM on behalf of the ordering physician 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 Texas℠ and Blue Advantage HMO℠ members* and the preferred statewide outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO℠ members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

**Quest Diagnostics Offers:**

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

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

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

* **Note:** Physicians 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 providers must file claims**
As a reminder, physicians, facilities, professional providers and ancillary 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 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 provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

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

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

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

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

**No additional medical records needed**
Physicians and professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) from AIM Specialty Health need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

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

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

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

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

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

Here are some tips to help prevent claims processing delays when there is only one
insurance carrier:
- CMS-1500, box 11-d – if there is no secondary insurance carrier, mark the “No”
  box.
- Do not place anything in box 9, a through d – this area is reserved for member
  information for a secondary insurance payer.

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

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

In the event that BCBSTX determines that a proposed service is not a covered service,
the physician or professional provider must inform the subscriber in writing in advance.
This will allow the physician or professional provider to bill the subscriber for the non-
covered service rendered.
In no event shall a contracted physician or professional provider collect payment from the subscriber for identified hospital acquired conditions and/or serious reportable events.

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

Visit the BCBSTX provider website at bcbstx.com/provider to access the 2014 Drug Dispensing Limits list.

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

For the 2014 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html and click on the Preferred Drug Guide offering in the left-side navigation list.

**Are utilization management decisions financially influenced?**
BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

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

**Contact Us**
Click here for a quick directory of contacts at BCBSTX.

**Update your contact information online**
To update your contact information, go to bcbstx.com/provider, click on the Network Participation tab and follow the directions under Update Your Contact Information. This process allows you to electronically submit a change to your name, office or payee address, email address, telephone number or other information. You should submit all changes at least 30 days in advance of the effective date of the change.
If your specialty, practice information/status or board certification is not correct on the BCBSTX Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the Other field or contact your Provider Relations office.

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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.

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