Urine drug testing policy, effective Dec. 15, 2014

Blue Cross and Blue Shield of Texas (BCBSTX) Medical Policy MED207.154 (Urine Drug Testing Including Pain Management and Substance Abuse Monitoring) became effective Dec. 15, 2014. This new policy addresses the overutilization of quantitative/confirmatory urine drug testing as a routine screening tool.

With few exceptions, this policy prohibits the routine use of quantitative/confirmatory testing as being not medically necessary. The most prominent exception being when a patient tests positive on a qualitative test and the physician determines it is medically necessary for treatment decisions to know the quantity of the drug in the patient’s system.

BCBSTX encourages providers to review this new policy as soon as possible to ensure they only submit claims that are consistent with this new policy. The BCBSTX Special Investigations Department will be monitoring provider compliance and may initiate investigations as appropriate. Independently contracted providers found billing inappropriately, contrary to this policy, may be subject to overpayment refunds and other actions as deemed appropriate based on the circumstances of each case.

Please visit the Standards and Requirements/Medical Policy section of the BCBSTX provider website for access to up-to-date medical policy information.

The BCBSTX Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are encouraged to exercise their own clinical judgment based on each individual patient’s health care needs. Some benefit plans administered by BCBSTX, such as some self-funded employer plans or governmental plans, may not utilize BCBSTX Medical Policy. Members should contact their BCBSTX Customer Service department for specific coverage information.

2014 HEDIS® antidepressant medication management results

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans, and it measures performance on important dimensions of care and service, including Behavioral Health. Because so many plans collect HEDIS data and the measures are so specifically defined, HEDIS makes it possible to compare performance among health plans.

The Antidepressant Medication Management HEDIS metric includes members who:

- Are 18 years of age or older,
• Have been diagnosed with major depression,
• Were newly treated with antidepressant medication, and
• Remained on an antidepressant medication treatment.

To evaluate if members are receiving the maximum benefit from an initiated antidepressant medication regimen, two rates are reported:
• Effective acute phase: Those who stayed on an antidepressant for at least 12 weeks (84 days)
• Effective continuation phase: Those who stayed on an antidepressant for at least 6 months (180 days)

What were the Blue Cross and Blue Shield of Texas (BCBSTX) member results?
HEDIS measurements are calculated annually and compared to national averages. For patients who stayed on an antidepressant for at least 12 weeks the 2014 national average was 64.26 percent, and the average for BCBSTX members was 65.17 percent. For patients who stayed on an antidepressant for at least six months the 2014 national average was 48.70 percent, and the average for BCBSTX members was 47.49 percent.

What is BCBSTX doing to help?
We have provided an educational article to members about the importance of staying on antidepressant medication, and we continue to work with our pharmacy and reporting departments to develop programs to assist members with their medications. If you have a patient you believe is not fully compliant with an antidepressant regime and you believe therapy would also be beneficial, we can help.

You or the patient can contact us via the BCBSTX number on the back of the member’s ID card. We can help them locate a behavioral health therapist, enroll them in one of our case management programs, or help coordinate care so that the patient is more successful with their antidepressant medication regime.

For additional information, visit the Clinical Resources/Behavioral Health Care Management Program section of the BCBSTX provider website.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

ClaimsXten™ updates – First quarter 2015
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. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) will continue to be posted on the BCBSTX provider website.
Beginning on or after April 20, 2015, BCBSTX will enhance the ClaimsXten code auditing tool by adding the first quarter 2015 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 the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the Education & Reference/Provider Tools/ Clear Claim Connection™ page on our provider website. Information also may be published in 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.

CPT copyright 2014 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

BlueCompare℠ for physicians
Blue Cross and Blue Shield of Texas (BCBSTX) evaluates the performance of Blue Choice PPO℠ network physicians in 18 measured specialties on Evidence Based Measures (EBM) and Physician Cost Assessment (PCA) as compared to peers in the same Working Specialty. Consistent with national guidelines, a cost-efficiency assessment is only performed if the specialty-specific, quality-related criteria are met.

This years' evaluation is underway and we will mail the affected physicians a communication with instructions for accessing their Performance Reports in a secure
online portal (if applicable). BCBSTX also has two additional transparency programs that provide quality related performance information on the National Doctor & Hospital Finder℠ and the BCBSTX Provider Finder®.

The Physician Quality Measurement Program (PQM) collects data on nationally endorsed physician quality measures, Evidence Based Measures. Physician practices PQM results shown on the physician's BlueCompare 2015 EBM Summary Report will be displayed on the National Doctor & Hospital Finder and the BCBSTX Provider Finder effective third quarter of 2015.

The Blue Physician Recognition (BPR) will use a BPR indicator to identify physicians who have demonstrated their commitment to delivering quality and patient-centered care, as determined by BCBSTX. If a physician receives a Blue Ribbon for the BCBSTX 2015 BlueCompare program, the BPR symbol will be displayed on the National Doctor & Hospital Finder and the BCBSTX Provider Finder effective third quarter of 2015.

If you have any questions, please visit the BCBSTX provider website for more detailed information. You may also find more information on the Provider Training under the Blue Compare for Physicians link. If you would like to speak to someone, please call your Provider Relations representative.

**Blue Advantage HMO℠ referral requirements overview**

Each Blue Advantage HMO member must select a primary care physician (PCP).

**PCP responsibilities:**
- Manage all aspects of the patient's care, including referrals to specialty care physicians or professional providers.
- Refer patients to other specialty care physicians or professional providers who participate in the Blue Advantage HMO network before the patient receives services from a specialty care physician or professional provider.

**EXCEPTION:** Participating OBGyn physicians have the ability to directly manage and coordinate a woman's care for gynecological and obstetrical conditions, including obtaining referrals through iExchange for gynecological specialty care and testing to other participating Blue Advantage HMO physicians or professional providers.

**Referrals to specialty care physicians or professional providers:**
- Must be initiated by the Blue Advantage HMO primary care physician (or OBGYN physician) to a participating Blue Advantage HMO physician or professional provider.
- Blue Advantage HMO Utilization Management Department approval is required for all out-of-network referrals.
- A primary care physician may not refer to himself/herself as a specialty care physician when treating a member who is already on his/her Primary Care Physician list.
- A specialty care physician or professional provider cannot refer to other specialty care physicians or professional providers.

**iExchange System for referrals:**
• Provides an immediate referral confirmation number at the end of each transaction.
• Referral confirmation is not a verification and does not guarantee payment. Payment is subject, but not limited, to eligibility, contractual limitations, and payment of premium on the date(s) of service.
• If a Blue Advantage HMO member is treated by a Blue Advantage HMO physician or professional provider other than the Primary Care Physician or a participating OBGyn without a referral, the service provided will not be covered by Blue Advantage HMO.

Please have the following information readily available when initiating a referral notification:
• Patient's full name
• Member ID number
• Diagnosis (ICD-9/ICD-10 code)
• Procedure(s) anticipated (CPT code)
• Policy or group number
• Anticipated date(s) of service
• Referring physician name and iExchange ID
• Specialty care physician or professional provider name, iExchange ID and phone number

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<thead>
<tr>
<th>Method</th>
<th>Action by PCP</th>
<th>Action by BCBSTX</th>
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</thead>
<tbody>
<tr>
<td>iExchange Web</td>
<td>Access iExchange 24 hours a day/7 days a week to complete a referral. Once you have accessed iExchange, you will be guided through all the required steps to complete the referral.</td>
<td>The iExchange System provides an immediate referral confirmation number at the end of each transaction. Notification letters are automatically generated to the SCP and subscriber.</td>
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</table>

If iExchange is not available, non-iExchange prior referral notification can be initiated by:

<table>
<thead>
<tr>
<th>Method</th>
<th>Action by PCP</th>
<th>Action by BCBSTX</th>
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<tbody>
<tr>
<td>Telephone</td>
<td>Call 800-441-9188 between 6 am and 6 pm (CT), Monday through Friday; 9 a.m. and 12 noon on weekends and legal holidays.</td>
<td>Sends notification letters to the SCP and member.</td>
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<tr>
<td>Fax</td>
<td>Fax request to: 1-800-252-8815 or 1-800-462-3272</td>
<td>Sends notification letters to the member and SCP.</td>
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</table>
Blue Advantage HMO™
Preauthorization list effective Jan. 1, 2015
Out-of-Network/Out-of-Plan Services always require medical management review. If no preauthorization or referral is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement.

<table>
<thead>
<tr>
<th>PREAUTHORIZATION / NOTIFICATION / REFERRAL REQUIREMENTS</th>
<th>PROCESS IN iExchange</th>
<th>PREAUTHORIZATION</th>
<th>REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inpatient Facility Admissions - Hospital - Rehab - Skilled Nursing - Long Term Acute Care / Sub-acute</td>
<td>iExchange Notification for Selected Facility Admissions</td>
<td>Certain Facility Admissions Require Medical Management Review</td>
<td></td>
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<tr>
<td>2. Obstetrical Care</td>
<td>iExchange Maternity Notification</td>
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<td>3. Hospice</td>
<td>iExchange Notification</td>
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<td>4. Pain Management</td>
<td>iExchange Preauthorization</td>
<td>Preauthorization Requires Medical Management</td>
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<tr>
<td>5. High Tech Outpatient Diagnostic Radiology Procedures*</td>
<td></td>
<td>Call AIM Specialty Health® (AIM) for a Radiology Quality Initiative (RQI) at 800-859-5299</td>
<td></td>
</tr>
<tr>
<td>6. Outpatient Renal Dialysis</td>
<td>iExchange Preauthorization</td>
<td>Preauthorization Requires Medical Management Review</td>
<td></td>
</tr>
<tr>
<td>7. Outpatient Lumbar Fusions</td>
<td>iExchange Preauthorization</td>
<td>Preauthorization Requires Medical Management Review</td>
<td></td>
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<tr>
<td>8. Durable Medical Equipment (DME)</td>
<td>DME greater than $2500.00 requires preauthorization. DME less than $2500.00 requires either: (1) a preauthorization or (2) a referral from the Primary Care Physician (PCP) or rendering physician. <strong>Note:</strong> Only one of the above is required, not both.</td>
<td>DME greater than $2500.00 requires preauthorization. DME less than $2500.00 requires either: (1) a preauthorization or (2) a referral from the Primary Care Physician (PCP) or rendering physician. <strong>Note:</strong> Only one of the above is required, not both.</td>
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<tr>
<td>9. In-Network/In-Plan Services</td>
<td>iExchange Referral for ALL Primary Care Physician (PCP) Referrals to in-network providers outside of the PCP’s Call Group/Back Ups</td>
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<tr>
<td>10. Out-of-Network/Out-of-Plan Services</td>
<td>Out-of-Network/Out-of-Plan Services always requires Medical Management Review. If no preauthorization is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement. HMO Blue Texas physicians and professional providers in a Limited Provider Network must refer care to HMO Blue Texas physicians and professional providers contracted in the same Limited Provider Network.</td>
<td>Out-of-Network/Out-of-Plan Services always requires Medical Management Review. If no referral is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement. HMO Blue Texas physicians and professional providers in a Limited Provider Network must refer care to HMO Blue Texas physicians and professional providers contracted in the same Limited Provider Network.</td>
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<tr>
<td>11. Home Health Services</td>
<td>Preauthorization Requires Medical Management Review</td>
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<tr>
<td>12. Hyperbaric Treatment</td>
<td>Preauthorization Requires Medical Management Review</td>
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<td>13. Drug/Alcohol Treatment</td>
<td>Call Magellan for Preauthorization</td>
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<tr>
<td>14. Mental Health Services</td>
<td>Call Magellan for Preauthorization</td>
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<tr>
<td>15. Physical Therapy</td>
<td>iExchange Referral Referral is not required for outpatient facility therapy</td>
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<tr>
<td>16. Occupational Therapy</td>
<td>iExchange Referral Referral is not required for outpatient facility therapy</td>
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</tbody>
</table>
17. Speech Therapy

iExchange Referral

Referral is not required for outpatient facility therapy

18. Sleep Studies

Preauthorization is not required for In-Network/In-Plan outpatient sleep studies.

19. Oral Dental Surgery Procedures

Preauthorization Requires Medical Management Review

High Tech Outpatient Diagnostic Radiology Procedures (CT/CTA scans, MRI/MRA scans, SPECT/Nuclear Cardiology studies and PET Scans) require a Radiology Quality Initiative (RQI) number prior to services. View a list of CPT Codes requiring an RQI.

Physicians and professional providers should contact AIM at 800-859-5299 to obtain an RQI number. Note: This program does not apply to imaging studies performed in conjunction with any Inpatient, Emergency Room, 23-hour Observation or Day Surgery admissions.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

NOTICES AND ANNOUNCEMENTS

Anthem® Blue Cross and Blue Shield introduces Cancer Care Quality Program

Effective Jan. 1, 2015, Anthem® Blue Cross and Blue Shield implemented a Cancer Care Quality Program administered through AIM Specialty HealthSM (AIM). This new program is targeted for national and local groups and is designed to provide services for Anthem members the provider is treating to help address the variations in cancer care delivery. This program is not applicable to other Blue Plan members.

This innovative quality initiative is an evidence-based cancer treatment program designed to support provider decision making as it relates to selecting cancer treatment regimens that are consistent with current evidence and consensus guidelines. These Cancer Treatment Pathways have been developed based on medical evidence and best practices from leading cancer experts to support oncologists to identify therapies that are highly effective and affordable for Anthem’s Blue members.

Although providers are not required to choose a Pathway regimen, oncology claims submitted for services rendered will be adjudicated according to the terms of the Anthem members’ benefit plan. Claim information collected may help identify members for Anthem’s Case Management programs which may result in maximizing the impact to the patients’ overall health.

Additional information about this program can be found on AIM’s website.
New effective date for sleep study medical policy updates

In the January issue of Blue Review, we included an article titled, “Diagnosis and Medical Management of Sleep Related Breathing Disorders,” announcing medical policy revisions that will be effective for dates of service beginning April 15, 2015. **The new effective date for this medical policy change is now extended to May 1, 2015.**

This article addressed recent revisions to the BCBSTX Medical Policy (MED205.001), Diagnosis and Medical Management of Sleep Related Breathing Disorders. These revisions align our Medical Policy with nationally recognized clinical criteria and current industry standards.

The revised policy establishes the medically appropriate utilization of home sleep apnea testing and polysomnography (PSG) in the diagnosis of Obstructive Sleep Apnea (OSA). For services rendered on or after this date, PSG and facility based sleep study tests related to OSA and this medical policy will be subject to medical necessity review under the new Medical Policy criteria.

Providers are encouraged to obtain a medical necessity determination prior to services being rendered by submitting a Predetermination Request Form. Access to this form can be obtained by visiting the Education & Reference/Forms of the BCBSTX provider website. Please follow the directions on the form for completion and submission.

To review the full medical policy, important details and general medical necessity criteria for OSA testing and treatment, visit Standards and Requirements/Medical Policies page on our website.

*The BCBSTX Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient’s health care needs. Some benefit plans administered by BCBSTX, such as some self-funded employer plans or governmental plans, may not utilize BCBSTX Medical Policy. Members should contact their local customer services representative for specific coverage information.*

HEDIS® annual data collection reminder

In the October 2014 Blue Review, Blue Cross and Blue Shield of Texas (BCBSTX) provided an overview of the Healthcare Effectiveness Data and Information Set (HEDIS) and the annual data collection process.
As a reminder, BCBSTX will begin contacting physician offices and facilities over the next few months in preparation for the collection of annual HEDIS data.

In an effort to decrease interruption of the day-to-day functions of your office, BCBSTX offers alternative methods of medical record collection in place of on-site visits, such as the option to fax requested medical records to BCBSTX or to send electronic medical records to us via secure email. The annual HEDIS data collection process includes the following:

- A nurse from BCBSTX will be contacting your office to obtain key contact information and confirm your preferred data collection method (fax, secure email or on-site visit).

- Appointments for on-site visits also may be scheduled with your staff.

- You will receive a letter or fax from BCBSTX outlining the information that is being requested, including a list with members’ names and the identified measures that will be reviewed. Please send medical records only upon request and only for the members listed in the letter from BCBSTX. A timely response – within 5 business days – is requested.

All data collected from medical records are protected by the Health Information Portability and Accountability Act (HIPAA) of 1996. The HIPAA Privacy Rule (CFR 160, 164) allows the collection and release of HEDIS data without patient consent or authorization.

If you have questions regarding on-site nurse visits, alternative means of data collection or requests for medical records, please contact Shival McNabb, FEP Hedis Coordinator, at 972-766-7396.

HEDIS is a registered trademark of NCQA.

**Legislative update: Expedited formulary exception process for urgent circumstances**

On May 27, 2014, the Department of Health and Human Services issued a final regulation entitled, Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond.

Beginning with coverage years on or after Jan. 1, 2015, issuers providing essential health benefits must provide consumers with an expedited formulary exception process for urgent circumstances that exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

After receiving a request from an enrollee or the prescribing physician, a health plan issuer must make its coverage determination on these expedited reviews and notify the enrollee or the prescribing physician of its coverage determination no later than 24 hours after it receives the request. A health plan that grants an exception based on urgent
circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

For additional information, we encourage you to refer to the final rule.

BCBSTX is committed to achieving full compliance by reviewing and responding to formulary exception requests within the timeframes according to the law.

The information provided above is only intended to be a brief summary of legislation that has been proposed or laws that have been enacted and is not an exhaustive description of the law or a legal opinion of such law. This material is for informational purposes only and is not legal advice. If you have any questions regarding this legislation, you should consult with your legal advisor.

Diagnosis and medical management of sleep-related breathing disorders

Updates have been made to the Blue Cross and Blue Shield of Texas (BCBSTX) Diagnosis and Medical Management of Sleep Related Breathing Disorders Medical Policy (MED205.001). The changes below will be effective for dates of service beginning April 15, 2015.

The policy coverage was revised to indicate that for adult patients with symptoms suggestive of Obstructive Sleep Apnea (OSA) and without significant co-morbidities, home sleep studies may be considered medically necessary.

Facility/laboratory polysomnography (PSG) is considered not medically necessary when the criteria for unattended home sleep studies are met. The use of an abbreviated daytime sleep study as a supplement to standard sleep studies, Positive Airway Pressure-Negative Airway Pressure (PAP-NAP), is considered experimental, investigational and/or unproven.

The BCBSTX Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient’s health care needs. Some benefit plans administered by BCBSTX, such as some self-funded employer plans or governmental plans, may not utilize BCBSTX Medical Policy. Members should contact their local customer services representative for specific coverage information.

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>
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<tbody>
<tr>
<td>Blue Choice Bronze PPO 005</td>
<td>Blue Advantage Bronze HMO 005</td>
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<tr>
<td>Blue Choice Bronze PPO 006</td>
<td>Blue Advantage Bronze HMO 006</td>
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<tr>
<td>Blue Choice Gold PPO 001</td>
<td>Blue Advantage Gold HMO 001</td>
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<tr>
<td>Blue Choice Gold PPO 002</td>
<td>Blue Advantage Gold HMO 002</td>
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<td>Blue Choice Gold PPO 011</td>
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<td>Blue Cross Blue Shield Basic 5, a Multi-State Plan</td>
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<td>Blue Cross Blue Shield Premier 1, a Multi-State Plan</td>
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<td>Blue Cross Blue Shield Premier 2, a Multi-State Plan</td>
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<td>Blue Cross Blue Shield Solution 3, a Multi-State Plan</td>
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<td>Blue Cross Blue Shield Solution 4, a Multi-State Plan</td>
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<tr>
<td>Blue Security Choice PPO 010</td>
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If you have questions, please contact the BCBSTX Provider Relations department.
After-hours access is required
Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians and specialty care physicians and professional providers provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. They must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

Acceptable after-hours access mechanisms may include:
- An answering service that offers to call or page the physician or on-call physician;
- A recorded message that directs the patient to call the answering service and the phone number is provided; or
- A recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.

For more detail, please refer to the provider manuals for Blue Choice PPOSM Physician and Professional Provider (Section B) and HMO Blue TexasSM / Blue Advantage HMOSM 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

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

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

To obtain a Blue Choice PPO, Blue Advantage HMO and HMO Blue Texas RQI, log in to AIM’s provider portal at [aimspecialtyhealth.com](http://aimspecialtyhealth.com) and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive a RQI. 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 “RQI.”

**Notes:**
1. 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.

2. Facilities cannot obtain a RQI from AIM on behalf of the ordering physician.

3. The RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX 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, 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](http://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 2015 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: [bcbstx.com/provider/pharmacy/index.html](http://bcbstx.com/provider/pharmacy/index.html) and click on the Preferred Drug Guide offering in the left-side navigation list.

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

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

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

If your specialty, practice information/status or board certification is not correct on the BCBSTX Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the Other field or contact your Provider Relations office.

Blue Review is published for Blue Choice PPOSM, HMO Blue TexasSM, Blue Cross Medicare Advantage (PPO)SM, Blue Advantage HMO™ and ParPlan contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; email BlueReviewEditor@bcbstx.com.

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

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