System edit for self-administered specialty drugs billed on professional/ancillary (837P and CMS-1500) claims

For medications approved by the U.S. Food and Drug Administration (FDA) for self-administration, Blue Cross and Blue Shield of Texas (BCBSTX) members are required to use their pharmacy benefit and acquire self-administered drugs (oral, topical and injectable) through a pharmacy provider. Self-administered drugs must be billed under the member’s pharmacy benefit for your patients to receive coverage.

If services are submitted on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500) claims for drugs that are FDA-approved for self-administration and covered under the member’s prescription drug benefit, BCBSTX will notify the provider that these claims need to be re-filed through the member’s pharmacy benefit. In this situation, the following message will be returned on the electronic payment summary or provider claim summary:

“Self-administered drugs submitted by a medical professional provider are not within the member’s medical benefits. These charges must be billed and submitted by a pharmacy provider.”

To help you determine the correct path for medication fulfillment and ensure that the correct benefit is applied, please refer to the Pharmacy Program/Specialty Drug Programs section of the BCBSTX provider website at bcbstx.com/provider.

Note: The member’s benefits may require the use of a preferred specialty pharmacy to receive in-network benefits. Please call the number on the member’s ID card to verify coverage restrictions. For members whose benefits require them to use Prime Therapeutics Specialty Pharmacy, you may fax the prescription to 877-828-3939 or call 877-627-MEDS (877-627-6337) for additional information. Medication(s) can be delivered to any requested location (e.g., member’s home or physician’s office).

Pharmacy benefits and limits are subject to the terms set forth in the member’s certificate of coverage, which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions.

Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy) is a wholly owned subsidiary of Prime Therapeutics LLC a pharmacy benefit management company. Prime Therapeutics LLC is a partially owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent...
licensee of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of Texas is a Division of HCSC, which contracts with Prime Therapeutics LLC to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services.

**Enhancements to ClaimsXten™ code auditing tool**

Blue Cross and Blue Shield of Texas (BCBSTX) will enhance the ClaimsXten code auditing tool by adding the new 2013 CPT/HCPCS codes and additional bundling logic into its claim processing system beginning on or after May 6, 2013.

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 will result in improved performance of overall claims management.

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

For updates on the ClaimsXten implementation and other BCBSTX news, programs and initiatives, refer to the BCBSTX provider website at bcbstx.com/provider. Additional information also may be included in upcoming issues of *Blue Review*.

Verification of 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 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.*

**Take advantage of electronic options for faster, more convenient payments**

The electronic options offered by Blue Cross and Blue Shield of Texas (BCBSTX) can make it easier to do business with us. Your office workflow is streamlined when you opt to receive claim payments, remittance information and payment summaries online.

**Electronic Funds Transfer (EFT)**

When you enroll in EFT, your claim payments from BCBSTX are deposited directly into the bank account of your choice. Providers currently enrolled in EFT have noted many advantages, including:

- Easy and convenient payments
- Greater security against potential fraud – no lost or stolen checks
- Funds may be available sooner than with paper checks
- Less paper handling
Electronic Remittance Advice (ERA)
The ERA is a HIPAA-compliant electronic file that contains claim payments, claim adjustments and remittance data (e.g., claims that were paid, payment amounts, status of processed claims). The purpose of the ERA is to enable automated posting of your patient accounts. Also known as the ANSI 835 transaction, the ERA works in conjunction with practice management software packages that can accommodate the 835 file.

Using ERA can help increase office efficiencies by:
- Streamlining administration
- Eliminating the need for manual posting
- Increasing security of your patient’s protected health information

Please contact your software vendor, billing service or clearinghouse to make sure they are aware of your electronic preferences. Although BCBSTX does not charge a fee to provide the ERA/EPS files, your authorized agent, billing service, clearinghouse or other vendor may charge a fee for the services they provide to you. Your vendor may require that they receive the ERA on your behalf if they have the ERA component integrated in their software.

Note: You or your authorized billing agent (billing service or clearinghouse) must be registered with Availity® to enroll for ERA. For more information on Availity, visit availity.com or contact 800-AVAILITY (800-822-4548) for assistance.

Electronic Payment Summary (EPS)
The companion to the ERA is the EPS, which is the electronic version of the paper Provider Claim Summary (PCS). The EPS is delivered in conjunction with your ERA, so you receive payment information in your office the day after the claim is finalized, depending on your payment cycle.

If you have designated a billing agent (billing service or clearinghouse) as the receiver for your EPS, you should check with your receiver/vendor/clearinghouse to determine whether or not special software (such as Adobe Acrobat) may be needed to view the EPS file, once your vendor posts the file or delivers it to you.

If you currently receive the ERA, we recommend that you also use the EPS when reconciling your BCBSTX payments. The EPS cannot be used for automatic posting, however, and is only available in combination with the ERA.

For more detailed information, such as enrollment forms, answers to frequently asked questions and an Electronic Options Tutorial, visit the Claims and Eligibility/Electronic Commerce section of our provider website at bcbstx.com/provider. You may also call the Electronic Commerce Center at 800-746-4614 for assistance.

Availity is a registered trademark of Availity, LLC. Availity is a partially owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association. Availity operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to Blue Cross and Blue Shield of Texas (BCBSTX), a Division of HCSC. Availity is solely responsible for the products and services it provides.
Training to prepare for the conversion to ICD-10

We’re just six months away from the Centers for Medicare & Medicaid Services (CMS) recommended deadline for providers to begin internal system testing for ICD-10. At this point, you should have a plan in place to train all staff impacted by the changes from ICD-10.

Key Elements of Training

Here are some questions to consider for your ICD-10 training plan:

- Have you budgeted for the necessary and required training?
- Have you identified which staff members will need training?
- Will you need to hire temporary personnel for staff who are in training?
- Have you decided which type of training is best for your staff: in-person, online or a combination?
- Have you identified and hired qualified coding instructors?
- Have you addressed and identified resources to maintain productivity during the learning curve?

There are a number of organizations and commercial resources to assist providers with a training plan. One group, the American Association of Professional Coders (AAPC), recommends a five-phase approach to training for ICD-10. AAPC suggests coding staff begin with a review of anatomy and physiology, since the ICD-10 CM code set is considerably more granular than ICD-9 and will require more familiarity with these subjects.

Identification and implementation of ICD-10 training plans will involve multiple aspects of your practice. The ICD-10 section of our provider website contains a map illustrating some of ICD-10’s potential impact around your office, which you can find in the Standards and Requirements section of the Blue Cross and Blue Shield of Texas (BCBSTX) provider website, bcbstx.com/provider.

Additional Resources

The ICD-10 page in the Standards and Requirements section of our website includes additional information along with links to ICD-10 training plan resources, such as:

- **ICD-10 Playbook**: The Healthcare Information and Management Systems Society’s (HIMSS) ICD-10 Playbook can be used as a reference to help develop a project plan that includes training in preparation for the transition to ICD-10.

- **ICD-10-CM/PCS Transition: Planning and Preparation Checklist**: The American Health Information Management Association’s (AHIMA) checklist describes some of the ICD-10 knowledge required for specific roles in an organization, and identifies user groups who may need education and training.

All trademarks are property of their respective companies. All companies listed here are independent third party entities and are solely responsible for the services they provide. The mention of a specific vendor is not an endorsement by BCBSTX, and BCBSTX makes no representations or endorsements regarding any of the vendors listed here.
**Note:** This material is provided for informational purposes only and is not an endorsement of any particular site or resource. The owners/operators of each website are solely responsible for the content on their respective websites.

**Notices and Announcements**

**Category I CPT codes for care coordination services**
Blue Cross and Blue Shield of Texas (BCBSTX) recognizes the following Category I CPT® codes for billing care coordination services: 99487, 99488 and 99489. BCBSTX reimbursement will be subject to the maximum benefit limit specified in the member’s benefit plan.

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

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

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

Below are answers to frequently asked questions regarding Blue Advantage HMO.

Please feel free to contact your local Provider Relations office if you have any further questions regarding Blue Advantage HMO.

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

**Q: If I choose not to participate in Blue Advantage HMO, will this affect my participation in other BCBSTX provider networks?**
A: No. Participation in Blue Advantage HMO is optional. Accepting or declining the invitation in no way impacts a provider’s participation in any other BCBSTX networks.

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

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

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

Q: **Who are the target markets for BCBSTX’s Blue Advantage HMO network?**
A: **Employees/Individuals**
- Employees who cannot afford their employer sponsored plans for themselves and/or their dependents
- Employees whose employers are not offering an employer-sponsored plan
- Employees of small businesses
- Individuals

  **Employers**
- Small businesses with 2-50 employees

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

Q: **How can I learn more about this program?**
A: Please contact your local Provider Relations office.
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 other 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 BlueChoice® Physician and Other Professional Provider Manual (Section B) and the HMO Blue® Texas Physician and Other Professional Provider Manual (Section B), available on the BCBSTX 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:

![logo](image)

The “MA” in the suitcase indicates a member who is covered under the BCBS MA PPO network sharing program. BCBS MA PPO Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID card.

Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?

If you are a contracted BCBS MA PPO provider with BCBSTX, you should provide the same access to care as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local BCBS MA PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

How do I verify benefits and eligibility?

Call BlueCard Eligibility at 800-676-BLUE (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 Availity, or RealMed or your preferred vendor
- Enter required data elements
- Submit your request

Where do I submit the claim?

You should submit the claim to BCBSTX under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.
What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?
If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

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

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

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

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

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

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

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

Thank you for your cooperation!

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

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

**Surgical procedures performed in the physician’s office**
When performing surgical procedures in a non-facility setting, the physician and other professional provider reimbursement is all-inclusive.

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

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

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

To obtain a BlueChoice RQI number 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 number 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 number or Preauthorization from AIM on behalf of the ordering physician. Also, the RQI and Preauthorization program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS or HMO coverage are included in the program.

AIM Specialty Healthy (AIM) is an operating subsidiary of WellPoint, Inc.
**Quest Diagnostics, Inc., is the exclusive HMO and preferred statewide PPO/POS clinical reference lab provider**

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

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

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

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

* **Note:** Physicians & other professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians & professional providers who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.

**Fee schedule updates**

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

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. Also, the Drug/Injectable Fee Schedule will be updated on June 1 in 2013.
Improvements to the medical records process for BlueCard® claims
BCBSTX is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.

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

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

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

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

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

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

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

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

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

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

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

**Medical policy disclosure**
New or revised medical policies, when approved, will be posted on the BCBSTX provider website 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 [bcbtx.com/provider](http://bcbtx.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 [bcbtx.com/provider](http://bcbtx.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 other professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from AIM Specialty Health need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

Predetermination does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.
**Importance of obtaining preauthorizations for initial stay and add-on days**
Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and other professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or other professional provider obtains preauthorizations for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

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

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

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

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

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

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

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

In no event shall a contracted physician or other professional provider collect payment from the subscriber for identified hospital acquired conditions and/or never events.
Dispensing QVT (quantity versus time) limits
To help minimize health risks and to improve the quality of pharmaceutical care, dispensing QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer’s package insert.

Visit the BCBSTX provider website at bcbstx.com/provider to access the 2013 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 2013 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 its customers through the provision of health care coverage and related benefit services. Our mission calls for us to respond to our customers with promptness, sensitivity, respect and dignity.

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

This topic has been addressed in the Blue Review provider newsletter and in previous BCBSTX employee communications as a requirement of our Utilization Review Accreditation Commission accreditation. This serves as a reminder for all physicians and other professional providers in the BCBSTX provider networks, e.g. BlueChoice PPO/POS, HMO Blue Texas, Blue Medicare Advantage and ParPlan.

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

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

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

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