March 2015

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BCBSTX joins Texas Medical Association to create unique opportunity for physicians to remain independent

The Texas Medical Association (TMA) and Blue Cross and Blue Shield of Texas (BCBSTX) are launching TMA PracticeEdge, LLC, to help empower a strong base of independent physicians to provide quality, cost-effective care to their patients. This first-of-its-kind joint effort leverages the strengths of TMA’s statewide physician membership and BCBSTX’s resources to benefit the entire Texas health care community, including patients, hospitals, payers, and other physicians.

TMA’s membership includes more than 48,000 Texas physicians and medical students. BCBSTX serves more than 5 million members in all 254 Texas counties.

TMA PracticeEdge will offer physicians access to enhanced patient care tools and resources so they can better provide cost-effective, patient care. Physicians working with TMA PracticeEdge will be able to take advantage of the opportunities available in the rapidly changing health care marketplace.

TMA and BCBSTX share the goals of increased quality and cost-effective care found in existing physician-led accountable care organizations (ACOs). TMA PracticeEdge similarly will provide tools to reduce physicians’ growing data-entry burden to allow them to focus on taking care of their patients. The goal is to establish a system that pays physicians and providers based on the quality of patient outcomes and patient care.

While most ACOs are constrained by a specific hospital system, TMA PracticeEdge will help connect physicians centered on the needs of their specific patients. TMA PracticeEdge will offer participating physicians the means to provide coordinated collaborative care, including prevention and management of chronic disease.

According to the 2014 TMA Survey of Texas Physicians, approximately two-thirds of Texas physicians work for themselves or in practices that are wholly owned and controlled by other physicians. Most of these independent physicians traditionally have not had access to the tools and resources needed to participate in an ACO.

“BCBSTX will work with TMA to give physicians alternatives to today’s fee-for-service system,” said TMA President Austin I. King, MD. “With today’s announcement, BCBSTX becomes the first health insurer to stand by independent Texas physicians in support of 21st century patient care.”

“This represents a significant investment in our relationship with the TMA and Texas physicians, and will benefit our members, who value their relationships with their
independent physicians,” said Bert Marshall, President of Blue Cross and Blue Shield of Texas.

TMA PracticeEdge will help physicians lead health care innovation in today’s evolving marketplace. PracticeEdge will offer participating physicians several services, including:

- Consultations to help reduce administrative burdens so they can spend more time focusing on patient care.
- Help for practices wishing to create care management teams to better serve patients with complex or chronic health problems.

Physicians and office managers who are interested in learning more about TMA PracticeEdge should contact TMAPracticeEdge@texmed.org by email.

**Tobacco cessation: Coverage expanded to include approved medications**

Tobacco cessation counseling and screening for adult members who use tobacco products are covered benefits under the Affordable Care Act (ACA). As of Sept. 1, 2014, Blue Cross and Blue Shield of Texas (BCBSTX) expanded coverage for eligible members to include two 90-day treatments for tobacco cessation medications per benefit period with no cost sharing.

This coverage includes certain U.S. Food and Drug Administration (FDA) approved tobacco cessation drugs. In order for benefits to be considered for coverage, the patient must present a prescription from an in-network provider according to the member’s benefit plan. A prescription also is required for approved over-the-counter drugs.

A new flier is available to help educate our members about tobacco cessation preventive services under ACA. If you are interested in viewing or sharing this flier with your patients who use tobacco products, go to the BCBSTX provider website and visit the Standards and Requirements/Affordable Care Act/Patient Perspective section.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

**Diagnosis, medical management of sleep-related breathing disorders – revised medical policy reminder**

Recently, we announced a change to the Blue Cross and Blue Shield of Texas (BCBSTX) Medical Policy for Diagnosis and Medical Management of Sleep Related Breathing Disorders (MED205.001) that will take effect for services rendered on or after May 1, 2015. This policy has been revised to establish new criteria and guidance for testing in the diagnosis of Obstructive Sleep Apnea (OSA). The revised policy is intended to align BCBSTX’s Medical Policy with nationally recognized clinical criteria and current industry standards.

The revised policy establishes the criteria for when utilization of unsupervised home sleep apnea tests and supervised polysomnography (PSG) in the diagnosis of OSA will be considered medically necessary under the terms of the member’s benefit plan. For
adult patients with symptoms suggestive of OSA and without significant comorbidities, unsupervised home sleep apnea tests may be considered medically necessary. **PSG administered in a facility or lab will not be considered medically necessary for these patients unless one or more of the following criteria are met:**

- A previous home study was found to be technically inadequate.
- A previous home study failed to establish the diagnosis of OSA in a patient with a high pretest probability of OSA.
- A home study is contraindicated due to co-morbid health conditions that may decrease the accuracy of the study, including but not limited to, moderate to severe pulmonary disease, neuromuscular disease, congestive heart failure or hypo-ventilation syndrome.

PSG and facility-based sleep study tests related to OSA and this medical policy will be subject to medical necessity review under the revised BCBSTX Medical Policy criteria for services rendered on or after May 1, 2015. You are encouraged to obtain a medical necessity determination prior to services being rendered by submitting a benefit Predetermination Request Form. This form is available in the Education and Reference/Forms section of our website at bcbstx.com/provider.

To view the revised BCBSTX Medical Policy for Diagnosis and Medical Management of Sleep Related Breathing Disorders, visit the Standards and Requirements/Medical Policy section of our Provider website and look for the Pending Policies link. Pending policies are listed alphabetically – select the title of the policy you wish to view to open the document.

*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 government plans, may not utilize BCBSTX Medical Policy. Members should contact their local customer service representative for specific coverage information.*

**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 our 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 our 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 the Blue Review.

Reminder: ClaimsXten to Add Correct Coding Initiative Rule
The following reminder includes information from an announcement that was posted in the News and Updates on our provider website in December 2014; this information also appeared in our January 2015 provider newsletter.

Beginning on or after March 23, 2015, BCBSTX will enhance the ClaimsXten code auditing tool by adding the CMS Correct Coding Initiative Rule into our claim processing system. The purpose of this new rule is to identify claims containing code pairs found to be unbundled according to the CMS NCCI. The CMS NCCI coding policies are based on coding conventions defined in the American Medical Association (AMA) CPT manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice and/or current coding practice.

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

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NOTICES AND ANNOUNCEMENTS

Diagnostic imaging management program change notice
Blue Advantage HMO℠ and Blue Cross Medicare Advantage PPO℠
Effective April 1, 2015, Blue Cross and Blue Shield of Texas will no longer require physicians and professional providers to obtain a Radiology Quality Initiative (RQI) number for all high-tech outpatient diagnostic MRI/MRA scans, CT/CTA scans, PET scans and SPECT/Nuclear Cardiology studies from the vendor AIM Specialty Health® (AIM) for Blue Advantage HMO℠ members and Blue Cross Medicare Advantage PPO℠ members.

HMO Blue Texas℠ and Blue Choice PPO℠
All high-tech outpatient diagnostic MRI/MRA scans, CT/CTA scans, PET scans and SPECT/Nuclear Cardiology studies scheduled on or after April 1, 2015 for HMO Blue Texas℠ members and Blue Choice PPO℠ members will continue to require a RQI number by contacting AIM by logging into the AIM provider portal at aimspecialtyhealth.com or by calling AIM at 1-800-859-5299.

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.

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.

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

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

- Blue Advantage HMO℠
- Blue Choice PPO℠

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

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

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Blue Choice Silver PPO 024 | Blue Advantage Silver HMO 003
Blue Choice Silver PPO 025 | Blue Advantage Silver HMO 004
Blue Choice Silver PPO 027 | Blue Advantage Silver HMO 018
Blue Choice Silver PPO 028 | Blue Advantage Silver HMO 020
Blue Choice Silver PPO 029 | Blue Advantage Silver HMO 021
Blue Cross Blue Shield Basic 5, a Multi-State Plan
Blue Cross Blue Shield Premier 1, a Multi-State Plan
Blue Cross Blue Shield Premier 2, a Multi-State Plan
Blue Cross Blue Shield Solution 3, a Multi-State Plan
Blue Cross Blue Shield Solution 4, a Multi-State Plan
Blue Security Choice PPO 010

If you have questions, please contact your Network Management 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 professional providers provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. They must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

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

For more detail, please refer to the provider manuals for **Blue Choice PPO**Physician and Professional Provider (Section B) and **HMO Blue Texas** / **Blue Advantage HMO** Physician and Professional Provider (Section B) available on our provider website at [bcbstx.com/provider](http://bcbstx.com/provider). Click on the "Education & Reference" tab, then click on "Manuals" and enter the password.
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:

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 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 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 TexasSM 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 freestanding ambulatory surgery centers).

**Quest Diagnostics Offers:**
- On-line scheduling for Quest Diagnostics’ Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto QuestDiagnostics.com/patient 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 to access the 2015 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 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 Network Management office.

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

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

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