National Drug Code (NDC) reminders for professional/ancillary claims

When drugs are billed under the medical benefit on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims, it is important to include NDCs and related data. Using NDCs on medical claims facilitates more accurate payment and better management of drug costs based on what was dispensed.

As a reminder, when submitting NDCs on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims to Blue Cross and Blue Shield of Texas (BCBSTX), you must also include the following related information:

- The applicable Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code
- Number of HCPCS/CPT units
- NDC qualifier (N4)
- NDC unit of measure (UN – Unit, ML – Milliliter, GR – Gram, F2 – International Unit)
- Number of NDC units (up to three decimal places)
- Your billable charge/price per unit

Attention electronic claim submitters: If you have converted to ANSI 5010, there should be no additional software requirements when NDCs are included on electronic claims. However, please verify with your software vendor to confirm that your Practice Management System accepts and transmits the NDC data fields appropriately. If you use a billing service or clearinghouse to submit electronic claims on your behalf, please check with them to ensure that NDC data is not manipulated or dropped inadvertently.

For additional information to assist you with using NDCs on medical claims, please refer to the Billing with National Drug Codes (NDC) information in the Claims and Eligibility/Submitting Claims section of the BCBSTX provider website at bcbstx.com/provider. You will also find other NDC-related resources on the website, such as answers to Frequently Asked Questions.

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Ready or not? Here comes ICD-10

We may wish it was a game of hide-and-seek, but the transition to ICD-10 is serious business. The U.S. Department of Health and Human Services (HHS), which has mandated the transition to ICD-10, has stated that there will be no more delays and no grace period. On Oct. 1, 2014, health care entities covered by HIPAA will be required to replace ICD-9 codes with ICD-10 codes.

As we have discussed in previous Blue Review articles, the transition requires careful long-term planning. The consequences of inadequate preparation may be costly. For example, claims submitted with ICD-9 codes for dates of service on or after Oct. 1, 2014, will be rejected.

While the transition will require considerable work, there will be a light at the end of the tunnel for the industry. ICD-10 codes are expected to have a net positive impact on the health care industry¹. Here are some of the anticipated benefits of ICD-10:

- Better identification of patient diagnoses
- Greater accuracy of data submitted on claims, resulting in greater accuracy in claims reimbursement
- Improved health care data for quality assurance measures and medical research initiatives
- Global coordination of health-related issues, including disease outbreaks and epidemics, as the U.S. joins the majority of developed nations in adopting ICD-10

Regardless of the potential costs and anticipated benefits, one thing is certain: The Oct. 1, 2014, ICD-10 transition deadline is final and there will be no turning back. With adequate planning, however, you can be prepared to make the transition with confidence – without jeopardizing claim payments or staff productivity.

Get game ready. Visit the ICD-10 page in the Standards and Requirements section of our Provider website at bcbstx.com/provider to find planning materials, frequently asked questions and our readiness survey, which can help you assess your preparedness for the transition to ICD-10.


Self-administered specialty drug reminder: Hemophilia drugs

In last month’s Blue Review, we included a reminder that Blue Cross and Blue Shield of Texas (BCBSTX) members are required to use their pharmacy benefit for U.S. FDA-approved self-administered specialty drugs (oral, topical and injectable) and obtain these medications through a pharmacy provider that is contracted to provide specialty pharmacy services.

Self-administered drugs should not be submitted on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500) claims. In addition, effective July 1, 2013, the following message will be returned on the electronic payment summary or provider claim summary to providers billing for self-administered drugs, including self-administered drugs for hemophilia: “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.”

Sample List of Hemophilia Brand Name Drugs*
*Trademarks mentioned above are the property of their respective owners.

<table>
<thead>
<tr>
<th>Brand Name Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advate</td>
</tr>
<tr>
<td>Alphanate</td>
</tr>
<tr>
<td>Alphanate/Von Willebrand</td>
</tr>
<tr>
<td>Factor Complex/Human</td>
</tr>
<tr>
<td>Alphanine SD</td>
</tr>
<tr>
<td>Bebulin</td>
</tr>
<tr>
<td>Bebulin VH</td>
</tr>
<tr>
<td>Benefix</td>
</tr>
<tr>
<td>Feiba NF</td>
</tr>
<tr>
<td>Feiba VH Immuno</td>
</tr>
<tr>
<td>Helixate FS</td>
</tr>
<tr>
<td>Hemofil M</td>
</tr>
<tr>
<td>Humate-P</td>
</tr>
<tr>
<td>Koate-DVI</td>
</tr>
<tr>
<td>Kogenate FS</td>
</tr>
<tr>
<td>Kogenate FS Bio-Set</td>
</tr>
<tr>
<td>Monoclate-P</td>
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<tr>
<td>Mononine</td>
</tr>
<tr>
<td>Novoseven</td>
</tr>
<tr>
<td>Novoseven RT</td>
</tr>
<tr>
<td>Profilnine SD</td>
</tr>
<tr>
<td>Recombinate</td>
</tr>
<tr>
<td>Refacto</td>
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<tr>
<td>Xyntha</td>
</tr>
</tbody>
</table>

Please note: This list is subject to change from time to time.

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

Note: In accordance with their benefits, members may be required to use a preferred specialty pharmacy. Please call the number on the member’s ID card to verify coverage or for further assistance or clarification on the member’s benefits. For member’s 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. BCBSTX is a Division of HCSC, which contracts with Prime Therapeutics LLC to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services.

**Be Smart. Be Well.®: Addressing addictions**

According to the National Institute on Drug Abuse (NIDA), more than 20 million Americans have a drug or alcohol problem. BeSmartBeWell.com features addiction as its newest topic. The site may be helpful to your patients facing addiction problems themselves, or with someone they know. Real-life stories are shared to help inspire individuals to make positive changes in their lives.

**Be Smart. Be Well.** information on addiction includes:

- A discussion and interviews with leading health experts about the science of addictions
- The importance of treating it as a disease
- A quiz to test general knowledge of addiction
- Guidance for those affected by a loved one addicted to drugs or alcohol
- Links to helpful related resources

**Be Smart. Be Well.** is a free health and wellness resource available to Blue Cross and Blue Shield of Texas (BCBSTX) members and the general public. In addition to information on addiction, the website features a variety of other topics, including traumatic brain injuries, food safety, teen driving, childhood obesity, domestic violence, mental health and childhood asthma. Please feel free to refer your patients to BeSmartBeWell.com for valuable health and wellness information. You and your patients can also sign up for the bimonthly *Spotlight Newsletter* and biweekly *News Alerts* for in-depth articles and breaking news on important health and wellness topics.

These programs are for informational purposes only, and are not a substitute for the sound medical judgment of a doctor. Members are encouraged to talk to their doctor if they have any questions or concerns regarding their health.

**Forging alliances to improve the health of Texas communities**

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to promoting wellness initiatives throughout our state by collaborating with health care institutions and community groups. Our 2012 Social Responsibility Report website features stories and videos that highlight our engagement in the communities where our employees,
providers and members live and work.

In 2012, BCBSTX awarded $4.6 million in contributions, grants and scholarships to more than 350 Texas organizations focused on promoting health and wellness, reaching out to disadvantaged Texas children and providing support to underserved/underinsured Texans.

We collaborated with 37 non-profit community partners as part of the Healthy Kids, Healthy Families initiative to improve the health status of at least 1 million children. This initiative focuses on four key areas: nutrition education, promoting physical activity, preventing and managing disease and supporting safe environments.

We support the Caring for Children Foundation of Texas, whose Care Van® Program operates a fleet of 10 vans to serve uninsured families across Texas. This year, the Foundation’s Care Van® Program celebrated a major milestone: it gave its one-millionth free immunization since the program began in 1997. The program screened/immunized 66,152 children and provided 79,848 immunizations in 2012 alone. The foundation also offered preventive dental services for children in various Texas cities, with free dental screenings and sealants to 27,792 pre-school and elementary school age children.

You can review our 2012 Social Responsibility Report available at bcbstx2012srr.com. From the public at large to our members in your practice, BCBSTX will continue to promote health and wellness initiatives in our community.

The real costs of prescription coupons
The use of promotional discount cards and copayment coupons for prescriptions has tripled in the last five years, according to health research firm IMS Health.¹ Consumers may obtain coupons from manufacturer websites, drug ads and providers.

What’s wrong with saving money?
Drug discount cards and coupons definitely offer short-term savings for consumers; however, they can contribute to increased health care costs in the long run.

How do coupons add to health care costs?
According to the Pharmaceutical Care Management Association (PCMA), a national association of pharmacy benefit managers, some drug coupons are marketing tools that can encourage using brand name drugs instead of generics.

Under a typical pharmacy benefit, patients pay a copayment or coinsurance for every prescription. The remaining cost of the prescription is typically covered by the member’s benefit plan. With a manufacturer’s coupon, the member pays a discounted price for a brand name drug. The manufacturer pays a small portion (typically making up the difference between the discounted price and the member’s copay). The member’s benefit plan still pays the bulk of the cost for the prescription.

By incentivizing members to use brand name drugs, manufacturer coupons shift the focus away from cost-effective solutions (e.g., generic drugs) that our members may likely have chosen. PCMA has projected that the additional costs behind drug coupons
will add up to $32 billion in the next decade. Consumers unaware of hidden and potential costs may not realize that using drug coupons now may lead to higher health insurance premiums in the future.

How can you help?
Our members look to you for care and guidance when making decisions about their health care. We encourage you to help increase patient awareness about the real costs of prescription coupons. You can help by promoting the use of generic medications as first-line therapy, whenever appropriate.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. 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. Regardless of benefits, the final decision about any medication is between the member and their health care provider.


Medicare Part D formulary updates
A summary of recent Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Part D formulary changes can be found below. The Blue MedicareRx formulary is updated monthly by our pharmacy provider, Prime Therapeutics.

For a complete formulary listing and for future inquiries regarding prior authorizations, step therapy, coverage determinations/RE-determinations, transition plan benefits, and appointment of representative for your BCBSTX members, please follow the following instructions:

Utilize the following link (https://www.myprime.com) to access the Prime Therapeutics’ Medicare Part D member website:
  a) Click on ‘Find Drugs & Estimates’,
  b) Follow directions to
      • ‘Select your Health Plan’ click on ‘BCBS Texas’,
      • Medicare Part D Member?’ Click ‘YES’,
      • ‘Select Your Health plan type’ Click ‘Blue MedicareRx’
  c) From this page you will be able to determine the formulary status and applicable utilization management programs for individual drugs or access any of the important databases outlined above.

<table>
<thead>
<tr>
<th>TRADE NAME (generic name)</th>
<th>Brand/Generic Product</th>
<th>Effective Date</th>
<th>Description of Change</th>
<th>Comments</th>
</tr>
</thead>
</table>

Blue Review, May 2013
<table>
<thead>
<tr>
<th>Trade Name (Generic Name)</th>
<th>Brand/Generic Product</th>
<th>Effective Date</th>
<th>Description of Change</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>abacavir tabs, 300 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for ZIAGEN.</td>
</tr>
<tr>
<td>ANDROGEL (testosterone) gel packet, 1.62%</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 3. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>BACITRACIN ophth oint, 500 units/g</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 4.</td>
</tr>
<tr>
<td>BOSULIF (bosutinib) tabs, 100 mg, 500 mg</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 5. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>calcipotriene cream, 0.005%</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. First generic for DOVONEX cream.</td>
</tr>
<tr>
<td>candesartan/hydrochlorothiazide tabs, 16-12.5 mg, 32-12.5 mg, 32-25 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for ATACAND HCT.</td>
</tr>
<tr>
<td>cidofovir IV inj, 75 mg/mL</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. First generic for VISTIDE.</td>
</tr>
<tr>
<td>cisplatin inj, 200 mg/200 mL</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Cost Share Reduction</td>
<td>Change to Tier 2 (was 4).</td>
</tr>
<tr>
<td>COMBIVENT RESPIMAT (ipratropium/albuterol) inhal soln, 20-100 mcg/actuation</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 4. Quantity limits apply.</td>
</tr>
<tr>
<td>diclofenac/misoprostol tabs, 50-0.2 mg, 75-0.2 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. First generic for ARTHROTEC.</td>
</tr>
<tr>
<td>ELELYSO (taliglucerase alfa) for inj, 200 units</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 5.</td>
</tr>
<tr>
<td>fenofibrate tabs, 48 mg, 145 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for TRICOR.</td>
</tr>
<tr>
<td>griseofulvin ultramicrosize tabs, 125 mg, 250 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. First generic for GRIS-PEG.</td>
</tr>
<tr>
<td>TRADE NAME (generic name)</td>
<td>Brand/Generic Product</td>
<td>Effective Date</td>
<td>Description of Change</td>
<td>Comments</td>
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<tr>
<td>phenytoin chew tabs, 50 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. First generic for DILANTIN chew tabs.</td>
</tr>
<tr>
<td>pioglitazone tabs, 15 mg, 30 mg, 45 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for ACTOS.</td>
</tr>
<tr>
<td>prednisone dose-pack, 5 mg, 10 mg</td>
<td>Generic</td>
<td>1/1/13</td>
<td>Cost Share Reduction</td>
<td>Change to Tier 1 (was 2).</td>
</tr>
<tr>
<td>PREZISTA tabs, 800 mg</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 4. Quantity limits apply.</td>
</tr>
<tr>
<td>TRADE NAME (generic name)</td>
<td>Brand/Generic Product</td>
<td>Effective Date</td>
<td>Description of Change</td>
<td>Comments</td>
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<tr>
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</tr>
<tr>
<td>VIOKACE (pancrelipase (lipase/protease/amylase)) tabs, 10440-39150-39150 units, 20880-78300-78300</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 4.</td>
</tr>
<tr>
<td>Drug Name</td>
<td>Type</td>
<td>Date</td>
<td>Status</td>
<td>Remarks</td>
</tr>
<tr>
<td>---------------------------</td>
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<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>XTANDI (enzalutamide)</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 5. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>ZALTRAP (ziv-aflibercept)</td>
<td>Brand</td>
<td>1/1/13</td>
<td>Addition</td>
<td>Tier 5.</td>
</tr>
<tr>
<td>rizatriptan orally</td>
<td>Generic</td>
<td>1/6/13</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for MAXALT-MLT.</td>
</tr>
<tr>
<td>rizatriptan tabs, 5 mg, 10 mg</td>
<td>Generic</td>
<td>1/6/13</td>
<td>Addition</td>
<td>Tier 2. Quantity limits apply. First generic for MAXALT</td>
</tr>
<tr>
<td>AMEVIVE (alefacept)</td>
<td>Brand</td>
<td>4/25/13</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>ergotamine/caffeine tabs, 1-100 mg</td>
<td>Generic</td>
<td>4/25/13</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>GANCICLOVIR caps, 250 mg, 500 mg</td>
<td>Brand</td>
<td>4/25/13</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>LYBREL (levonorgestrel-ethinyl estradiol) tabs, 90-20 mcg</td>
<td>Brand</td>
<td>4/25/13</td>
<td>Removal</td>
<td>Manufacturer has discontinued marketing this drug.</td>
</tr>
<tr>
<td>MYDRIACYL (tropicamide) ophth soln, 1%</td>
<td>Brand</td>
<td>4/25/13</td>
<td>Removal</td>
<td>RxCUI removed by CMS. No longer Med D eligible.</td>
</tr>
<tr>
<td>tropicamide ophth soln, 0.5%, 1%</td>
<td>Generic</td>
<td>4/25/13</td>
<td>Removal</td>
<td>RxCUI removed by CMS. No longer Med D eligible.</td>
</tr>
<tr>
<td>COMETRIQ (cabozantinib) caps, kit, 60 mg, 100 mg, 140 mg</td>
<td>Brand</td>
<td>2/1/13</td>
<td>Addition</td>
<td>Tier 5. Prior authorization and quantity limits apply.</td>
</tr>
<tr>
<td>clindamycin in D5W IV soln, 300 mg/50 mL, 600 mg/50 mL, 900 mg/50 mL</td>
<td>Generic</td>
<td>2/10/13</td>
<td>Addition</td>
<td>Tier 2. First generic for CLEOCIN/D5W injection.</td>
</tr>
</tbody>
</table>
NOTICES AND ANNOUNCEMENTS

**AIM Specialty Health℠ Provider Portal℠ update for the BlueChoice® PPO/POS network**

Blue Cross and Blue Shield of Texas (BCBSTX), a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, is dedicated to meeting the ever-changing needs of our members. We are therefore enhancing our tools and data to assist PPO members in optimizing the value of care and their healthcare dollars. With consumers looking for tools to guide them through their healthcare decisions, we are pleased to announce changes to our radiology management program that support these goals.

Beginning April 15th, 2013, as an ordering physician, when you submit your high-tech radiology order through the AIM Specialty Health Provider Portal, you will experience a revision to the initial imaging provider suggestion display. The initial suggestions will only include imaging sites that have an “A” score.

**Please note:** As an ordering physician, you will still be able to search for additional servicing providers in the BlueChoice PPO/POS network.

**Enhancements to ClaimsXten™ code auditing tool**

BCBSTX will implement an expanded version to the ClaimsXten code auditing tool into our claim processing system beginning on or after **July 15, 2013**. Within this implementation will be the new second-quarter updates, including but not limited to, revision to A4550 – Surgical Tray. BCBSTX will no longer reimburse for code A4550 Surgical Tray when billed with services performed in the physician's or other professional provider’s office.

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 BCBSTX believes 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](http://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](http://bcbstx.com/provider). Additional information also may be included in upcoming issues of the 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.
Annual procedure code update
Effective Jan. 1, 2013, BCBSTX implemented the new 2013 CPT codes. Retired codes will not be accepted for service dates on or after Jan. 1, 2013.

Coding
Billing CPT 62290 as a “primary” surgical procedure is inappropriate, based on the CPT definition for this code: Injection procedure for discography, each level; lumbar. Therefore, billing 62290 is only appropriate in the context of performing a discography procedure.

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 reimbursted 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 reimbursted at the member’s in-network benefit level. Other services will be reimbursted 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:

![Image of Medicare Advantage logo]

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

Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?
If you are a contracted BCBS MA PPO provider with BCBSTX, you should provide the same access to care for BCBS MA members from other BCBS Plans as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursted 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 reimbursted 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 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 other professional provider’s office.

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician’s or other 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 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 and equipment.

AIM RQI/Preauth reminder
Physicians and professional providers must contact AIM Specialty Health℠ (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 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 revised Reimbursable Lab
Services list to be effective May 1, 2013, at 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.

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 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 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 BCBS TX 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 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 BCBS TX provider website at bcbstx.com/provider to access the 2013 Drug Dispensing Limits list.

**Preferred drug list**
Throughout the year, the BCBS TX 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 BCBS TX 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?**
BCBS TX is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBS TX 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](http://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 Provider Relations office.

*Blue Review* is published for BlueChoice®, HMO Blue® Texas, Blue Medicare Advantage, 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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