



**Issue 6, 2011**

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**2010 HCSC Social Responsibility Report available online**

One of the most compelling stories we can share as the country's largest customer-owned health insurer is our commitment to the communities where we live and work. For the first time, Health Care Service Corporation (HCSC), which operates the Blue Cross and Blue Shield Plans in Illinois, New Mexico, Oklahoma and Texas – will tell that story online in the 2010 HCSC Social Responsibility Report.

This easy-to-use format enables us to bring together the tremendous community outreach of HCSC and our four Blue Plans, as well as reach more people than ever before. Employees and external audiences will be able to see how our company is changing communities through health and wellness initiatives — particularly nutrition education, physical activity programs, disease prevention and management, and supporting safe environments.

Our commitment to social responsibility not only includes corporate giving, local community relations and volunteer efforts but also diversity and inclusion, ethics and compliance, wellness, and environmental sustainability initiatives — all of which are featured in the new report. These activities reflect our core values, which drive us to make a positive impact on our employees, customers, communities, business associates and the environment.

During 2010, HCSC and our Plans once again showed why we are called a "company that cares" by:

- providing more than 140,000 immunizations, primarily to uninsured and medically underserved children through our four-state Care Van programs;
- employees volunteering more than 20,000 hours to many causes dedicated to improving health and wellness; and
- both employees and the company combining to provide millions of dollars to various organizations to support efforts that address health care access and affordability.

We invite you take a few minutes to review our [2010 Social Responsibility Report](#) and learn more about the efforts of HCSC and our Plans and why we continue to be well-respected corporate citizens across our four states.

**Facing the facts: ANSI version 5010 and ICD-10**

ANSI v5010 goes into force on Jan. 1, 2012 – *less than seven months from now*. Less than two years later, on Oct. 1, 2013, ICD-10 becomes the new diagnostic and coding standard. These new transaction and coding protocols will affect previous, long-standing

requirements for standard health care transactions, such as submitting claims and receiving prompt payment.

Since August 2010, Blue Cross and Blue Shield of Texas (BCBSTX) has responded to hundreds of provider emails relating to the ANSI v5010 and ICD-10 mandates announced by the U.S. Department of Health and Human Services (HHS). In our May 2011 issue, we shared a sampling of some of the most frequently asked questions, along with our answers.

Here are more examples of questions that currently head the list, with an emphasis on ANSI v5010, which provides the foundation for ICD-10:

**Is the ANSI v5010 compliance date the same for both professional providers and facilities?**

Yes. The Jan. 1, 2012, date applies to both professional providers and facilities.

**Will BCBSTX accept ANSI v5010 transactions before Jan. 1, 2012?**

We began external ANSI v5010 testing with a select group of providers, billing agents, clearinghouses and other trading partners during the second quarter of 2011. The list is growing as more are identified and can demonstrate their readiness. *Providers who are not identified testing partners cannot submit ANSI v5010 transactions before Jan. 1, 2012.*

**How does a provider become an ANSI v5010 testing partner with BCBSTX?**

If you are interested in becoming a testing partner, send an email to us at [ansi\\_icd@bcbstx.com](mailto:ansi_icd@bcbstx.com). Once identified, potential testing partners will be contacted individually regarding their testing partner status. If you utilize a billing service/clearinghouse, you should contact your vendor(s) to discuss their testing plans.

**Will ANSI v4010A1 transactions be accepted once ANSI v5010 transactions are in full effect?**

Upon the required compliance date of Jan. 1, 2012, all ANSI v4010A1 claims will be rejected by BCBSTX as invalid formats.

**Is BCBSTX offering any training for providers?**

BCBSTX is offering informational webinars to provide a general overview of ANSI v5010 and ICD-10. To date, more than 1,000 providers have participated in these online training sessions. The next webinar series will be held in **July 2011**. Visit the Standards and Requirements/ANSI v5010 and ICD-10 section of our website at [bcbstx.com/provider](http://bcbstx.com/provider) for details and online registration. The contents of previous webinars also may be found on our website.

For an expanded list of FAQs, visit the Standards and Requirements / ANSI 5010 and ICD-10 / Related Resources section of our website at [bcbstx.com/provider](http://bcbstx.com/provider). Additional questions may be submitted to [ansi\\_icd@bcbstx.com](mailto:ansi_icd@bcbstx.com).

### Changes to Billing Provider Address, Loop 2010AA

Beginning Jan. 1, 2012, all HIPAA-standard electronic transactions submitted by a “covered entity”<sup>\*</sup> must be exchanged using the new ANSI v5010 standards. Please note the following **major change** regarding the requirement for how the Billing Provider Address must be submitted under ANSI v5010.

The new implementation guides for ANSI v5010, now known as Technical Reports Type 3 (TR3s), specify that:

**“The Billing Provider Address must be a street address. P.O. Box or Lock Box addresses are to be sent in the Pay-to Address Loop (Loop ID-2010AB), if necessary.”<sup>\*\*</sup>**

This change applies to all claim formats, i.e., Dental, Institutional and Professional (ANSI 837D, 837I and 837P).

Electronic claims under ANSI Version 4010A1 submitted with a P.O. Box or Lock Box in the Billing Provider Address, Loop 2010AA, Segment N3 will soon begin to receive the following Warning (W) message(s):

- Message ID QCA – (Addr 1 – P.O. Box Not Allowed in ANSI v5010)
- Message ID QCB – (Addr 2 – P.O. Box Not Allowed in ANSI v5010)

Watch the *Blue Review* and the News and Updates section of our website for an announcement regarding when these warning messages will be implemented.

It is imperative that you heed these warning messages and begin submitting a physical address now, including a street number and name for the billing provider, along with the billing provider’s nine-digit zip code. Under ANSI v5010, electronic claims submitted with the P.O. Box or Lock Box instead of a physical address for the Billing Provider Address will cause the claim to reject.

Please contact your IT staff, software vendor, billing service and/or clearinghouse to make sure they are aware of your electronic preferences and are making the necessary programming updates to your practice management system for compliance with the new ANSI v5010 standard.

If you have any questions regarding this notification, contact our Electronic Commerce Center at 800-746-4614.

Need more information about the ANSI v5010/ICD-10 conversion?

- Visit the ANSI v5010/ICD-10 page in the Standards and Requirements section of our Provider website at [bcbstx.com/provider](http://bcbstx.com/provider)
- Attend an ANSI v5010/ICD-10 Webinar! Visit our online Education and Reference section for dates and times of upcoming sessions.
- Email us at [ansi\\_icd@bcbstx.com](mailto:ansi_icd@bcbstx.com)

*\*The definition of a covered entity includes health plans, health care clearinghouses, health information trading partners, health information networks, and health care providers.*

*\*\*TR3s and TR3 Errata may be obtained through the Washington Publishing Company (WPC) at [wpc-edi.com](http://wpc-edi.com). The WPC is an independent third party vendor that is solely responsible for its products and services.*

*BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions regarding any of the products or services offered by a vendor, you should contact the vendor directly.*

### **Coming Aug. 1: New member ID cards with bar code technology**

Beginning Aug. 1, 2011, the back of member ID cards will be printed with a bar code instead of a magnetic stripe, a move that will make it more convenient for members to share benefit information with their health care providers.

The bar code will carry the same information as the magnetic stripe, including the subscriber name and ID number, plan and date of birth. Unlike the magnetic stripe, which requires the member to have the card in hand when using it, the bar code technology allows the member either to use the card itself or to present an image of the bar code (e.g. as an image on a smartphone or as a photocopy) to a provider who has the proper scanning technology.

What's a bar code? A bar code is a series of parallel lines that can be read by an optical scanner and decoded by a computer into usable information. Bar codes are found on a wide variety of everyday products – from clothes to food to medication.

In addition to providing an additional convenience to members, the new bar code technology will make the ID cards more eco-friendly. The card will be thinner yet durable, and, by removing the petroleum-based magnetic stripe, it better serves the environment.

Members who become enrolled in Blue Cross and Blue Shield of Texas (BCBSTX) health coverage on or after Aug. 1, 2011, will receive bar-coded ID cards. Members who currently have the magnetic stripes on their card will receive the bar-coded cards upon annual renewal.

BCBSTX will alert members, employers and providers of the pending change in member ID cards on its public and secure websites as well as through its various publications.

### **Introducing Blue Access Mobile<sup>SM</sup> web**

Our new Blue Access Mobile website at [bcbstx.com/mobile](http://bcbstx.com/mobile) provides current and prospective Blue Cross and Blue Shield of Texas (BCBSTX) members with two “on the go” options for obtaining secure access to some of our most popular information and tools.

#### **Mobile Web**

Potential and current members can simply type “bcbstx.com” into their mobile phone's Web browser to search for a participating doctor or hospital, obtain an insurance quote, or look up contact information. Members also may log in to their secure Blue Access for Members<sup>SM</sup> site where they can view their member ID card details and coverage information, check claim status, and more. There is no charge to use Blue Access Mobile Web. However, we advise members to contact their wireless service provider to inquire about any connectivity or Internet usage fees.

## Mobile Applications

Our new Provider Finder® Application (App) offers current and prospective members the option to use their mobile phone's Global Positioning System (GPS) for directions to the nearest participating doctor, hospital or urgent care facility. To get started, users will need to search for BCBSTX in the iPhone App Store or Android Market to download the free App to their smartphone. Searching by the following keywords also will return the Provider Finder App: *provider, locator, doctor, health, blue, cross, shield, locate, find a doctor, insurance*.

As a provider with a mobile device, you too can use our Blue Access Mobile tools. In particular, the Provider Finder App can assist you with locating participating BlueChoice® and HMO Blue® Texas physicians and other professional providers for patient referrals. The App also offers a quick and easy way to search for your own information to confirm that all details are current. If changes are needed, you may visit our provider website at [bcbstx.com/provider](http://bcbstx.com/provider) and select the Network Participation tab and scroll down to the "Update Your Information" offering. This will help ensure that members who may be conducting a search will have access to correct information about your practice.

## Online assessment process for low-tech imaging providers

Last month, we announced an enhancement to our Radiology Quality Initiative (RQI) program, which American Imaging Management® (AIM®) administers for Blue Cross and Blue Shield of Texas (BCBSTX). This enhancement utilizes AIM's **OptiNet®** tool to assess modality-specific data for imaging facilities.

**Effective June 27, 2011**, we will begin collecting capability information from BlueChoice® providers that perform the technical component of the following imaging services:

- X-Ray
- Ultrasound
- Echocardiography
- Mammography

Areas of assessment include facility and staff qualifications, accreditation and equipment specifications. **The deadline for completing the assessment is Sept 1, 2011.**

After you complete the assessment, a score will be assigned to your facility for each modality you register. These results will provide BCBSTX with accurate and current information regarding the capabilities of participating imaging facilities and providers. Your modality score(s) will not be made available for viewing by ordering providers. Modality scores will not be generated for mammography.

Before you begin the online assessment process, please visit the Education and Reference/Provider Tools section ([bcbstx.com/provider/tools/index.html](http://bcbstx.com/provider/tools/index.html)) of our website at [bcbstx.com/provider](http://bcbstx.com/provider) where you will find answers to Frequently Asked Questions, a Registration Information Checklist, and more.

When you are ready, you may access the **OptiNet** assessment tool at [americanimaging.net/goweb](http://americanimaging.net/goweb). The information on **OptiNet** is based on information given by providers. Providers can update their information whenever necessary.

*OptiNet is a registered trademark of AIM, an independent, third-party vendor that is solely responsible for its products and services. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions about the products or services they offer, you should contact the vendor directly.*

### **Get answers faster with online Claim Inquiry Resolution**

Our Claim Inquiry Resolution (CIR) tool is available via a tab in our Electronic Refund Management (eRM) system. By providing a method for online assistance with specific inquiries on **finalized claims**, the CIR tool can help save your staff time by reducing the need for phone calls and written correspondence.

Currently, we accept five different kinds of inquiries through the CIR tool:

- Medicare/Other Insurance EOB
- Duplicate Denial
- Additional Information
- Corrected Claim
- Fee Schedule/Pricing Inquiry

To assist you with navigating this helpful tool, we've added a new **CIR Tip Sheet** to the Education and Reference Center/Provider Tools/Claim Inquiry Resolution (CIR) Tool section of our website at [bcbstx.com/provider](http://bcbstx.com/provider). If you have questions or need assistance with CIR, send an email to our Provider Access Channel Specialist team at [PACS@bcbstx.com](mailto:PACS@bcbstx.com).

*\* You must be enrolled for eRM in order to gain access to the CIR tool. CIR may not be accessed through our Customer Advocates on the phone. CIR **cannot** be used to obtain Eligibility & Benefit information, Claim Status, Claim Appeal, Predeterminations, or Pended claims. Please refer to the CIR Tip Sheet for additional details.*

### **Women and heart disease: Early screening and prevention program**

A 2003 American Heart Association study of more than 1,000 women by Harris Interactive, Inc., revealed the lack of understanding women have of the dangers of heart disease and stroke. According to the study, only 13 percent of American women believe heart disease and stroke are the greatest health threat to women.

In 2009 and 2010, Blue Cross and Blue Shield of Texas (BCBSTX) Quality Improvement Programs implemented a preventive initiative designed to:

- Encourage healthy women age 35-55 years to obtain an annual physical examination and cholesterol screening, and
- Determine which member outreach method(s) resulted in the greatest number of women obtaining the recommended services.

Members received educational email messaging, automated telephone calls and mailers over six months, which provided important information related to women and heart disease. Results over the two years demonstrate improved compliance with obtaining these important screenings.

BCBSTX supports physicians in providing preventive care for their patients. If you have questions or comments about BCBSTX preventive initiatives, please contact the Quality Improvement Programs department at 800-863-9798.

## Notices and Announcements

### Clotting factor product management

Bleeding disorders, such as hemophilia, are chronic conditions. Bleeding can occur spontaneously or following trauma. That means patients need ready access to clotting factor and related products when bleeding occurs.

Many physicians prescribe clotting factor for patients to keep on hand in case of acute bleeding episodes. It is important that the amounts prescribed be appropriate to each patient's condition and medical need. Blue Cross and Blue Shield of Texas (BCBSTX) recommends the [Medical and Scientific Advisory Council Recommendation Concerning Prophylaxis](#) as a helpful resource to manage your patients with bleeding disorders.

A physician should assess each patient's clinical status before prescribing a refill of clotting factor or related products. The assessment should include documentation of:

- Number of hemarthroses and infusions since the last refill;
- Incidence of adverse events, emergency room visits and hospitalizations;
- Amount of clotting factor the patient currently has on hand; and
- Patient and family adherence to the medical treatment plan.

BCBSTX will review prescription data for clotting factor and related products. When we identify high utilization for a patient, we will send the physician a form to report key clinical information and the medical rationale for the prescribed dose.

Review a sample of the [Hemophilia Therapy: Quantity vs. Time Documentation Form](#)

When received, a medical director will review the completed forms. The medical director will call the physician with questions or concerns.

If you have any questions about this review program, please contact Dr. Allan Chernov at 972-766-1149 or by email at [allan\\_chernov@bcbstx.com](mailto:allan_chernov@bcbstx.com). You may information about the clotting factor management initiative on the BCBSTX provider website by clicking on the Clinical Resources navigation tab and then clicking on [Clotting Factor Product Initiative](#).

### Dependent eligibility audit for HealthSelect<sup>SM</sup> participants

The Employees Retirement System of Texas (ERS) is conducting a dependent eligibility audit of all members who carry dependents on state-funded health plans, including HealthSelect of Texas.

BCBSTX is the third-party administrator of HealthSelect, a plan for employees and retirees of state agencies and state-funded higher education institutions (except the University of Texas at Austin and Texas A&M University).

More than 100,000 ERS members will be required to prove eligibility of their dependents during the audit, which began in March and will end on Aug. 31 of this year. Members who do not prove the eligibility of their dependents will have their dependent coverage automatically dropped.

For ERS members, health coverage end dates are always the last calendar day of the month. **Be sure to check benefits for all HealthSelect participants, particularly around the first of the month.**

Aon Hewitt is the independent company working with ERS to conduct the eligibility audit. HealthSelect participants with questions about the audit should contact Aon Hewitt at 800-987-6605.

### **Removal of unapproved prescription cough, cold and allergy products from market**

The U.S. Food and Drug Administration (FDA) recently announced that it intends to remove certain unapproved prescription cough, cold and allergy drug products from the U.S. market. Many of these are older products and have never been fully evaluated by the FDA for safety, effectiveness and quality. People may be at greater risk when using these products than when using FDA-approved prescription drugs or drugs that are appropriately marketed over-the-counter (OTC).

Manufacturers will be required to cease production of these unapproved medications within 90 days and distribution to the market within 180 days. During May we will evaluate current utilization of these products and the need to notify members if there is a significant number of members still using the unapproved products. We anticipate that utilization will be significantly reduced since manufacturers are discontinuing production of these products and pharmacies will be converting members to approved products.

For more information and a list of unapproved cough, cold and allergy products, please visit the FDA's website: [fda.gov/ForConsumers/ConsumerUpdates/ucm244852.htm](http://fda.gov/ForConsumers/ConsumerUpdates/ucm244852.htm)

### **Billing with National Drug Codes (NDCs)**

Currently, Blue Cross and Blue Shield of Texas (BCBSTX) requires inclusion of the National Drug Code (NDC) along with the applicable Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code(s) on claim submissions for unlisted or "Not Otherwise Classified" (NOC) physician-administered and physician-supplied home infusion therapy drugs.

BCBSTX currently accepts NDC for billing of all physician-administered and physician-supplied drugs. Effective Dec. 1, 2011, BCBSTX will begin reimbursing claims submitted with an NDC in accordance with the NDC schedule posted on the BCBSTX website ([bcbstx.com/provider](http://bcbstx.com/provider)) under "Drugs." Including the NDC on claims helps provide a more consistent pricing methodology for payment and will also facilitate better management of drug-associated costs. Physicians are encouraged to begin including the NDC information on claims as soon as possible. For information about how to add the additional NDC and other required elements, please refer to the BCBSTX provider website at [bcbstx.com/provider](http://bcbstx.com/provider). BCBSTX will continue to accept the HCPCS or CPT

code elements without NDC information (excluding unlisted or “Not Otherwise Classified” drugs).

Please remember the following to help ensure proper submission of valid NDCs and related information:

- \* The NDC must be submitted along with the applicable HCPCS procedure code(s)
- \* The NDC must be in the proper format (11 numeric characters, no spaces or special characters)
- \* The NDC must be active for the date of service
- \* The appropriate qualifier, unit of measure, number of units, and price per unit also must be included, as indicated below

**ELECTRONIC CLAIM GUIDELINES**

Field Name	Field Description	ANSI (Loop 2410) – Ref Desc
Product ID Qualifier	Enter <b>N4</b> in this field.	LIN02
National Drug CD	Enter the 11-digit NDC (without hyphens) assigned to the drug administered.	LIN03
Drug Unit Price	Enter the price per unit of the product, service, commodity, etc.	CTP03
NDC Units	Enter the quantity (number of units) for the prescription drug.	CTP04
NDC Unit / MEAS	Enter the unit of measure of the prescription drug given. (Values: <b>F2</b> – international unit; <b>GR</b> – gram; <b>ML</b> – milliliter; <b>UN</b> – unit)	CTP05-1

If you have any questions about how to include the NDC code on your **electronic** claims, contact our Electronic Commerce Center at 800-746-4614.

**PAPER CLAIM GUIDELINES**

In the *shaded portion* of the line-item field 24A-24G on the CMS-1500, enter the qualifier **N4** (left-justified), immediately followed by **the NDC**.\* Next, enter the appropriate qualifier for the correct dispensing unit (**F2** – international unit; **GR** – gram; **ML** – milliliter; **UN** – unit), followed by the quantity and the price per unit, as indicated in the example below.

\*Note: The HCPCS/CPT code corresponding to the NDC is entered in field 24D.

Example:

24. A. DATE(S) OF SERVICE			B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From	To		PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	QTY/	UNIT	UNIT	RENDERING
MM	DD	YY	SERVICE	EMG	OPT/HCPCS	MODIFIER	PORTER		OR	UNIT	DRG	PROVIDER ID. #
N449500267230 UN1 50.00					J7603		1	50.00	2.5	N	1B	12345678901
10	01	05	10	01	05	11				N	NR	0123456789

For additional CMS-1500 details, refer to the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, available on the NUCC website at [nucc.org](http://nucc.org).

For more information, continue to visit the News and Updates and Electronic Commerce Alerts sections of our website at [bcbstx.com/provider](http://bcbstx.com/provider). Updates also will be included in upcoming issues of Blue Review.

*Current Procedural Terminology (CPT®), copyright 2008, by the American Medical Association (AMA). CPT is a registered trademark of the AMA.*

### **Fee schedule update**

The ParPlan, BlueChoice® and HMO Blue® Texas (Independent Provider Network and THE Limited Network only) maximum allowable fees for practitioners will be updated to reflect 2011 relative values effective Sept. 1, 2011:

- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.
- HMO Blue Texas, BlueChoice, and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility).
- A multiple procedure payment reduction will be made on the technical component (TC) of certain diagnostic imaging procedures. The reduction applies to TC only services and the TC portion of global services for the procedures listed on the website. The reduction does not apply to professional component (26) services. The highest priced procedure will be reimbursed at 100% of the allowable and each additional procedure, when performed during the same session on the same day, will be reimbursed at 50% of the allowable. In addition, the 11 families of imaging procedures will be consolidated into one family.
- If a claim (or claims) from the same physician, for the same date of service, for the same member includes both a procedure and a general ophthalmological service (CPT codes 92002 - 92014) or an evaluation and management service (CPT codes 99201 - 99499), the general ophthalmological service or evaluation and management service will be considered as the primary service and payable at 100 percent of the allowable amount and the procedure will be considered the secondary service payable at 95 percent of the allowable amount. The procedure list can be found on the BCBSTX provider website Home Page, under the Standards & Requirements tab, click on 'View General Reimbursement Information', then scroll down to the 'All Product News' section, then click on 'Procedure Plus an Evaluation and Management Service'.
- BCBSTX currently accepts NDC for billing of all physician-administered and physician-supplied drugs. Effective Dec. 1, 2011, BCBSTX will begin reimbursing claims submitted with an NDC in accordance with the NDC schedule posted on the website under "Drugs." BCBSTX will continue to accept the HCPCS or CPT code elements without NDC information (excluding unlisted or "Not Otherwise Classified" drugs).
- The CPT/HCPCS Fee Schedule will be updated on the following dates: June 1, 2011; Sep. 1, 2011; Dec. 1, 2011; March 1, 2012; and June 1, 2012.

BCBSTX provides general reimbursement information policies, request forms for allowable fees and fee schedule information at [bcbstx.com/provider](http://bcbstx.com/provider). To view this information, visit the General Reimbursement Information section on this website. If you

would like to request a sample of maximum allowable fees or if you have any other questions, please contact your local Professional Provider Network office.

Reimbursement changes will be posted under "Reimbursement Changes/Updates" in the Professional Reimbursement Schedules section on the BCBSTX provider website. 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.

### How to prepare for a physician on-site review

The physician on-site review (POR) is an integral part of the overall credentialing process for all family, internal medicine, pediatric and OB/GYN physicians that provide primary care services to BCBSTX members. Once a mutually acceptable time for the review is established, a scheduling letter outlining the expected performance goals and a copy of the review criteria will be faxed or emailed to the physician's office.

The review will be performed by an RN, On-Site Quality Audit Specialist, whom you may contact prior to the review with any questions or changes in scheduling. Preparing for the POR has been streamlined by providing you with the review criteria. By reviewing the criteria ahead of time, you will be assured of a smooth and successful outcome.

To summarize, the review consists of:

- Access information (not scored)
- Safety and environment: adequacy of facility, written policies, medication administration and medical records (performance goal of 90 percent)
- Laboratory services, if applicable (performance goal of 90 percent)
- Radiology services, if applicable (performance goal of 90 percent)
- Medical record-keeping practice (performance goal of 85 percent)

### In Every Issue

#### 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 reminder**

Physicians and professional providers must contact American Imaging Management® (AIM) first to obtain an RQI number 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 PPO RQI number, log in to AIM's provider portal at [americanimaging.net](http://americanimaging.net) and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an RQI number. 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 provider portal uses the term "Order" rather than "Preauth" or "RQI."

**Note:** *Facilities cannot obtain an RQI number from AIM on behalf of the ordering physician. Also, the RQI program does not apply to Medicare enrollees with Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program.*

#### **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 220 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 provider website. Also, the Drug/Injectable Fee Schedule will be updated on June 1, 2011.

### **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 and other professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician and 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.

### **Proper use of the AS and SA modifiers when billing**

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 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 our provider website portal on the 1<sup>st</sup> or 15<sup>th</sup> day of each month. Those policies requiring disclosure will become effective 90 days from the posting date. Policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each policy that is posted.

To view active and pending policies go to [bcbstx.com/provider](http://bcbstx.com/provider), click on the Policies link toward the bottom of the page and then click on the Medical Policies link. After reading and agreeing to the disclaimer, you will 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 our provider portal and provide your feedback online. The documents will be made available for your review around the 1<sup>st</sup> and the 15<sup>th</sup> of each month with a review period of approximately two weeks.

To view draft policies go to [bcbstx.com/provider](http://bcbstx.com/provider), click on the Policies link toward the bottom of the page and then click on the Draft Medical Policies link.

### **Urgent versus standard predeterminations**

At times, a predetermination for services may need to be handled as priority. Urgent predetermination requests include, but are not limited to:

- Procedures and/or drugs needed to relieve pain
- Acute medical conditions
- Continuities of care in a chronic condition
- Treatments that need to be given within one week of the date the request is received

Cosmetic procedures and bariatric surgery would not be considered urgent.

In order for a predetermination request to be processed as priority, check the box marked "URGENT" located at the top of the completed predetermination form and indicate the anticipated date of service. Urgent predetermination requests only should be faxed to 888-579-7935.

Note that photographs will not be accepted via fax. They should be placed in a sealed envelope with the words "Request for Predetermination — Original Photos — Do Not Bend" written on both sides and sent to the appropriate address found on the form.

Remember, all predetermination requests are considered standard and should be mailed to the appropriate address found on the form if treatment is to be provided more than one week from the date of the request.

### **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 American Imaging Management 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.

### **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.

### **QVT (quantity versus time) limits**

To help minimize health risks and to improve the quality of pharmaceutical care, 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.

The BCBSTX Clinical Pharmacy and Marketing Departments have finalized the QVT list for 2011. Visit [bcbstx.com/provider/pharmacy/index.html](http://bcbstx.com/provider/pharmacy/index.html) for a detailed list under the Pharmacy section.

### **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.

The BCBSTX Clinical Pharmacy and Marketing Departments have finalized the preferred drug list for 2011.

For the 2011 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: [bcbstx.com/provider/pharmacy/index.html](http://bcbstx.com/provider/pharmacy/index.html).

### **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 network.

### **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, e-mail 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<sup>®</sup>, 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.

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

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