Predetermination process for the Respiratory Syncytial Virus
The Respiratory Syncytial Virus (RSV) season is upon us. Blue Cross and Blue Shield of Texas (BCBSTX) would like to take this opportunity to review the predetermination process for the RSV Prophylaxis program.

STEP 1 – BCBSTX Health Plan Predetermination/Authorization Process
- Complete the BCBSTX Synagis Request Form in its entirety. Two types of forms are posted at bcbstx.com/provider/downloadable_forms.htm.
- Submit the online version of the form or fax the completed hard-copy version of the Synagis Request Form to Allan J. Chernov, M.D. (Medical Director, Health Care Quality & Policy) at 972-766-5559.
- If the form is submitted using the online option, BCBSTX will send notification of the review outcome by e-mail. If the mail or fax option is utilized, notification will be sent by mail, unless e-mail notification is specifically requested.

STEP 2 – Ordering Process for Triessent™
- Fax the Synagis Request Form, along with written authorization from BCBSTX, to Triessent at 866-203-6010.
- If the request form is incomplete or does not have the BCBSTX written authorization attached, the order will not be processed, and it will be returned to the physician for completion.
- If approved, the predetermination will cover a maximum of five monthly injections for that patient for the 2010-2011 RSV season, which runs from Oct. 1, 2010, to March 15, 2011. No additional reviews will be needed.
- For out-of-state members, the member’s Home Plan will need to be contacted for eligibility and benefit information. The Home Plan’s phone number will be on the back of the member’s ID card.

California experiences a seven-fold increase in whooping cough cases
The California Department of Public Health (CDPH) has recently announced a significant increase in the state’s pertussis (whooping cough) case rate. As of Aug. 31, 2010, CDPH noted 3,600 confirmed, probable and suspected year-to-date cases of pertussis for a state rate of 9.2 cases/100,000. This is a seven-fold increase from the number of reported cases during the same time period in 2009 when 501 cases were reported.

Of all hospitalized cases, 75 percent (132/177) were for infants less than six months of age. There were also eight deaths, all in infants too young to receive the recommended immunization to prevent its occurrence. The total of 3,837 cases reported is the most since 1958. It also represents the highest incidence since 1963 with 9.3 cases/100,000 reported. Previously, the peak was in 2005, when there were 3,182 cases reported.
Similar concerns are also being raised in other states such as Michigan (902 cases in 2009 vs. 315 in 2008), where the increase in reported cases has public health officials concerned.

Pertussis is a highly contagious respiratory tract infection caused by the bacterium Bordetella pertussis. In the first half of the 20th Century, whooping cough was a leading cause of childhood illness and death in the United States. With the introduction of an effective vaccine, the number of cases gradually declined, reaching a low in the mid-1970's.

Once infected with whooping cough, it usually takes three to 12 days for symptoms to appear. Initially mild, resembling a common cold, the signs and symptoms usually worsen and may result in severe and prolonged coughing attacks. Common complications include: nausea and vomiting, pneumonia, encephalopathy and seizures. Unfortunately, infections in infants can be particularly severe.

Use of appropriate antibiotics (i.e. azithromycin, clarithromycin or erythromycin) early in the course of the disease is very important. If treatment for pertussis is started in the first two weeks or prior to the start of coughing paroxysms, symptoms may be lessened. In those patients diagnosed with whooping cough in the later stages, antibiotics have not been shown to be effective in altering the course of the illness. As a consequence, vaccination is the best defense against whooping cough. However, the immunity from vaccines wanes over time and pertussis booster vaccination rates in adolescents and adults continues to be low. There are currently two types of pertussis vaccines: a) DTaP for infants and children and b) Tdap for adolescents and adults. Both vaccines protect against whooping cough, tetanus and diphtheria. Getting vaccinated with Tdap is especially important for family members and/or caregivers of the very young.

Current vaccination recommendations:

- **Infants** and children are recommended to receive five doses of the DTaP vaccine at 2, 4, and 6 months, at 15 through 18 months, and at 4 through 6 years. All five doses are needed for maximum protection.

- **Adolescents** are recommended to receive the Tdap vaccine at their regular check-up at age 11 or 12. If teenagers (13 through 18 years) missed getting the Tdap vaccine, parents should ask the doctor about getting it for them now.

- **Adults** who are 19 through 64 years old are recommended to get a one-time dose of Tdap in place of the Td booster they’re recommended to receive every 10 years. No need to wait until the patient is due for their Td booster — the dose of Tdap can be given earlier than the 10-year mark since the last Td booster. It's a good idea for adults to talk to a health care provider about what's best for their specific situation.

- **Pregnant women** should ideally receive Tdap before pregnancy. Otherwise, it is recommended that Tdap be given after delivery, before leaving the hospital or birthing center. If a pregnant woman is at increased risk for getting whooping cough, such as during a community outbreak, her doctor may consider giving Tdap during pregnancy. Although pregnancy is not a contraindication for receiving Tdap, a pregnant woman and her doctor
should discuss the risks and benefits before choosing to receive Tdap during pregnancy.

- **People 65 years and older** do not currently have a pertussis booster vaccine licensed for their age group. However, people in this age group can talk to their health care provider to see if getting Tdap is a good decision for them. This discussion can include weighing the risks and benefits of receiving Tdap. Receiving Tdap may be especially important during a community outbreak and/or if caring for an infant.

The Center for Medicare and Medicaid Services (CMS) recently (Aug. 16, 2010) released a memo to all Medicare Part D Plan Sponsors and Medicare Advantage organizations discussing the recent outbreak in California, reiterating CDPH’s recommendation for broader use of the pertussis booster vaccine (i.e. immunize children as young as seven years of age as well as older California residents over 64) for the duration of the epidemic. Vaccination of those over the age of 64 is important because neither prior vaccination nor natural disease confers life-long immunity, and those over 64 years of age have increasingly become primary care givers for their grandchildren.

Lastly, CMS reminds providers that the Tdap vaccine is a Part D covered drug and is on-compendia for use in patients 65 and older. The Tdap vaccine may be obtained from a network pharmacy and administered by a pharmacist registered for vaccine administration or in a network provider’s office. This will benefit members by providing a choice in access and administration to the vaccine.

**References:**

American Imaging Management® to launch new, improved provider homepage
American Imaging Management (AIM®) in November will revamp its ProviderPortal℠ homepage with a fresh, new look that offers providers more efficient navigation, enhanced reports and better, quicker access to the site’s valuable features.

To view a tutorial that explains the portal’s coming enhancements, [click here](http://www.americanimaging.com). Upon logging into the ProviderPortal, viewers will immediately notice the site’s improved functionality, including:

- Access to all of your online tools in one convenient, customized location
- The ability to view all order requests submitted for you or your group in the "Access Your Reports" module
- Access to an interactive tutorial for every tool available on the homepage
The ability to initiate order requests directly from the homepage with the "Start Your Order Request Here" module

AIM embarked on revamping the ProviderPortal homepage based on feedback during a usability study conducted earlier in the year. If you have questions regarding the upcoming change to the homepage, contact AIM Customer Service at 800-859-5299.

New code auditing tool will improve overall claims management performance
Blue Cross and Blue Shield of Texas (BCBSTX) will be implementing the ClaimsXten™ code auditing tool into our claim processing system during the first quarter of 2011. Developed by McKesson Information Solutions, Inc., ClaimsXten will replace the current ClaimCheck®* code auditing software used by BCBSTX.

ClaimsXten is a service solution that will expand the capabilities of our existing claims processing system. This tool offers flexible, rules-based claims management with the capability of creating customized rules as well as the ability to read historical claims data. ClaimsXten can automate claim review, code auditing and payment administration, which we believe will result in improved performance of overall claims management.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™* (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX’s code-auditing software. Refer to our website at bcbstx.com/provider for additional information on gaining access to C3.

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

* ClaimsXten, ClaimCheck and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent, third-party vendor.

Calling us for claim status?
Automated interactive voice response (IVR) phone systems have a dual reputation. Some users find them to be quick and easy. Others find them to be challenging.

On the plus side, IVR systems are often available after hours, they offer reliable information, and they’re an alternative to waiting on hold. For offices with online access, we have also been communicating the positive aspects of obtaining patient information via Web-based transactions through Availity® or your preferred online vendor portal.

If your office has yet to adopt an electronic connectivity solution or only has limited online access, then the Blue Cross and Blue Shield of Texas (BCBSTX) IVR offers the next best method for obtaining the information you need. Our IVR is designed to respond quickly and efficiently to address your requests for eligibility, benefits and claim status information.
**Claim Status Menu Changes in October**

We are continuing to modify the IVR claim status menu options to better suit your needs. The IVR quotes claim status information at two levels:

1. Overall status – check amount, paid date, etc.
2. Line item detail (professional claims only) – allowable amounts, ineligible reason codes, etc.

**Beginning Oct. 18, 2010,** you will have the option to speak to a Customer Advocate (CA) *only after* you obtain responses via the IVR at both of the above claim status levels. By using the IVR, you allow our CAs to dedicate more time to addressing and resolving claim inquiries beyond status quotes.

Since the IVR pulls data directly from our claim system, claim status information quoted to you by the IVR is:

- **Current** – The IVR provides the most updated claim status information available.
- **Accurate** – Information quoted by the IVR will match your Provider Claim Summary (PCS) or Electronic Payment Summary (EPS).
- **Detailed** – There are limited reasons to speak with a CA after obtaining information from the IVR, *as the IVR and CA quote from the same source: our claim system.*

For assistance with navigating the automated phone system, refer to the IVR Caller Guides, available in the Provider Library/Reference Guides section of our website at [bcbstx.com/provider](http://bcbstx.com/provider).

*Availity is a registered trademark of Availity, L.L.C.*

*Availity, L.L.C. is an independent third party vendor and is solely responsible for its products and services.*

**Frequently Asked Questions available for new administration of Behavioral Health program**

As previously announced in the June *Blue Review*, effective January 2011, Blue Cross and Blue Shield of Texas (BCBSTX) will manage behavioral health (i.e., mental health and substance abuse) services for all non-HMO members, replacing Magellan Health Services. We have prepared Frequently Asked Questions (FAQs) that review the upcoming preauthorization requirement changes and other highlights of the program. You can access the FAQs in the What’s New section of the website at [bcbstx.com/provider](http://bcbstx.com/provider).

Behavioral health care management will be more integrated with our medical care management program as part of Blue Care Connection®. The goal of the integrated Behavioral Health program is to support early identification of members who should benefit from co-management of behavioral health and medical conditions. This service delivery model may result in improved outcomes, enhanced continuity of care, greater clinical efficiency and reduced costs over time.

Updates about the integrated Behavioral Health program will be communicated in the What’s New and UM/QI/Medical Management sections of our website on 


bcbstx.com/provider and in future issues of Blue Review. If you have any questions, please contact your local Professional Provider Network representative.

Notices and Announcements

Reminder: Secure Provider Portal is Coming!
The secure provider portal, Blue Access® for Providers, is coming soon. Watch the November Blue Review, BCBSTX provider website at bcbstx.com/provider and your mail for up-to-the-minute launch status, details and instructions.

Be prepared: Know the facts about ANSI 5010 and ICD-10
Blue Cross and Blue Shield of Texas (BCBSTX) is dedicated to increasing provider awareness of the ANSI 5010 and ICD-10 mandates, some of which the U.S. Department of Health and Human Services (HHS) will begin to enforce in just over a year. That's very little time, considering the number of tasks at hand, to achieve system readiness and coding compliance.

Phase 1: Laying the foundation with ANSI 5010
The ANSI 4010 transaction standard is now limited and outdated because of the new drugs, diseases, procedures and devices that have appeared since it was adopted more than 30 years ago. The new ANSI 5010 standard expands provider data-collecting capabilities with more than 500 changes* and, according to the Centers for Medicare & Medicaid Services (CMS) Director of Medical Billing Procedures, will "offer consistency of processing for payers and clearinghouses."

To make the transition to ANSI 5010 as smooth as possible, every provider should contact their vendors (if they haven't already) to learn when the system migration will be available for in-house testing and to commit to it being fully operational before the mandated compliance date of Jan. 1, 2012. CMS permits testing for ANSI 5010 to begin on Jan. 1, 2011, and BCBSTX will begin external testing with providers and clearinghouses after April 17, 2011.

Phase 2: Setting the new standard with ICD-10
The ANSI 5010 implementation is the foundation for ICD-10, the new transaction standard that also brings an additional set of provider and patient benefits. The transition from ICD-9 to ICD-10 may seem like a massive endeavor — and it can be — if providers wait too long to begin adoption.

Again, providers should contact their vendors to see when ICD-10 coding will be available for testing and to confirm that it will be fully operational before the mandated compliance date. Testing for ICD-10 will begin Oct. 1, 2012, with a mandated compliance date of Oct. 1, 2013. HHS has already pushed back the compliance date. According to recent reports, it will not delay compliance again.

What can you do right now? Start talking with your vendors!
No matter the size of your facility or practice, there’s no time to lose. The consequences of not being in compliance on the mandated dates can — and should — be avoided at
all cost. Contact your vendors now and ask them to establish a comprehensive approach that will deliver compatible products well ahead of the transition deadlines.

Be sure to discuss these critical issues with your vendor(s):

- When will software upgrades (and any new hardware systems) be available for testing and implementation?
- What can you expect in terms of customer support before, during and after the transitions?
- Will the vendor’s products and services perform all functions in both ICD-9 and ICD-10 as you work with claims for services provided both before and after the transition deadline?
- Are any hardware system upgrades needed to accommodate migration to ANSI 5010 and ICD-10?
- Are upgrades covered by your existing contract(s)? If not, what costs are involved?

Your vendor’s goal should be to help you avoid potential reimbursement issues. Insist on having fully functional, compliant products and services ready in plenty of time to allow complete ANSI 5010 and ICD-10 testing.

**BCBSTX can help you stay on track**

Early adoption is essential to making a smooth and accurate migration. The following options and resources can help you assess your progress with respect to the established testing timelines and mandatory compliance dates:

- **Consider Becoming a Testing Partner**
  BCBSTX invites your facility or practice to become a testing partner to help ensure all systems are “go” before the mandated compliance dates. Interested? E-mail us at [ansicd@bcbstx.com](mailto:ansicd@bcbstx.com) to request details.

- **Watch for Newsletter Articles and Online Alerts**
  More ANSI 5010 and ICD-10 articles will appear in future issues of Blue Review. Also check the online What’s New section of our website at [bcbstx.com/provider](http://bcbstx.com/provider) for important announcements.

- **Download our “How-to” Booklet**
  We are developing an ANSI 5010 and ICD-10 “how-to” booklet — complete with timelines, calendar reminders, vendor suggestions and other important information. This booklet and other related resources will be available soon on our provider website.

- **Ask for Assistance**

Do you have questions or concerns related about becoming a testing partner? Do you need direction on where to find more information about ANSI 5010 or ICD-10? We’re here to help:

- Check information at [bcbstx.com/provider](http://bcbstx.com/provider)
- E-mail us at [ansicd@bcbstx.com](mailto:ansicd@bcbstx.com)
- Contact your Facility or Professional Provider Network office.

As a reminder, add these milestones and dates to your calendar:
Jan. 1, 2011  
- CMS begins accepting ANSI 5010 claims (ANSI 4010 claims will continue to be accepted).  
- External testing of ANSI 5010 for electronic claims can begin.  

April 18, 2011  
- BCBSTX internal implementation and external testing begins  

Dec. 31, 2011  
- External testing of ANSI 5010 for electronic claims must be completed to achieve Level II ANSI 5010 compliance.  

Jan. 1, 2012  
- Every electronic claim must be submitted via ANSI 5010.  
- Claims submitted on ANSI 4010 will no longer be accepted.  

Oct. 1, 2012  
- Begin testing of ICD-10 coding.  

Oct. 1, 2013  
- All claims for services provided must use ICD-10 codes for medical diagnoses and inpatient procedures.  
- CPT codes remain valid and should be used for outpatient services.  

*http://www.icd10watch.com/blog/7-benefits-hipaa-5010

**Correction: Billing with National Drug Codes (NDCs)**  
In an article titled, “Billing with National Drug Codes (NDCs)” in Issue 3, 2010, of Blue Review, guidelines for appropriate submission of valid NDCs and related information were specified for professional providers submitting electronic (837P) and/or paper (CMS-1500) claims. In this article, the qualifier or value to indicate an international unit of measure was incorrectly listed as “FR.” Please note that the correct qualifier or value to include for an international unit of measure, where applicable, is “F2.”

**Place of service: Office versus Outpatient**  
A patient’s benefit can vary, depending on the place-of-service. Two of the most commonly misused places of service are Office and Outpatient.

To ensure Blue Cross and Blue Shield of Texas is providing you with the most accurate information, it is very important to know the difference between Office and Outpatient, and to always provide the appropriate place of service when obtaining benefits.

As defined in the 2010 Current Procedural Coding Expert:

**Office:** “Location, other than a hospital, skilled nursing facility, military treatment facility, community health center, state or local public health clinic, or intermediate care facility, where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.”

Examples*:  
- Office  
- Urgent Care Facility
• Non-Residential Substance Abuse Treatment Facility
• Rural Health Clinic

**Outpatient:** “A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.”

Examples*:
• Outpatient Hospital
• Emergency Room - Hospital
• Ambulatory Surgical Center

*Not all inclusive

**iEXCHANGE – pended cases**
Please be aware that an enhancement has been implemented to the iEXCHANGE system. If you have a case that pends, you can now add Clinical Notes while in the Preview Page.

If you do not have clinical notes, but can furnish the name and/or number of the person/area who will be assigned to the case – such as a nurse or case worker – please provide that in the Clinical Notes field. This will allow Blue Cross and Blue Shield of Texas to contact them directly for clinical information, if needed.

Please do not add notes in the Clinical Notes field unless a case pends, as they are unnecessary and will not be reviewed on cases that are automatically approved.

**Modifier 22: BCBSTX to review surgical claims**
Effective Aug. 23, 2010, Blue Cross and Blue Shield of Texas (BCBSTX) began pending for review all surgical claims when modifier 22 is present. Our processing area will review to determine if an operative report has been submitted. If so, the claim will be sent to our Medical Review Unit for review to determine if additional reimbursement is warranted. If the operative report is not found, the claim will be adjudicated as normal. The claim will be reconsidered if submitted as an inquiry with the operative report.

To accommodate electronic claim submissions, you may fax the operative report to one of the following numbers listed below within 72 hours of submitting your claims:
• 972-468-3980
• 972-468-3982
• 972-468-3983
• 972-468-3984

The following information **must be** included on the coversheet to ensure the operative report is routed to the appropriate processing area:
• Claim Number
• Group Number
• Subscriber Number (Including Alpha Prefix)
New preferred provider for IVIG home infusion
Effective Sept. 1, 2010, Coram Specialty Infusion Services became the preferred provider of intravenous immune globulin (IVIG) home infusion therapy services for members in the Blue Cross and Blue Shield of Texas (BCBSTX) PPO network.

If you currently have patients receiving IVIG home infusion, Coram will be contacting your office to obtain orders and begin transitioning service from the patient’s current pharmacy provider. Your patients are also being notified concurrently about the transition by mail and via telephone.

The program, EyeOn Therapy Management, is designed to enhance the level of service and safety to BCBSTX members receiving IVIG therapy, improve their continuity of care and monitor the expense of medication and treatment. In addition, the program provides added homecare and alternate site infusion support for you and your staff through a single resource for your patients’ needs.

Coram will do everything necessary to ensure timely, uninterrupted service for you and your patients. If you have any questions about the EyeOn Therapy Management program, please contact Coram directly at 888-4EyeOn1 (888-439-3661).

Useful information when billing for a Rapid Desensitization Procedure
Rapid desensitization procedures utilizing procedure code 95180 represent each hour of service. According to CPT® guidelines, allergen immunotherapy codes 95115-95199 include the necessary professional services. Evaluation and management codes may be submitted in addition to allergen immunotherapy, including code 95180, if other identifiable services are provided at that time. Modifier-25 may be appended to the evaluation and management code only if those services are considered significant, separately identifiable as indicated by the definition of Modifier-25 in the CPT Manual. The patient’s medical record documentation must support the use of Modifier-25.

Preauthorization and the Interactive Voice Response (IVR) phone system
The Interactive Voice Response (IVR) is the automated phone system that manages call flow to our Provider Customer Service area. The primary function of the IVR is to manage general inquiries such as claim status and eligibility and benefits. The IVR provides our Customer Advocates valuable time to address your more complex and critical inquiries.

Most HMO and PPO benefit contracts require the member or provider to contact Blue Cross and Blue Shield of Texas to receive preauthorization (also known as precertification) for inpatient hospital admissions, including acute care, inpatient rehab, skilled nursing, long-term acute care, inpatient hospice coordinated health care such as skilled nursing visits and care provided in the home setting such as administration of IV medication, or Physical/Speech/Occupational therapy.
When calling the IVR to obtain eligibility and benefits, you will be advised by the system if preauthorization is or may be required. If the IVR does not mention preauthorization, then preauthorization is not required for the services. It is not necessary to opt out to speak to a Customer Advocate to verify the preauthorization requirement.

**Electronic claims with NPI-related errors**

In June 2008, we published a complete listing of electronic claim edits that were implemented in support of an NPI-only claims processing environment. This document provided the three-digit error code along with a defining message indicating the severity level of the error and the resulting impact on the claim – “W” for Warning and “R” for Rejection.

An updated NPI-only Electronic Claim Submission Edits listing has been posted under the Alerts link in the Electronic Commerce section of the BCBSTX website at bcbstx.com/provider. Please be advised that most of the edits/error listings that were formerly set at the Warning level were set to Reject as of Aug. 1, 2010. The only two error types that will continue to remain at the Warning level are as follows:

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Message</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>BA6</td>
<td>Rendering NPI is not on file (Claim Level Error Message)</td>
<td>W</td>
</tr>
<tr>
<td>CA6</td>
<td>Rendering NPI is not on file (Service Line Level Error Message)</td>
<td>W</td>
</tr>
</tbody>
</table>

It is important to ensure that you and/or all of your electronic trading partners (billing services, clearinghouses and software vendors) are aware of and responsive to these messages. If you have any questions on these edits, please contact our Electronic Commerce Center at 800-746-4614.

If your office refers to a printed copy of the 2008 NPI-only Electronic Claim Submission Edits listing, please replace it with the updated version posted under the Alerts link in the Electronic Commerce section of the BCBSTX website at bcbstx.com/provider.

**Clotting factor management initiative**

Patients with bleeding disorders, such as hemophilia, need immediate access to clotting factor and related products to manage bleeding episodes. Therefore, it is important that physicians who prescribe clotting factors prescribe amounts appropriate to the patient’s clinical situation.

Blue Cross and Blue Shield of Texas (BCBSTX) recommends the Medical and Scientific Advisory Council Recommendation Concerning Prophylaxis as a helpful resource in managing these patients. In addition, BCBSTX has implemented a review of prescription data to identify high utilization of clotting factors and related products. If high utilization is identified, a form requesting key clinical information and medical rationale may be sent to the prescribing physician. Completed forms are reviewed by a medical director, who will contact the prescribing physician with any questions or concerns. For additional information, visit bcbstx.com/provider/clotting_factor.htm.
Clear Claim Connection™ available to BCBSTX physicians and other professional providers

Clear Claim Connection (C3)*, a web-based code auditing reference tool, is now available to all contracted Blue Cross and Blue Shield of Texas (BCBSTX) physicians and other professional providers. You may access this tool through the secure provider portal at bcbstx.com.

C3 mirrors the ClaimCheck®** auditing rules that BCBSTX has adopted as part of its claim adjudication process. It provides easy access to ClaimCheck payment policies and rules in addition to clinical rationales, clarifications and source information for ClaimCheck edits. Certain claims, such as Medicare Primary and BlueCard, are exempt from ClaimCheck auditing.

The BCBSTX ClaimCheck database is updated periodically and upgraded to a new version annually, which may result in certain edit combinations being modified. Appropriate notice of such modifications will be provided on our website and through this Blue Review newsletter.

BCBSTX-contracted physicians and other professional providers are able to access the C3 web link via Availity®***, in addition to RealMed. Registration with RealMed or Availity is required prior to the first time you access C3. Instructions for registering with RealMed or Availity are located with the link to the respective portal. Once your registration process is completed, you will have access to C3.

To use C3, log on to the BCBSTX website at bcbstx.com and click on the Providers tab. You will find Clear Claim Connection in the General Reimbursement Information section under Bundling Information.

ClaimCheck audit results obtained on the BCBSTX website are specific to BCBSTX. Another carrier who offers C3 may have different edits, which will produce different results. This information is confidential and proprietary, and it is not to be shared. If you need more information, please contact your local Professional Provider Network (PPN) office or Provider Customer Service at 800-451-0287.

* Clear Claim Connection™ is a trademark of McKesson Information Solutions Inc.

** ClaimCheck™ is a registered trademark of McKesson Information Solutions Inc.

*** Availity is a registered trademark of Availity, L.L.C., an independent, third-party vendor. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

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 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 Blue Cross and Blue Shield of Texas (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](http://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.

*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.

**BlueChoice® Solutions Large Employer Groups List**
For your reference, the following is an alphabetical list of large employer groups currently enrolled in BlueChoice Solutions. Note that the employer groups listed below include insured and self-funded health plans. These employer groups may have chosen the BlueChoice Solutions network as an optional network for their employees. In addition, BlueChoice Solutions is offered to individual members.

<table>
<thead>
<tr>
<th>BlueChoice® Solutions Large Employer Group List As of August 2010</th>
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<tbody>
<tr>
<td>A.H. Beck Foundation Co., Inc.</td>
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<tr>
<td>Air Force Villages, Inc.</td>
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<tr>
<td>City of Sanger</td>
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<tr>
<td>DCTA</td>
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<tr>
<td>Naegeli Transportation, Inc.</td>
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<tr>
<td>Overland Mortgage Corporation</td>
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<tr>
<td>Reef Industries, Inc.</td>
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<tr>
<td>Research Analysis &amp; Maintenance, Inc.</td>
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<tr>
<td>Southwest Ford, Inc.</td>
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<tr>
<td>The Care Group of Texas</td>
</tr>
<tr>
<td>The City of Glenn Heights</td>
</tr>
<tr>
<td>United Graphics</td>
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</tbody>
</table>
Fee schedule updates
Reimbursement changes and updates for BlueChoice® and HMO Blue® Texas (Independent Provider Network only) practitioners will be posted under Reimbursement Changes/Updates in the Professional Reimbursement Schedules section on the Blue Cross and Blue Shield of Texas 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 provider website. Also, the Drug/Injectable Fee Schedule will be updated on the following dates: 9-1-2010, 12-1-2010, 3-1-2011 and 6-1-2011.

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
Blue Cross and Blue Shield of Texas (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.

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 Blue Cross and Blue Shield of Texas (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 1st or 15th 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 pending policies, go to the Medical Policy section at bcbstx.com/provider and click on Active/Pending Medical Policies. After reading the disclaimer, click on “I Agree” to advance to the medical policy page. The policies can be accessed by clicking the View Pending Policies tab.

**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 1st and the 15th of each month with a review period of approximately two weeks.

To view draft policies, go to the Medical Policy section of the BCBSTX website at bcbstx.com/provider and click on Draft Medical Policies. After reading the disclaimer, click on “I Agree” to advance to the Medical Policy page.
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 Blue Cross and Blue Shield of Texas (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**

Blue Cross and Blue Shield of Texas 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 supplemental charges, 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 Blue Cross and Blue Shield of Texas 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 Blue Cross and Blue Shield of Texas (BCBSTX) Clinical Pharmacy Department is currently working on updating the QVT list for 2010. Visit [bcbstx.com](http://bcbstx.com) for an updated and detailed list under the Pharmacy section.

**Preferred drug list**

Throughout the year, the Blue Cross and Blue Shield of Texas (BCBSTX) Clinical Pharmacy Department team frequently reviews the preferred drug list. Tier placement
decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

For the 2010 drug updates, visit the BCBSTX provider website under the Pharmacy section, or follow this link: bcbstx.com/provider/quantity_time.htm

Are utilization management decisions financially influenced?
Blue Cross and Blue Shield of Texas (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.