Reminder: New administration for behavioral health begins January 2011
As previously announced, effective January 2011, Blue Cross and Blue Shield of Texas (BCBSTX) will integrate behavioral health with medical care management. BCBSTX independently licensed behavioral health professionals will manage the program for all non-HMO members, replacing Magellan Health Services.

This update highlights upcoming program changes to help facilitate a smooth transition for you and your patients. (Outpatient care management services and outpatient preauthorization requirements do not apply to those patients/members who do not have outpatient behavioral health benefits with BCBSTX.)

Important Updates and Information
1. Integrated Behavioral Health Model – for overall care management
   • Behavioral health care management will be more integrated as part of the Blue Care Connection® (BCC) medical care management program.
   • The goal is to support early identification of members who could benefit from co-management of behavioral health and medical conditions.
   • This model should result in improved outcomes, enhanced continuity of care, greater clinical efficiencies and reduced costs over time.

2. Services provided by the Behavioral Health program
   • Care/Utilization Management for inpatient, outpatient and partial hospitalization
   • 24-hour referral assistance
   • Condition Management support for behavioral disorders – depression, alcohol/substance abuse, anxiety/panic, bipolar, eating disorders, schizophrenic/other psychotic disorders
   • Case Management services for complex needs/issues
   • Referrals to other BCC medical care management programs

3. Transition of care
   • BCBSTX will work with you to help limit the possibility for disruptions in patient care coordination during the transition.
   • During this transition, Magellan Health Services will:
     o Continue to authorize covered outpatient services and inpatient admissions for dates of service that begin on or before Dec. 31, 2010.
     o Make medical necessity determinations for covered behavioral health services for service dates that begin on or before Dec. 31, 2010.
     o Answer questions for care authorized with service dates on or before Dec. 31, 2010.
• Beginning Jan. 1, 2011, members and behavioral health professionals and physicians can contact BCBSTX at the phone number on the back of the member ID card to request preauthorization, submit treatment or continuity of care plans and more.

4. Preauthorization process
• Members must request preauthorization for all covered behavioral health services before treatment.
• You, or a member's family member, may request preauthorization on the member's behalf.
• Members beginning treatment and those with treatment ongoing must request preauthorization, regardless of how long the member has been a patient.
• To request preauthorization, call the number on the back of the member ID card.
• All services must be medically necessary, including:
  o Inpatient services - acute inpatient treatment, residential treatment centers (RTCs are only applicable for employer groups whose health plans include this coverage option.)
  o Outpatient services - intensive outpatient programs, office visits, group therapy
  o Partial hospitalization admissions
• Members may be financially responsible for services that are not covered in their plan or that are deemed medically unnecessary.
• Changes to existing preauthorization requirements are not effective until the member’s 2011 group renewal.

5. Failure to preauthorize
• Outpatient - If a member receives outpatient behavioral health visits without requesting preauthorization, a reminder will be sent to the member with their Explanation of Benefits including instructions for how to request preauthorization. The provider will also be notified.
  o There will be no benefit reduction for failing to request preauthorization for outpatient treatment. However, BCBSTX may request clinical information to determine medical necessity.
• Inpatient or partial hospitalization admissions – There are no changes to inpatient preauthorization requirements. Members who fail to request preauthorization for inpatient treatment may experience the same benefit reductions that apply for inpatient medical services.

6. Outpatient services – additional information
• Outpatient visits exceeding an initial 10 office visits will require you to submit an Outpatient Treatment Request (OTR) form via phone or fax for a medical necessity review. You may submit at any time before the 11th visit. OTR forms will be posted online at bcbstx.com/provider under Forms by the end of the year.
  o Counting outpatient office visits toward the annual 10 visit authorization allowance does not begin until the member’s 2011 group plan renewal.

7. Important telephone and fax numbers, P.O. Box address (effective Jan. 1, 2011)
• All BCBSTX customer service and other phone numbers as well as service hours will remain the same.
  o New fax number: Toll-free 877-361-7646
• New P.O. Box address: P.O. Box will also be posted on bcbstx.com/provider
  o Blue Cross and Blue Shield of Texas BH Unit
  P.O. Box 660241
  Dallas, TX 75266-0241

8. Other important information
• There is no change to the claim submission process.
• There is no change to the BCBSTX provider contract language.
• In January, call the number on the back of the member’s ID card to:
  o Request preauthorization
  o Submit treatment plans
  o Obtain OTR/Psychological testing forms
  o Contact customer service
• iEXCHANGE, a Web-based application that supports an automated
  preauthorization process for BCBSTX, will be available in 2011. Details and
  training will be announced at a later date.
• The BCBSTX Provider Manual, other reference materials and forms will be
  updated and posted on bcbstx.com/provider by Jan. 1, 2011.

More information is available in the updated Frequently Asked Questions (FAQs),
available on our website at bcbstx.com/provider. If you have any questions, please
contact your professional provider network representative.

BCBSTX to post updated hospital quality ribbons and affordability scales in
January 2011
Blue Cross and Blue Shield of Texas (BCBSTX) recently completed its annual
evaluations of quality and cost-related performance for Texas PPO-contracted general
acute-care hospitals and will be posting the updated BlueCompare designations in its
Provider Finder® in January. Results of the evaluation were mailed to these hospitals in
early November 2010.

BlueCompare for Hospitals is a program BCBSTX created to help consumers obtain
quality-related performance and general affordability information on general acute-care
hospitals in the PPO networks. Hospitals are given a quality-related ribbon based on the
BlueQ scorecard, which uses publicly reported data. The affordability scale is based on
inpatient claims data. These designations, along with a brief explanation, appear beside
the names of general acute PPO hospitals in Provider Finder, BCBSTX’s online search
engine used by consumers to look for providers within the Blue Cross and Blue Shield
networks.

BlueCompare is designed to provide general information, not to suggest which hospital a
consumer should choose. We also have BlueCompare for Physicians, a program that
provides quality-related performance information on physicians.

For more information about BlueCompare for Hospitals, please visit
bcbstx.com/provider/bluecompare_hospitals.htm.
If you have any questions, please contact your Facility Provider Representative. If you are unsure who your Facility Provider Representative is, please visit bcbstx.com/provider/contact_us.htm#localnetwork.

**Are you ready for ANSI 5010 and ICD-10?**

The changes required by the regulation may have a significant impact on your business operations, and you (with the help of your software vendor and clearinghouse) should be ready to test your transmissions with each other to assess the potential impact on your practice. If you haven’t started yet, you may risk increasing your compliance cost to meet the dates.

**ANSI 5010 testing and compliance**
The migration to ANSI 5010 allows you to comply with the mandated ICD-10 adoption. Version 5010 includes the following infrastructure changes in preparation for the ICD-10 codes:

- Increases the field size for ICD codes from five numeric characters to seven alphanumeric characters
- Adds a one-digit version indicator to the ICD code to indicate Version 9 versus Version 10
- Increases the number of diagnosis codes allowed on a claim
- Includes additional data modification in the standards adopted by Medicare Fee For Service (FFS).

More than a year away, the more complex transition to the ICD-10 code set depends on a successful transition to ANSI 5010, which must be fully operational on Jan. 1, 2012, to transmit the expanded ICD-10 version of standard procedure and diagnosis codes. That makes two compliance dates to circle on your calendars: Jan. 1, 2012, and Oct. 1, 2013, as mandated by the U. S. Department of Health and Human Services.

**Level I**
- Level I testing is the period when covered entities perform all of their internal readiness activities to prepare for testing the new versions of the standards with their trading partners.
- Level I compliance means a covered entity can create and receive compliant transactions that result from the completion of all internal activities and testing.

**Level II**
- Level II testing activities involves external testing with trading partners. Covered entities, however, must be compliant with Level I activities before they can prepare for Level II testing.
• Level II compliance means that a covered entity has completed end-to-end testing with each of its trading partners, and that it can operate in production mode with Versions 5010 and D.0 (the pharmacy component).
• Covered entities must be Level II compliant by Dec. 31, 2011.

| BCBSTX will begin external testing of ANSI 5010 in the second quarter of 2011. |
| This initial testing will focus on direct submitters, such as clearinghouses, billing services and other vendors. |

Get a jump start on compliance. Here’s how.
Commit early to the process by checking your options and applying your resources to the effort. Benchmark your progress. BCBSTX can help you get up to speed. Here’s how:

• **Attend a BCBSTX Webinar**
  BCBSTX will be hosting a series of Webinars starting in January 2011 to review the conversion process and important transactional details of ANSI 5010. For Webinar dates, times and online registration, visit the Education and Reference section at bcbstx.com/provider.

• **Become a Testing Partner**
  BCBSTX invites your practice or facility to join with us as a testing partner to help ensure all systems are fully functional before the mandated compliance dates. E-mail your interest to ansi_icd@bcbstx.com.

• **Watch for Ongoing Articles and Alerts**
  You will continue to find ANSI 5010 and ICD-10 articles in future issues of the Blue Review. Online, be sure to check the News and Updates section at bcbstx.com/provider for important announcements.

• **Download our Booklet “ANSI 5010 – What Providers Need to Know”**
  Our handy ANSI 5010 booklet includes timelines, calendar reminders, vendor suggestions and other important information. For other helpful resources, visit the ANSI 5010/ICD-10 page in the Standards and Requirements section at bcbstx.com/provider.

• **Questions? Need assistance?**
  - E-mail ansi_icd@bcbstx.com,

ANSI 5010 and ICD-10 timeline
Add these important dates and reminders to your calendar.

| Jan. 1, 2011        | - CMS begins accepting ANSI 5010 claims (ANSI Version 4010A1 claims will continue to be accepted). |
| 2Q 2011            | - External testing of ANSI 5010 for electronic claims can begin. |
| Dec. 31, 2011      | - BCBSTX internal implementation and external testing begins. |
|                   | - External testing of ANSI 5010 for electronic claims must be |
completed to achieve Level II ANSI 5010 compliance.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 1, 2012</td>
<td>- Every electronic claim must be submitted via ANSI 5010.</td>
</tr>
<tr>
<td></td>
<td>- Claims submitted on ANSI v4010A1 will no longer be accepted.</td>
</tr>
<tr>
<td>Oct. 1, 2012</td>
<td>- Begin testing of ICD-10 coding.</td>
</tr>
<tr>
<td>Oct. 1, 2013</td>
<td>- BCBSTX will accept standard electronic transactions with an ICD-10</td>
</tr>
<tr>
<td></td>
<td>diagnosis and procedure code for transactions with a service or</td>
</tr>
<tr>
<td></td>
<td>discharge date on or after Oct. 1, 2013.</td>
</tr>
<tr>
<td></td>
<td>- CPT codes remain valid and should be used for outpatient services.</td>
</tr>
</tbody>
</table>

### Blue Medicare Rx (PDP)*SM Medicare Part D Formulary changes 2010 to 2011

The Medicare Part D six-week Annual Open Enrollment Period (AEP) begins Nov. 15, 2010, and ends on Dec. 31, 2010. In mid-October the 2011 Blue MedicareRx*, Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Part D formulary was approved by the Centers for Medicare and Medicaid Services (CMS) and, as with all Medicare Part D drug plans, you can expect some changes for 2011. Some of the changes were mandated by CMS (safety concerns, drugs that no longer meet CMS’ definition of a ‘Part D medication’, etc.) but others were a result of dynamic changes in the pharmaceutical marketplace. The 2011 Blue MedicareRx formulary changes include the addition of some new drug therapies as well as the migration to some important generic equivalents that became available in 2010.

A copy of 2010 to 2011 formulary changes (i.e. drug removals and new Prior Authorization and Step Therapy utilization management programs) is included in the Annual Notice of Change (ANOC) that is sent to all current members of HISC’s Medicare Part D plans. In addition, individual member letters will be mailed in late November 2010, alerting them of 2011 formulary changes (removals, tier changes, new utilization management programs, etc.) affecting them. Finally a copy of the 2011 formulary is already available on the BCBSTX Provider website [bcbstx.com/provider](http://bcbstx.com/provider) in time for the start of the Medicare Part D AEP. Please refer to our list below for a handy reference to the Top 30 medications that will be impacted by a change to the 2011 formulary and, therefore, have the most potential to affect current members. Coverage determinations for changes can be submitted by the prescribing physician after Dec. 17, 2010, with an effective date of Jan. 1, 2011.

*Blue MedicareRx (PDP) is a stand-alone prescription drug plan with a Medicare contract offered by HCSC Insurance Services Company, an independent Licensee of the Blue Cross and Blue Shield Association under contract S5715 with the Centers for Medicare and Medicaid Services.*

<table>
<thead>
<tr>
<th>#</th>
<th>Formulary Change</th>
<th>2010 Tier</th>
<th>2011 Tier</th>
<th>Description of Formulary Change</th>
<th>Formulary Alternative if Applicable</th>
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<tbody>
<tr>
<td>1</td>
<td>acetaminophen w/codeine,</td>
<td>1</td>
<td>1</td>
<td>Is on our formulary, however quantity limit may apply</td>
<td>On formulary, quantity limit may apply</td>
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<td>acetaminophen / hydrocodone</td>
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<td></td>
<td></td>
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<td></td>
<td>Medicine</td>
<td>Formulary Status</td>
<td>Explanation</td>
<td>Cost Tier Details</td>
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<td>-----------------------------------------------------------------------------------</td>
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<tr>
<td>2</td>
<td>ACTOS, ACTOPLUS MET, ACTOPLUS MET XR</td>
<td>On formulary</td>
<td>Is on our formulary, but will be covered in a higher cost tier; quantity limit may apply</td>
<td>On formulary, higher tier; quantity limit may apply</td>
<td></td>
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<tr>
<td>3</td>
<td>ARICEPT, ARICEPT ODT</td>
<td>On formulary</td>
<td>Is on our formulary, but will be covered in a higher cost tier; quantity limit may apply</td>
<td>On formulary, higher tier; quantity limit may apply</td>
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<td>AVODART</td>
<td>On formulary</td>
<td>Is on our formulary, however quantity limit may apply</td>
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<td>5</td>
<td>benazepril, benazepril/ hydrochlorothiazide</td>
<td>On formulary</td>
<td>Is on our formulary, however quantity limit may apply</td>
<td>On formulary, quantity limit may apply</td>
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<td>6</td>
<td>BENICAR, BENICAR HCT</td>
<td>On formulary</td>
<td>Is on our formulary, however quantity limit may apply</td>
<td>On formulary, quantity limit may apply</td>
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<td>7</td>
<td>citalopram</td>
<td>On formulary</td>
<td>Is on our formulary, however quantity limit may apply</td>
<td>On formulary, quantity limit may apply</td>
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<td>8</td>
<td>COZAAR tabs, HYZAAR tabs</td>
<td>Not on formulary</td>
<td>Is not covered on our 2011 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated • Equal to brand-name drugs in terms of safety and effectiveness • Less expensive</td>
<td>Losartan potassium tabs 25 mg, 50 mg, 100 mg; losartan/hydrochlorothiazide tabs 50-12.5 mg, 100-12.5 mg, 100-25 mg</td>
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<td>9</td>
<td>CYMBALTA</td>
<td>On formulary</td>
<td>Is on our formulary, however quantity limit may apply</td>
<td>On formulary, quantity limit may apply</td>
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<tr>
<td>10</td>
<td>DIOVAN, DIOVAN HCT</td>
<td>On formulary</td>
<td>Is on our formulary, however quantity limit may apply</td>
<td>On formulary, quantity limit may apply</td>
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<td>doxazosin, terazosin</td>
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<td>On formulary, quantity limit may apply</td>
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<td>12</td>
<td>finasteride</td>
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<td>Is on our formulary, however quantity limit may apply</td>
<td>On formulary, quantity limit may apply</td>
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<td>13</td>
<td>FLOMAX caps 0.4 mg</td>
<td>Not on formulary</td>
<td>Is not covered on our 2011 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated • Equal to brand-name drugs in terms of safety and effectiveness • Less expensive</td>
<td>Tamsulosin caps 0.4 mg</td>
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<td></td>
<td>Product</td>
<td>Quantity</td>
<td>Limit</td>
<td>Formulary Status</td>
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<td>----------</td>
<td>-------</td>
<td>---------------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>14</td>
<td>fluoxetine, fluoxetine DR</td>
<td>1</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>15</td>
<td>glimepiride</td>
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<td>16</td>
<td>glipizide, glipizide ER</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>17</td>
<td>glyburide 1.25 mg, 2.5 mg, 5 mg; glyburide/metformin</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>18</td>
<td>lisinopril, lisinopril hydrochlorothiazide</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>19</td>
<td>losartan, losartan hydrochlorothiazide</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>20</td>
<td>metformin, metformin ER</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>21</td>
<td>MIRTAZAPINE, MIRTAZAPINE ODT</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>22</td>
<td>NAMENDA, NAMENDA TITRATION PAK</td>
<td>2</td>
<td>2</td>
<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>23</td>
<td>paroxetine hcl, paroxetine hcl ER</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>ramipril</td>
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<td>25</td>
<td>sertraline</td>
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<td>tamsulosin</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>27</td>
<td>tramadol, tramadol/acetaminophen</td>
<td>1</td>
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<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
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<td>28</td>
<td>TRICOR tabs 48 mg, 145 mg</td>
<td>2</td>
<td>3</td>
<td>Is on our formulary, but will be covered in a higher cost tier On formulary, higher tier</td>
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<tr>
<td>29</td>
<td>XALATAN</td>
<td>2</td>
<td>3</td>
<td>Is on our formulary, but will be covered in a higher cost tier On formulary, higher tier</td>
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<tr>
<td>30</td>
<td>zolpidem tartrate</td>
<td>1</td>
<td></td>
<td>Is on our formulary, however quantity limit may apply On formulary, quantity limit may apply</td>
<td></td>
</tr>
</tbody>
</table>

posted 11/2010

Notices and Announcements
Glucose meter announcement

Beginning Jan. 1, 2011, step therapy will be implemented for glucose test strips under the BCBSTX fully-insured plans. The use of a preferred glucose test strip will be required before the member can obtain a non-preferred brand. Roche brand ACCU-CHEK® Compact Plus and ACCU-CHEK® Aviva Meter Systems and Bayer brand CONTOUR® and BREEZE® 2 products are the preferred brands.

To help members with this change, BCBSTX will be offering members (fully-insured and ASO) who are currently utilizing non-preferred brand test strips a choice of a preferred glucose monitoring system at no charge. Members may learn more about their meter options at Roche accu-chek.com and Bayer simplewins.com websites and by talking with their health care provider.

Members may obtain one free glucose meter by calling the toll-free number listed in the announcement letter that will be sent to them. We will send these announcement letters throughout the rest of this year and into 2011 based on their group’s renewal dates. This free glucose meter offer will be available through Dec. 31, 2011.

New non-contracting fee schedule

Effective Sept. 1, 2010, BCBSTX implemented a new standard pricing schedule for non-participating providers. This new pricing schedule will be implemented for new and renewing employer groups as of Sept. 1, 2010.

As a result of this change, your BCBSTX patients may see a change in their out-of-pocket costs when care is directed to non-participating providers. As always, the use of non-participating providers could result in the member being balance billed.

To help minimize these situations, remember to direct your BCBSTX patients to in-network facilities, physicians and other professional providers. Due to the breadth of the Blue Cross and Blue Shield network, we anticipate the use of non-participating providers to be low.
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 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.

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.

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**BlueChoice Solutions Large Employer Group List**
**As of October 2010**

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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: 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
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.)
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 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 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 are finalizing the QVT list for 2011.
Visit bcbstx.com/provider/quantity_time.htm for an updated and 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 are finalizing the preferred drug list for 2010.

For the 2010 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/pdf/1010_drug_list.pdf.

**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.