ANSI Version 5010: Make it work for your practice

Are you ready to generate new standard transaction formats?

The new HIPAA electronic transaction standard, ANSI Version 5010 (ANSI v5010), will be the only transaction version that will be accepted by Blue Cross and Blue Shield of Texas (BCBSTX) and other payers beginning Jan. 1, 2012. All covered entities* will be impacted, including hospitals and physician practices. Assessing your readiness and the readiness of all of your vendors is critical. This includes successful completion of the testing of ANSI v5010 transactions prior to the Jan. 1, 2012, implementation date.

If your practice management system and billing entities (billing service and/or clearinghouse) are unable to support ANSI v5010 transactions on Jan. 1, 2012, BCBSTX will be unable to process your electronic claims (ANSI 837 transactions). In addition, other HIPAA-standard Electronic Data Interchange (EDI) transactions, such as eligibility and benefits inquiries (ANSI 270/271), claim status requests (ANSI 276/277) and the Electronic Remittance Advice (ANSI 835 ERA), must also conform with the new ANSI v5010 standard transaction format.

Note: Practice management/hospital information system software developers and vendors are not required to be HIPAA compliant. It is your responsibility to contact your software vendor to confirm that your system is running the most current, HIPAA-compliant software.

Who is your primary contact?

Many providers may utilize a billing service and/or clearinghouse to handle their health care transactions, such as claims. Who has been assigned the task of getting your claims “out the door” and to BCBSTX? Do you know if all of your claims are sent electronically? Do you know if your vendor ever “drops” your claims to paper for submission to BCBSTX?

If your billing service is your primary contact, and if you have not done so already, start a dialogue with them about ANSI v5010 readiness. Ask them what they have done to meet the mandated requirements of ANSI v5010, and ask what they need from you to help ensure you will be in compliance.

By knowing your primary contact, and by becoming aware of the additional contacts and the exact route your transactions take from your office to your payers, you will be better equipped to manage any issues and resolve any problems.

Know where your claims go

Many providers believe that their claims are submitted directly to BCBSTX. Actually, only a small number of claims are directly submitted to us. Almost all claims go through
intermediaries before arriving at BCBSTX. An intermediary could include one or more of the following:

- A practice management system (PMS) or hospital information system (HIS)
- A billing service
- One or multiple clearinghouses

Since a claim may be handled by multiple entities along its way to us, there is a potential for processing delays at each of these points. At each point of contact, the transaction must be validated before it can move on to the next point of contact. A transaction can only progress to the next entity if it meets all requirements – including all new claim submission mandates, such as those related to use of the National Provider Identifier (NPI) and changes to Billing Provider Address/Loop 2010AA requirements.

If it meets all of the format and data requirements along the way, the transaction is forwarded to our primary claims clearinghouse, where it is subjected again to format and data validation. If the transaction passes this point of review, it makes its way to BCBSTX. Failure to pass the validation requirements will result in rejection, sending the transaction back through each step to the point of origin.

After a claim leaves your office, it should not become “out of sight, out of mind.” Follow up with your primary contact. They should be confirming receipt of all transactions and whether those transactions were passed successfully on to the next entity. Ask the following questions of your primary contact:

- Did your primary contact receive a successful report back?
- If the claim was rejected at the next connection point, ask why, or “Where are my response reports?”
- Were rejections/errors fixed to enable the transaction to continue on its way?
- Is each intermediary entity along the way getting ready for the conversion to ANSI v5010? Is each entity testing now? **When will each entity be fully compliant?**

Get involved in your own claim process. ANSI v5010 is coming, and you need to test now to continue receiving claims payments. Make your primary contact accountable. Make sure you and your staff are trained and ready.

**Paper claims are not the solution**

Though providers submitting paper claims are not immediately impacted by the conversion from ANSI v4010 to v5010, now is a good time to convert to a practice management system that supports electronic medical records as well as electronic claim filing. Doing so allows providers to take advantage of government incentives, which could, in turn, help cover the related costs. It will also likely ease the conversion to ICD-10, which all covered entities must complete by Oct. 1, 2013.

**For more information**

Visit the ANSI v5010/ICD-10 page in the Standards and Requirements section of our website at bcbstx.com/provider where you can:

- Register online for an October webinar. View session dates and times and register online at bcbstx.com/provider by clicking the Education & Reference tab, Training and then ANSI Version 5010/ICD-10 2011 Webinars. **Here’s a direct link.**
• View preparation tips and timeline reminders
• Find links to helpful resources on other sites, such as the Centers for Medicare and Medicaid Services (CMS)
• View answers to frequently asked questions

Need assistance? Email your ANSI v5010/ICD-10 questions to us at ansi_icd@bcbstx.com.

* Covered entities include health plans, clearinghouses, health information trading partners, health information networks and health care providers who transmit HIPAA transactions electronically.

The above information is for educational purposes and is not legal advice. If you have any questions regarding compliance with the various laws or regulations, you should consult with your legal advisor.

Predetermination process for the RSV prophylaxis program
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. Two kinds of forms (online and hard-copy) are posted at bcbstx.com/provider/forms/index.html.
• Submit the completed online version of the form; or fax the completed hard-copy version to Allan J. Chernov, M.D. (Medical Director, Health Care Quality & Policy) at 972-766-5559.

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 include BCBSTX written authorization, Triessent will not process the order. It will return the request form to the prescribing physician to supply the missing information.

An approved predetermination will cover a maximum of five monthly injections for that patient for the 2011-2012 RSV season, which runs from Oct. 1, 2011, to March 15, 2012. No additional reviews will be needed.

For out-of-state members, contact the member’s Home Plan for eligibility and benefit information. The Home Plan’s phone number can be found on the back of the member’s ID card.

Delegation protocols for Advanced Practice Nurses and Physician Assistants
Blue Cross and Blue Shield of Texas’ (BCBSTX) Physician Office Review program assesses the practice of physicians providing primary care services to its members. Some practices may employ Advanced Practice Nurses (APN) and/or Physician Assistants (PA) and a site visit will include review for the presence of written delegation protocols (aka ‘Scope of Practice’, ‘Standing Delegation Orders’, etc.).
A delegation protocol defines the scope of practice, including limitations of practice and prescriptive authority of non-physician practitioners. Additionally, the delegation protocol is a written agreement between the supervising physician and each non-physician practitioner in their employ and is reviewed annually, updated, approved and signed by both parties to maintain current understanding of the scope of delegation. A copy of the agreement must be maintained at the location of the non-physician practitioner along with their current licensure.

For more information on ‘delegation protocols’ see the Texas Occupations Code – Chapter 157: Authority of Physician to Delegate Certain Medical Acts, for state law related to physician delegation. For further information on rules and regulations, reference the Board Governing each profession. For Nurse Practitioners, see the Texas Board of Nurse Examiners Rules 221.12 and for Physician Assistants, see the Texas Board of Medical Examiners Board Rules 185.11.

BCBSTX also recommends written notification to patients seen by APNs and PAs that clearly identifies their professional status. Additionally, patients should be given the option to be seen by a physician if they prefer.

**Claim frequency codes accepted on professional claims**

The Blue Cross and Blue Shield of Texas (BCBSTX) claim system was recently enhanced to recognize the claim frequency code on professional electronic claims (ANSI 837P transactions). Using the appropriate code will indicate that the claim is an adjustment of a previously adjudicated (approved or denied) claim. The claim frequency codes are as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Indicates the claim is an original claim</td>
</tr>
<tr>
<td>7</td>
<td>Indicates the new claim is a replacement or corrected claim. The information present on this bill represents a complete replacement of the previously issued bill.</td>
</tr>
<tr>
<td>8</td>
<td>Indicates the claim is a voided/canceled claim</td>
</tr>
</tbody>
</table>

**Replacement claims**

Replacement claims submitted electronically will reduce the potential for a claim to deny as a duplicate. If a replacement claim needs to be submitted, you may submit the correction electronically with the appropriate frequency code (7). **Modifier 25 and 59 corrections are excluded from this process and may not be submitted electronically.**

An example of the ANSI 837P file containing a replacement/corrected claim, along with the required REF segment and Qualifier in Loop ID 2300 – Claim Information, is provided below.

```
CLM*12345678*500***11::7*Y*A*Y*I*P~
REF*F8*(Enter the Claim Original Reference Number)
```

The first two digits (“11”) in the example above indicate the place of service on a professional claim. The colons (“::”) between the place of service and frequency code are known as **Sub-element Separators** (indicates that this field is currently not used).
The replacement claim will replace the entire previously processed claim. Therefore, when submitting a correction, send the claim with all changes exactly how the claim should be processed.

Examples:
1. A claim was previously submitted with procedure codes 99213, 88003 and 77090. The 88003 should have been 88004. An electronic replacement claim should be submitted for the line that needs to be corrected, along with the appropriate frequency code: 7, 99213, 88004 and 77090. This indicates to BCBSTX that all charges need to be deleted, and the claim will then be processed with 99213, 88004 and 77090.

2. A claim was previously submitted with procedure codes 99214, 70052 and 99213. Procedure codes 70052 and 99213 were submitted in error and need to be removed. An electronic replacement claim should be submitted with frequency code 7 and procedure code 99214. This claim will then be adjusted to remove 70052 and 99213, and it will be processed with 99214.

Note: If a charge was left off the original claim, please submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.

Void claims
If a claim was submitted to BCBSTX in error and needs to be voided, the claim to be voided should be submitted exactly as it was submitted previously, along with the appropriate frequency code to indicate that the claim should be voided (8).

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

* Corrected claims using modifiers 25 or 59 must be submitted on paper, along with medical records. For these requests, use the Claim Review Form, which is available in the Education and Reference/Forms section of our website at bcbstx.com/provider.

Medicare Part D formulary updates
A summary of recent Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Part D formulary changes can be found below. This list is updated monthly by our pharmacy provider, Prime Therapeutics. For a complete listing and for future inquiries of recent Medicare Part D formulary changes for your BCBSTX members, please follow these instructions:

- Navigate to myprime.com
- Click on ‘Find Drugs & Estimates’
- Follow directions to a corresponding health plan
  - Click on ‘BCBS Texas’
  - Part D Member? Click ‘YES’
  - Click on ‘Blue MedicareRxSM (PDP)’
- Click on hyperlink ‘Formulary Updates. Pdf’
- You can also inquire about plan-covered medications and network pharmacies as well as accessing the Blue MedicareRx Comprehensive Formulary.
Other useful informational sources can be found at this website, including: CY 2010 to CY 2011 formulary changes, prior authorization criteria, filing a grievance, transition policies, etc.

<table>
<thead>
<tr>
<th>Generic name (TRADE NAME)</th>
<th>BRAND Generic Product</th>
<th>Effective Date</th>
<th>Nature of Change</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diclofenac sodium DR tabs, 25mg</td>
<td>Generic</td>
<td>March 23, 2011</td>
<td>Cost Share Reduction</td>
<td>• Change to Tier 1 (was 3)</td>
</tr>
</tbody>
</table>
| Latanoprost opt soln, 0.005% | Generic | March 27, 2011 | Addition | • Tier 1  
• First generic for XALANTAN  
• Quantity Limits apply |
| exemestane Tabs 25mg | Generic | April 10, 2011 | Addition | • Tier 1  
• First generic for AROMASIN |
| Lithium carbonate tabs 300mg | Generic | April 12, 2011 | Cost Share Reduction | • Change to Tier 1 (was 3) |
| Disulfiram tabs, 250mg | Generic | April 17, 2011 | Addition | • Tier 1  
• First generic for ANTABUSE |
| Acetazolamide extended-release 12 hr caps 500mg | Generic | May 1, 2011 | Addition | • Tier 1  
• First generic for DIAMOX SEQUELS |
| Eplerenone tabs 25mg, 50mg | Generic | May 1, 2011 | Addition | • Tier 1  
• First generic for INSPRA |
| Letrozole tabs, 2.5mg | Generic | May 1, 2011 | Addition | • Tier 1  
• First generic for FEMARA |
| ANDROGEL PUMP (testosterone) transdermal gel, 20.25/mg/act | BRAND | May 8, 2011 | Addition | • Tier 2 |
| bromfenac ophth soln, 0.09% | Generic | May 15, 2011 | Addition | • Tier 1  
• First generic for XIBROM |
| Paroxetine hcl extended release 24 hr tabs, 37.5mg | Generic | May 22, 2011 | Cost Share Reduction Utilization Management change | • Change to Tier 1 (was 3)  
• Step Therapy NO longer applies  
• Quantity Limits continue to apply |
| Carbamazepine extended release 12 hr caps, 100mg, 200mg, 300mg | Generic | May 29, 2011 | Addition | • Tier 1  
• First generic for CARBATROL |
| Latanoprost ophth soln, 0.005% | Generic | June 1, 2011 | Utilization Management change | • Tier 1  
• Quantity Limits NO longer apply |
<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Type</th>
<th>Date</th>
<th>Utilization Management Change</th>
<th>Tier</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>XALANTAN (Latanoprost) ophth soln, 0.005%</td>
<td>BRAND</td>
<td>June 1, 2011</td>
<td>Utilization Management change</td>
<td>Tier 3</td>
<td>Quantity Limits NO longer apply</td>
</tr>
<tr>
<td>LUMIGAN (bimatoprost) ophth soln, 0.01%, 0.03%</td>
<td>BRAND</td>
<td>June 1, 2011</td>
<td>Utilization Management change</td>
<td>Tier 2</td>
<td>Quantity Limits NO longer apply</td>
</tr>
<tr>
<td>TRAVATAN. TRAVATAN Z (travoprost) ophth soln, 0.004%</td>
<td>BRAND</td>
<td>June 1, 2011</td>
<td>Utilization Management change</td>
<td>Tier 2</td>
<td>Quantity Limits NO longer apply</td>
</tr>
<tr>
<td>methylergonovine tabs, 0.2mg</td>
<td>Generic</td>
<td>June 19, 2011</td>
<td>Addition</td>
<td>Tier 1</td>
<td>First generic for METHERGINE</td>
</tr>
<tr>
<td>Triamcinolone nasal, 55mcg/spray</td>
<td>Generic</td>
<td>June 19, 2011</td>
<td>Addition</td>
<td>Tier 1</td>
<td>First generic for NASACORT AQ</td>
</tr>
<tr>
<td>Budesonide extended release 24 hr caps, 3mg</td>
<td>Generic</td>
<td>June 26, 2011</td>
<td>Addition</td>
<td>Tier 1</td>
<td>First generic for ENTOCORT EC</td>
</tr>
<tr>
<td>Levofloxacin oral soln, 25mg/ml; tabs, 250mg, 500mg, 750mg</td>
<td>Generic</td>
<td>June 26, 2011</td>
<td>Addition</td>
<td>Tier 1</td>
<td>First generic for LEVAQUIN</td>
</tr>
<tr>
<td>Leuprolide acetate (LUPRON DEPOT – 6 month) for inj kit, 45mg</td>
<td>BRAND</td>
<td>June 26, 2011</td>
<td>Addition</td>
<td>Tier 4</td>
<td></td>
</tr>
</tbody>
</table>

SM Service Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

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.

A stand-alone prescription drug plan with a Medicare contract.

Notices and Announcements

Procedure Plus an Evaluation and Management Service Reimbursement Methodology
In May 2011, Blue Cross and Blue Shield of Texas (BCBSTX) announced that the Procedure Plus an Evaluation and Management Service Reimbursement Methodology would be implemented effective Sept. 1, 2011. BCBSTX has decided NOT to implement
the Procedure Plus an Evaluation and Management Service Reimbursement Methodology.

**Billing with National Drug Codes (NDC)**
In May 2011, BCBSTX announced that claims submitted with an NDC will be reimbursed in accordance with the NDC schedule posted on the website under "Drugs" effective Dec. 1, 2011. The effective date of this change has been postponed until Jan. 1, 2012.

BCBSTX currently accepts NDC for billing of all physician administered and physician supplied drugs. Including the NDC on claims helps provide a more consistent pricing methodology for payment and will also facilitate better management of drug associated costs. Physicians are encouraged to begin including the NDC information on claims as soon as possible.

For information about how to add the additional NDC and other required elements, please refer to the BCBSTX provider website, bcbstx.com/provider. BCBSTX will continue to accept the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code elements without NDC information (excluding unlisted or "Not Otherwise Classified" drugs). BCBSTX requires inclusion of the NDC along with the applicable HCPCS or CPT code(s) on claim submissions for unlisted or “Not Otherwise Classified” (NOC) physician administered and physician supplied drugs.

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

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

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

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

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

Review a sample of the [Hemophilia Therapy: Quantity vs. Time Documentation Form](#)
When received, a medical director will review the completed forms. The medical director will call the physician with questions or concerns.

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

**FDA Updates – Summer 2011**

In order to help healthcare providers stay up to date on the latest U.S. Food and Drug Administration (FDA) news, we have listed a number of recent newsworthy FDA News Releases, Safety Information and Adverse Event Reporting, new drug approvals and withdrawals, etc. We hope you find the information useful.

**Generic Drug Information:**

- **Bromfenac (XIBROM) (May 16, 2011):** Mylan Pharmaceuticals Inc. has launched bromfenac ophthalmic solution, 0.09% (twice daily administration). This product is the first generic version of ISTA's Xibrom ophthalmic solution for the treatment of postoperative inflammation in patients who have undergone cataract extraction.

- **Budesonide extended release 24 hr caps (ENDOCORT EC) (May 16, 2011):** Mylan’s Abbreviated NDA to market a generic version of ENTOCORT EC was approved by the FDA on May 16, 2011.

- **Levofloxacin (LEVAQUIN) (June 20, 2011):** The FDA has approved the first generic versions of Levaquin (levofloxacin), a fluoroquinolone antibiotic indicated for infections caused by susceptible strains of certain microorganisms. Levofloxacin must be dispensed with a patient Medication Guide describing the drug's uses and warnings.

**New Drug Information:**

- **VICTRELIS (boceprevir) (May 16, 2011):** The FDA approved VICTRELIS (boceprevir), an HCV protease inhibitor, in combination with peginterferon alfa and ribavirin, for the treatment of chronic hepatitis C genotype 1 infection, in adult patients with compensated liver disease (including cirrhosis) who have not yet been treated or who have not responded to previous interferon and ribavirin therapy.

- **EDURANT (relpivirine) (May 20, 2011):** The FDA has approved EDURANT (relpivirine), a nonnucleoside reverse transcriptase inhibitor (NNRTI), in combination with other antiretroviral drugs for the treatment of HIV-1 infection in adults who have never taken HIV therapy.

- **INCIVEK (Telaprevir) (May 23, 2011):** The FDA has approved Vertex Pharmaceuticals’ INCIVEK (telaprevir), a hepatitis C virus protease inhibitor in combination with peginterferon alfa and ribavirin to treat patients with chronic hepatitis C infection who have not received interferon-based drug therapy for their
infection or who have not responded adequately to prior therapies.

- **NULOJIX (belatacept) (June 15, 2011):** The U.S. FDA approved Nulojix (belatacept) to prevent acute rejection in adult patients who have had a kidney transplant. The drug is approved for use with other immunosuppressants (medications that suppress the immune system) -- specifically basiliximab, mycophenolate mofetil, and corticosteroids. Nulojix is a type of drug called a selective T-cell costimulation blocker.

- **ARCAPTA (indacaterol) (July 1, 2011):** The U.S. FDA approved Arcapta Neohaler (indacaterol inhalation powder) for the long term, once-daily maintenance bronchodilator treatment of airflow obstruction in people with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and/or emphysema. Arcapta Neohaler is a new molecular entity in the beta₂-adrenergic agonist class. Arcapta Neohaler is not intended to treat asthma or sudden, severe symptoms of COPD.

- **XARELTO (rivaroxaban) (July 5, 2011):** The U.S. FDA approved Xarelto (rivaroxaban) to reduce the risk of blood clots, deep vein thrombosis (DVT), and pulmonary embolism (PE) following knee or hip replacement surgery. Xarelto is a pill taken once daily. Those undergoing a knee replacement should take the medication for 12 days, and patients undergoing a hip replacement procedure should take Xarelto for 35 days.

- **BRILINTA (ticagrelor) (July 20, 2011):** The U.S. FDA approved the blood-thinning drug Brilinta (ticagrelor) to reduce cardiovascular death and heart attack in patients with acute coronary syndromes (ACS). Brilinta has been studied in combination with aspirin and a boxed warning warns that aspirin doses above 100 milligrams per day decrease the effectiveness of the medication. In clinical trials, Brilinta was more effective than Plavix in preventing heart attacks and death, but that advantage was seen with aspirin maintenance doses of 75 to 100 milligrams once daily.

**Market Recalls or Withdrawals:**

- **Risperdal (risperidone) and Risperidone: Recall - Uncharacteristic Odor (June 20, 2011):** Ortho-McNeil-Janssen Pharmaceuticals notified healthcare professionals and the public of a recall of specific lots of Risperdal (risperidone) 3mg tablets and risperidone 2mg tablets. The recall stems from consumer reports of an uncharacteristic odor thought to be caused by trace amounts of TBA (2,4,6 tribromoanisole). TBA is a byproduct of a chemical preservative sometimes applied to wood often used in the construction of pallets on which materials are transported and stored. While not considered to be toxic, TBA can generate an offensive odor and a small number of patients have reported temporary gastrointestinal symptoms.

**FDA Product Safety:**

- **FDA announces new safety recommendations for high-dose simvastatin - Increased risk of muscle injury cited (June 8, 2011):** The FDA announced safety label changes for the cholesterol-lowering medication simvastatin because the highest approved dose--80 milligram (mg)--has been associated with an elevated risk of muscle injury or myopathy, particularly during the first 12 months
- **Ongoing safety review of pioglitazone (June 15, 2011):** The FDA informed the public that use of the diabetes medication Actos (pioglitazone) for more than one year may be associated with an increased risk of bladder cancer. Information about this risk will be added to the *Warnings and Precautions* section of the label for pioglitazone-containing medicines. The patient Medication Guide for these medicines will also be revised to include information on the risk of bladder cancer.

- **Modified Dosing for Erythropoiesis-Stimulating Agents (June 24, 2011):** The FDA has approved modified recommendations for more conservative dosing of erythropoiesis-stimulating agents (ESAs) in patients with chronic kidney disease (CKD). The new recommendations are based on clinical trials showing that using ESAs to target a hemoglobin level of greater than 11 g/dL in patients with CKD provides no additional benefit other than lower target levels and increases the risk of serious adverse cardiovascular events, such as heart attack or stroke.

- **Ongoing safety review of oral osteoporosis drugs (bisphosphonates) and potential increased risk of esophageal cancer (July 21, 2011):** The FDA is continuing to review data from published studies to evaluate whether use of oral bisphosphonate drugs is associated with an increased risk of cancer of the esophagus. There have been conflicting findings from studies evaluating this risk.

- **Dronedarone (MULTAQ) and increased risk of death and serious cardiovascular adverse events (July 21, 2011):** The FDA is reviewing data from a clinical trial that was evaluating the effects of the antiarrhythmic drug Multaq (dronedarone) in patients with permanent atrial fibrillation. The study was stopped early after the data monitoring committee found a two-fold increase in death, as well as two-fold increases in stroke and hospitalization for heart failure in patients receiving Multaq compared to patients taking a placebo.

- **Serious CNS reactions reported with linezolid and certain anti-psychotic medications (July 26, 2011):** The FDA has received reports of serious central nervous system reactions when the antibacterial drug linezolid (marketed as Zyvox®) is given to patients taking psychiatric medications that work through the serotonin system of the brain (serotonergic psychiatric medications).

- **Fluconazole use during pregnancy may cause birth defects (Aug. 3, 2011):** The FDA informed the public that chronic, high doses (400-800 mg/day) of the antifungal drug Diflucan (fluconazole) may be associated with a rare and distinct set of birth defects in infants whose mothers were treated with the drug during the first trimester of pregnancy.
News & Events:

- **FDA approves Boostrix to prevent tetanus, diphtheria, and pertussis in older people (July 8, 2011):** The FDA approved Boostrix vaccine to prevent tetanus, diphtheria, and pertussis (whooping cough) in people ages 65 and older. Currently, there are vaccines approved for the prevention of tetanus and diphtheria that can be used in adults 65 and older. Boostrix, which is given as a single-dose booster shot, is the first vaccine approved to prevent all three diseases in older people.

- **FDA approves Flu vaccines for the 2011-2012 influenza season (July 18, 2011):** The FDA announced that it had approved the 2011-2012 influenza vaccine formulation for all six manufacturers licensed to produce and distribute influenza vaccine for the United States. The vaccine formulation protects against the three virus strains (A/California, A/Perth, B/Brisbane) that surveillance indicates will be most common during the upcoming season and includes the same virus strains used for the 2010-2011 influenza season.

Lastly, if you would like additional information about these or many other drug related topics (e.g., drug safety, MEDWATCH adverse drug reaction reporting system, market recalls, regulations, educational programs, etc.) visit the FDA’s website (fda.gov) and click on ‘drugs.’ You may also sign up for the listservs provided by the FDA.

References:


4. FDA. FDA approves first generic versions of the antibiotic levofloxacin to treat certain infections (June 20, 2011). Accessed online on Aug. 5, 2011, at: fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm259951.htm


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 BCBSTX BlueChoice (PPO/POS) members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

Quest Diagnostics Offers:
- On-line scheduling for Quest Diagnostics’ Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto QuestDiagnostics.com/patient or call 888-277-8772.
- Convenient patient access to more than 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 under the General Reimbursement Information section located under the Standards and Requirements tab.

* Note: Physicians & other professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians & professional providers who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.

Fee schedule updates
Reimbursement changes and updates for BlueChoice and HMO Blue Texas (Independent Provider Network only) practitioners will be posted under Standards and Requirements / General Reimbursement Information / Reimbursement Schedules and Related Information / Professional Schedules section on the BCBSTX provider website at bcbstx.com/provider.

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the General Reimbursement Information section on the provider website. Also, the Drug/Injectable Fee Schedule will be updated on the following dates: Sept. 1, 2011; Dec. 1, 2011; March 1, 2012; and June 1, 2012.

Improvements to the medical records process for BlueCard® claims
BCBSTX is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.

As always, we will request that you submit your medical records to BCBSTX if needed for claims processing.

Requests for medical records from other Blues Plans before rendering services, as part of the preauthorization process, should be submitted directly to the requesting Plan.

Pass-through billing
BCBSTX does not permit pass-through billing. Pass-through billing occurs when the ordering physician or other professional provider requests and bills for a service, but the service is not performed by the ordering physician or other professional provider.

The performing physician or other professional provider should bill for these services unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

- The service of the performing physician and other professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician and other professional provider.

- The service is provided by an employee of a physician or other professional provider (physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is
under the direct supervision of the ordering physician or other professional provider) and the service is billed by the ordering physician or other professional provider.

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 active and pending policies go to bcbstx.com/provider, click on the Policies link toward the bottom of the page and then click on the Medical Policies link. After reading and agreeing to the disclaimer, you will have access to active and pending medical policies.

**Draft medical policy review**

In an effort to streamline the medical policy review process, you can view draft medical policies on our provider portal and provide your feedback online. The documents will be
made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

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

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

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

Cosmetic procedures and bariatric surgery would not be considered urgent.

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

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

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

**No additional medical records needed**
Physicians and other professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from American Imaging Management need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

**Importance of obtaining preauthorizations for initial stay and add-on days**
Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and other professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or other professional provider obtains preauthorizations for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

If an insured person does not obtain preauthorization for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.
Preauthorization does not guarantee payment. All payments are subject to determination of the insured person’s eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

**Avoidance of delay in claims pending COB information**

BCBSTX receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our physicians and other professional providers is a possible delay, or even denial of services, pending receipt of the required information from the member.

Here are some tips to help prevent claims processing delays when there is only one insurance carrier:

- CMS-1500, box 11-d – if there is no secondary insurance carrier, mark the “No” box.
- Do not place anything in box 9, a through d – this area is reserved for member information for a secondary insurance payer.

It is critical that no information appears in box 11-d or in box 9 a-d if there is only one insurance payer.

**Billing for non-covered services**

As a reminder, contracted physicians and other professional providers may collect payment from subscribers for copayments, co-insurance and deductible amounts. The physician or other professional provider may not charge the subscriber more than the patient share shown on their provider claim summary (PCS) or electronic remittance advice (ERA).

In the event that BCBSTX determines that a proposed service is not a covered service, the physician or other professional provider must inform the subscriber in writing in advance. This will allow the physician or other professional provider to bill the subscriber for the non-covered service rendered.

In no event shall a contracted physician or other professional provider collect payment from the subscriber for identified hospital acquired conditions and/or never events.

**QVT (quantity versus time) limits**

To help minimize health risks and to improve the quality of pharmaceutical care, QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer’s package insert.

The BCBSTX Clinical Pharmacy and Marketing Departments have finalized the QVT list for 2011. Visit bcbstx.com/provider/pharmacy/index.html for a detailed list under the Pharmacy section.
Preferred drug list
Throughout the year, the BCBSTX Clinical Pharmacy Department team frequently reviews the preferred drug list. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

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

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

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.

Contact us
Click here for a quick directory of contacts at BCBSTX.

Update your contact information online
To update your contact information, go to bcbstx.com/provider, click on the Network Participation tab and follow the directions under Update Your Contact Information. This process allows you to electronically submit a change to your name, office or payee address, email address, telephone number, tax ID or other information. You should submit all changes at least 30 days in advance of the effective date of the change.

If your specialty, practice information/status or board certification is not correct on Blue Cross and Blue Shield of Texas Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the “Other” field or contact your local Professional Provider Network office.

Blue Review is published for BlueChoice®, ParPlan and HMO Blue® Texas contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; email BlueReviewEditor@bcbstx.com.
The information provided in Blue Review does not constitute a summary of benefits, and all benefit information should be confirmed or determined by calling the customer service telephone number listed on the back of the member ID card.

BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent, third-party vendors mentioned in this newsletter. The vendors are solely responsible for the products or services they offer. If you have questions regarding any of the products or services mentioned in this periodical, please contact the vendor directly.

© 2011