Join BCBSTX in testing your readiness for the mandated ICD-10 transition

The transition to ICD-10, a mandate set by the US Department of Health and Human Services, means that all HIPAA-covered entities must discontinue the use of ICD-9 codes for service or discharge dates on or after Oct. 1, 2014, replacing those codes with the more detailed ICD-10 code sets.

Previous Blue Review articles describe some of the benefits of ICD-10 and the planning required for the transition, including technology considerations, staff training and budgeting tips. This month, we want to share some Blue Cross and Blue Shield of Texas (BCBSTX) planning activities as well as our commitment to being ready to meet the transition deadline.

In 2008 and 2009, BCBSTX completed an exhaustive impact assessment to begin preparing for the transition to ICD-10. The assessment helped identify impacts to our business operations, systems and external exchanges, and it assisted us in updating medical policies, contracts and business rules to be consistent with the ICD-10 code set.

Claims submitted after Oct. 1, 2014, may be for dates of service or discharge dates prior to the transition and will require the continued ability to process ICD-9. BCBSTX’s systems have been remediated for dual processing, which means claims can be processed based on the “date of service” or “discharge date”. Claims with incorrect ICD codes for their respective dates of service or discharge dates will still be rejected.

An important part of preparing for ICD-10 is testing, which will help ensure that problems with ICD-10 claim submissions are identified and addressed before Oct. 1, 2014. BCBSTX has already engaged in early testing with vendors and select providers. In early 2014, BCBSTX will conduct larger-scale testing with providers of all types and sizes. Providers interested in testing with BCBSTX in 2014 should first complete the Readiness Survey on the ICD-10 page of the Standards and Requirements section of the BCBSTX provider website at bcbstx.com/provider. BCBSTX will reach out to qualified providers in 2014 for testing opportunities.

BCBSTX is also committed to helping providers with the transition to ICD-10 by providing educational and planning resources. Visit our website to view on-demand webinars, download a visual map of changes to expect in your practice due to ICD-10 and access links to helpful resources from the Centers for Medicare & Medicaid Services (CMS), the American Health Information Management Association (AHIMA) and the Health Information and Management Systems Society (HIMSS).
Coming soon: Revised CMS-1500 paper claim form (Version 02/12)
The National Uniform Claim Committee (NUCC) maintains the CMS-1500 paper claim
form and makes updates according to health care industry requirements. NUCC recently
announced that the health care industry will transition to a revised version of the CMS-
1500 paper claim form in early 2014.

On June 10, 2013, the White House Office of Management and Budget (OMB) approved
the revised CMS-1500 paper claim form, known as OMB-0938-1197 FORM 1500 (02-
12). You will see this new code at the bottom of the revised version.

Notable changes include:
- Indicators added for differentiating between ICD-9-CM and ICD-10-CM diagnosis
codes
- The number of possible diagnosis codes expanded to 12
- Qualifiers added to identify provider roles:
  o Ordering
  o Referring
  o Supervising

The revised paper form also aligns with the requirements of the Accredited Standard
Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010
Technical Reports Type 3 (TR3s). The Washington Publishing Company (WPC) is an
independent publisher of implementation guides recognized by the Centers for Medicare
& Medicaid Services (CMS) as the industry standard. To purchase TR3s, visit the WPC
website at wpc-edi.com. Several fields on the previous paper form were removed for
CMS-1500 (version 02/12) since they are not reported in the 837 transaction.

The tentative implementation timeline is as follows:
- Jan. 6, 2014 – Medicare begins receiving and processing paper claims submitted
  on the revised CMS-1500 claim form (version 02/12).

- Jan. 6, 2014 through March 31, 2014 – Dual-use period during which Medicare
  continues to receive and process paper claims submitted on the old CMS-1500
  claim form (version 08/05), as well as on the new revised CMS-1500 claim form
  (version 02/12).

- April 1, 2014 – Medicare receives and processes paper claims submitted only on
  the revised CMS-1500 claim form (version 02/12).

The above timeline is pending finalization and is subject to change. For additional
information on the CMS-1500 claim form, visit the NUCC website at nucc.org. Please
share this information with your practice management software vendor, and/or your
billing service or clearinghouse, if applicable.

Please note: Blue Cross and Blue Shield of Texas (BCBSTX) encourages all providers
to use electronic claim submission. This can help streamline your administrative
processes, help protect your patients’ information, and may result in faster claim
processing and payment. To learn more visit the Electronic Commerce page in the
Claims and Eligibility section of the BCBSTX provider website bcbstx.com/provider.
In the know: Medicare marketing guidelines for providers

The 2014 Centers for Medicare & Medicaid Services (CMS) Annual Election Period for beneficiaries is fast approaching. For those providers who are independently contracted with Blue Cross and Blue Shield of Texas (BCBSTX) to provide Blue Medicare Advantage PPO services, it’s important to keep in mind the rules established by CMS when marketing to potential enrollees.

You may not be planning specific marketing activities, but what if a patient asks for information or advice? Remaining neutral when assisting with enrollment decisions is essential. Below, you’ll find a partial listing of additional “Dos” and “Don’ts” for providers, as specified within the CMS Medicare Marketing Guidelines for contract year 2014 (section 70.11.1 on Provider-Based Activities).

DO:
- Provide the names of Plans/Part D sponsors with which you contract and/or participate.
- Provide information and assistance in applying for the low-income subsidy (LIS).
- Make available and/or distribute plan marketing materials.
- Refer your patients to other sources of information, such as SHIPs*, plan marketing representatives, your state Medicaid office, local Social Security Office, CMS’ website at http://www.medicare.gov/ or 1-800-MEDICARE.

DON’T:
- Accept Medicare enrollment forms.
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Plans/Part D sponsors.
- Distribute materials/applications within an exam room setting.

The above list provides just a sampling of important points for your convenience. For a more in-depth review of the guidelines that are applicable to providers, please refer to the Medicare Marketing Guidelines Excerpt, located in the Network Participation/Blue Medicare Advantage section of the BCBSTX provider website at bcbstx.com/provider/network/bma_ppo.html.

If you have questions about these guidelines or are planning marketing activities, please refer to the Managed Care Marketing page located under Health Plans, in the Medicare section of the CMS website, at cms.gov.

*SHIPs are State Health Insurance Assistance Programs

Blue Cross and Blue Shield of Texas refers to HCSC Insurance Services Company (HISC), which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Advantage under contract H1666 with the Centers for Medicare and Medicaid Services.

HISC is a Medicare Advantage organization with a Medicare contract.
Spacers improve asthma outcomes
According to the National Institute of Health’s National Asthma Education and Prevention Program, all patients taking medium-to-high doses of inhaled corticosteroids are recommended to use a spacer/holding chamber with a metered dose inhaler (MDI).

Research shows that spacers/holding chambers decrease the amount of medication in the back of the throat and reduce systemic absorption of the medicine\textsuperscript{1,2,3,4}. Additionally, spacers/holding chambers have been shown to increase delivery of medicine to the lungs in those patients with poor MDI technique\textsuperscript{5,6}. While simple blue tubes are free and better than no spacer at all, they are not as effective in improving delivery in patients who have difficulty coordinating actuation and inhalation. Valved-holding chambers are preferred and are also recommended for use with albuterol MDI rescue inhalers.

Physicians and pharmacists can facilitate usage of spacers/holding chambers by their patients with asthma. It is recommended that practitioners write a prescription for a valved-holding chamber.

Providers should always verify patient benefits. In many cases, spacers and multiple rescue inhalers are a covered benefit for Blue Cross and Blue Shield of Texas (BCBSTX) members, subject to quantity limits. Multiple rescue inhalers may be needed for children that live in two households, need an additional device for the school health office, and/or attend childcare. If you are prescribing multiple rescue inhalers, be sure to describe which locations the medication is kept.

BCBSTX is committed to working with communities to help improve pediatric asthma care. Through a collaboration with the American Lung Association of the Upper Midwest (ALAUM), BCBSTX is supporting the “Enhancing Care for Children with Asthma Project”, a program that implements community-based interventions to improve the health outcomes of children with asthma. For more information about the “Enhancing Care for Children with Asthma Project”, visit the ALAUM at lung.org. If you have questions about spacers and holding chambers, please contact the ALA in Minnesota at 651-227-8014 or 800-LUNG-USA.

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility, any claims received during the interim period and the terms of the member’s certificate of coverage applicable on the date services were rendered.


Ahrens R, Lux C, Bahl T, Han SH. Choosing the metered-dose inhaler spacer or holding chamber that matches the patient’s need: evidence that the specific drug being delivered is an important consideration. (1995) J Allergy Clin Immunol. 96:288-94.


Medicare Part D formulary updates
A summary of recent Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Part D formulary changes can be found below. The Blue MedicareRx formulary is updated monthly by our pharmacy provider, Prime Therapeutics. For a complete formulary listing and for future inquiries regarding prior authorizations, step therapy, coverage determinations/RE-determinations, transition plan benefits, and appointment of representative for your BCBSTX members, please refer to the following instructions.

Utilize the following link (https://www.myprime.com) to access the Prime Therapeutics’ Medicare Part D member website:

a) Click on ‘Find Drugs & Estimates’,
b) Follow directions to
   - ‘Select your Health Plan’ click on ‘BCBS Texas’,
   - ‘Medicare Part D Member?’ Click ‘YES’,
   - ‘Select Your Health plan type’ Click ‘Blue MedicareRx’
c) From this page you will be able to determine the formulary status and applicable utilization management programs for individual drugs or access any of the important databases outlined above.

<table>
<thead>
<tr>
<th>TRADE NAME (generic name)</th>
<th>Brand/Generic Product</th>
<th>Effective Date</th>
<th>Description of Change</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>oxycodone tabs, 10 mg, 20mg</td>
<td>Generic</td>
<td>3.2.13</td>
<td>Addition</td>
<td>Tier 2</td>
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<tr>
<td>Buprenorphine/naloxone SL tabs, 2/0.5mg, 8/2mg</td>
<td>Generic</td>
<td>3.3.13</td>
<td>Addition</td>
<td>Tier 1, Quantity limits apply - First generic for SUBOXONE</td>
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<td>PROLASTIN (alpha 1 proteinase inhibitor) for IV soln, 500mg, 1,000mg</td>
<td>BRAND</td>
<td>3.6.13</td>
<td>REMOVAL</td>
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<tr>
<td>Zoledronic acid inj for IV infusion, 4mg/5ml</td>
<td>Generic</td>
<td>3.10.13</td>
<td>Addition</td>
<td>Tier 3 - First generic for ZOMETA</td>
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<td>Risperidone orally disintegrating tabs, 0.25mg</td>
<td>Generic</td>
<td>3.17.13</td>
<td>Cost Share Reduction</td>
<td>Change to Tier 2 (was 4) - Prior authorization and quantity limits continue to apply.</td>
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<td>Betamethasone valerate oint, 0.1%</td>
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<td>Cost Share Reduction</td>
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<td>Entacapone tabs, 200mg</td>
<td>Generic</td>
<td>3.31.13</td>
<td>Addition</td>
<td>Tier 2 - First generic for COMTAN</td>
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<td>Acyclovir oint, 5%</td>
<td>Generic</td>
<td>4.7.13</td>
<td>Addition</td>
<td>Tier 2 - First generic for ZOVIRAX</td>
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<tr>
<td>Sodium phenylbutyrate oral powder</td>
<td>Generic</td>
<td>4.14.13</td>
<td>Addition</td>
<td>Tier 5 - First generic for BUPHENYL Powder</td>
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<td>CREON (pancrelipase (lipase-protease-amylase)) DR caps, 36,000-114,000-180,000 units</td>
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<td>4.21.13</td>
<td>Addition</td>
<td>Tier 3</td>
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<td>Nystatin-triamcinolone cream, 100,000 units/gm 0.1%</td>
<td>Generic</td>
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<td>Cost Share Reduction</td>
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<td>BRILANTA (ticagrelor) tabs, 90 mg</td>
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<td>AFINITOR DISPERZ (everolimus) tabs for oral susp, 2 mg, 3 mg, 5 mg</td>
<td>BRAND</td>
<td>5.5.13</td>
<td>Addition</td>
<td>Tier 5, prior authorization and quantity limits apply</td>
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<td>Cephalexin caps, 750mg</td>
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<td>Candesartan tabs, 4mg, 8mg, 16mg, 32mg</td>
<td>Generic</td>
<td>5.26.13</td>
<td>Addition</td>
<td>Tier 2, quantity limits apply. First generic for ATACAND</td>
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<td>SUPRAX (cefixime) caps, 400mg</td>
<td>BRAND</td>
<td>6.3.13</td>
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<td>TAFINLAR (dabrafenib) caps, 50mg, 75mg</td>
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<tr>
<td>TRADE NAME (generic name)</td>
<td>Brand/Generic Product</td>
<td>Effective Date</td>
<td>Description of Change</td>
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<tr>
<td>MEKINIST (trametinib) tabs, 0.5mg, 2mg</td>
<td>BRAND</td>
<td>6.9.13</td>
<td>Addition</td>
<td>Tier 5. Prior authorization and quantity limits apply.</td>
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<td>REVLIMID (lenalidomide) caps, 20mg</td>
<td>BRAND</td>
<td>6.16.13</td>
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<td>Tier 5. Prior authorization and quantity limits apply.</td>
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<td>Riluzole tabs, 50 mg</td>
<td>Generic</td>
<td>6.23.13</td>
<td>Addition</td>
<td>Tier 5. First generic for RILUTEK</td>
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<tr>
<td>ABILIFY MAINTENA (aripiprazole) IM inj, 300mg, 400mg</td>
<td>BRAND</td>
<td>6.26.13</td>
<td>Addition</td>
<td>Tier 5. quantity limits apply</td>
</tr>
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</table>

**Notices and Announcements**

**Reminder: Initial treatment dates on ANSI v5010**
As a reminder, the ANSI Version 5010 format for electronic claims no longer has a field for the date your patient was first treated for a particular condition by you or a referring physician. However, you may receive a letter from Blue Cross and Blue Shield of Texas (BCBSTX) requesting this additional information.

When you receive this letter, you may submit the requested information to BCBSTX in one of the following ways:

- **Electronic (preferred method)** – Fill in the date and fax the letter to the number indicated on the letter
- **Phone** – Call the customer service number indicated on the letter to provide the date over the phone
- **U.S. Mail** – Fill in the date and mail to the return address indicated on the letter

If you utilize a billing service or clearinghouse to submit electronic claims on your behalf, please check with them to ensure they are aware of the above information.

We appreciate your patience and cooperation.

**2013/2014 synagis predetermination process**
The Respiratory Syncytial Virus (RSV) season is upon us. 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 types 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 Prime Specialty Pharmacy
• Fax the Synagis Request Form, along with written authorization from BCBSTX, to Prime Specialty Pharmacy at: 877-828-3939.

If the request form is incomplete, Prime Specialty Pharmacy will not process the order. The request form will be returned 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 2013-2014 RSV season, which runs from Oct. 1, 2013, to March 15, 2014. 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 is located on the back of the member’s ID card.

UPDATE: 2013 AIM® clinical guideline changes
Please note that the effective date of Oct. 21, 2013, for the AIM Clinical Appropriateness Guidelines has changed and will be Nov. 4, 2013.

Periodically, AIM Specialty HealthSM (AIM) will update its diagnostic imaging guidelines to better assist in preventing unnecessary utilization of radiology and diagnostic services.

AIM is increasing the value of its existing program to ensure members are receiving the most appropriate care. AIM has completed its 2013 guideline review and will be integrating the updates into its systems effective Nov. 4, 2013. Physicians and other professional providers can review complete details and updates of the new guidelines on AIM’s website at www.aimspecialtyhealth.com.

AIM is a registered trademark of AIM Specialty Health, an independent, third-party vendor that is solely responsible for its products and services. Blue Cross and Blue Shield of Texas (BCBSTX) makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions, you should contact the vendors directly.

Billing with National Drug Codes
BCBSTX currently accepts National Drug Code (NDC) for billing of all physicians or ancillary provider administered and supplied drugs. Effective Dec. 15, 2013, BCBSTX will begin reimbursing claims submitted with an NDC in accordance with the NDC Fee Schedule posted on the BCBSTX provider website, bcbstx.com/provider, under “Drugs.”
To locate this information, click the Standards & Requirements tab, then select General Reimbursement Information, enter password, then scroll down to the Reimbursement Schedules and Related Information area, then go to Professional and select the BlueChoice and HMO Blue Texas Schedules offering, then select 2013 Schedules effective Nov. 1, 2013, then scroll down to Drugs. The NDC Fee Schedule will be updated monthly on the first of the month, starting Jan. 1, 2014.

Lower-cost generic medications may be reimbursed with a larger margin compared to higher-cost generic and brand medications. In addition, effective June 1, 2014, BCBSTX will revise the methodology utilized for determining the allowables for Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes associated with multiple NDCs. The HCPCS or CPT code allowable generally will be equivalent to the lowest NDC allowable associated with the HCPCS or CPT code.

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

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 or ancillary provider administered and supplied drugs. BCBSTX will continue to accept the HCPCS or CPT code elements without NDC information (excluding unlisted or “Not Otherwise Classified” drugs).

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

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

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

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

After-hours Access is Required
Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians and specialty care physicians and other professional providers provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. They must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

Acceptable after-hours access mechanisms may include:
- An answering service that offers to call or page the physician or on-call physician;
- A recorded message that directs the patient to call the answering service and the phone number is provided; or
- A recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.

For more detail, please refer to the BlueChoice® Physician and Other Professional Provider Manual (Section B) and the HMO Blue® Texas Physician and Other Professional Provider Manual (Section B), available on the BCBSTX provider website at bcbstx.com/provider. Click on the “Education & Reference” tab, then click on "Manuals" and enter the password.

BCBS Medicare Advantage PPO Network Sharing
What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO network sharing?
All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

What does the BCBS MA PPO network sharing mean to me?
If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX) and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

If you are not a contracted BCBS MA PPO provider with BCBSTX and you provide services for any BCBS MA PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member’s in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.
How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a BCBS MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

![Logo](image)

**MEDICARE ADVANTAGE**

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

Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?

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

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local BCBS MA PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

How do I verify benefits and eligibility?

Call BlueCard Eligibility at 800-676-BLUE (800-676-2583) and provide the BCBS MA PPO member’s alpha prefix located on the member’s ID card.

You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:

- Log in to the Availity Portal, the Availity Revenue Cycle Management Portal or your preferred vendor
- Enter required data elements
- Submit your request

Where do I submit the claim?

You should submit the claim to BCBSTX under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.

Blue Review, September 2013
**What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?**

If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

**What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO Network Sharing?**

When you provide covered services to other BCBS MA PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the BCBS MA PPO claim, BCBSTX will send you the payment. However, these services will be paid under the BCBS MA member’s out-of-network benefits unless for urgent or emergency care.

**What is the BCBS MA PPO member cost sharing level and co-payments?**

A BCBS MA PPO member cost sharing level and co-payment is based on the BCBS MA PPO member’s health plan. You may collect the co-payment amounts from the BCBS MA PPO member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800-676-BLUE (800-676-2583).

**May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?**

No, you may not balance bill the BCBS MA PPO member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or co-pays.

**What if I disagree with the reimbursement amount I received?**

If there is a question concerning the reimbursement amount, contact Blue Medicare Advantage Customer Service at 877-774-8592.

**Who do I contact if I have a question about BCBS MA PPO network sharing?**

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Medicare Advantage Customer Service at 877-774-8592.

**Medical record requests: Include our letter as your cover sheet**

When you receive a letter from BCBSTX requesting additional information such as medical records or certificates of medical necessity, please utilize the letter as a cover sheet when sending the requested information to us.

This letter contains a barcode in the upper right corner of the page to help ensure that the information you send is matched directly to the appropriate file and/or claim. Do not submit a Claim Review Form in addition to the letter, as this could delay the review process.

Thank you for your cooperation!

**Technical and professional components**

**Modifiers 26 and TC:** Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services.
These modifiers should be used in conjunction with the appropriate lab and radiological procedures only.

**Note:** When a physician or other professional provider performs both the technical and professional service for a lab or radiological procedure, he/she must submit the total service, not each service individually.

**Surgical procedures performed in the physician's office**
When performing surgical procedures in a non-facility setting, the physician and other professional provider reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the physician's or other professional provider's office.

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician's or other professional provider's office. To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3.

Please note the physician and other professional provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied based on the fact that the global physician reimbursement includes staff and equipment.

**AIM RQI/Preauthorization Reminder**
Physicians and professional providers must contact AIM Specialty Health℠ (AIM®), first to obtain a Radiology Quality Initiative (RQI) number (for BlueChoice members) or a Preauthorization (for HMO Blue Texas members) when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician’s office, a professional provider’s office, the outpatient department of a hospital or a freestanding imaging center:

- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study
- PET scan

To obtain a BlueChoice RQI number or an HMO Blue Texas Preauthorization, log in to AIM’s provider portal at aimspecialtyhealth.com and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive a RQI number or Preauthorization (whichever is applicable). If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM’s *ProviderPortal℠* uses the term “Order” rather than “Preauth” or “RQI.”
**Note:** Facilities cannot obtain an RQI number or Preauthorization from AIM on behalf of the ordering physician. Also, the RQI and Preauthorization program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS or HMO coverage are included in the program.

AIM Specialty Healthy (AIM) is an operating subsidiary of WellPoint, Inc.

**Quest Diagnostics, Inc., is the exclusive HMO and preferred statewide PPO/POS clinical reference lab provider**

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for HMO Blue® Texas members* and the preferred statewide outpatient clinical reference laboratory provider for BCBSTX BlueChoice (PPO/POS) members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

**Quest Diagnostics Offers:**
- On-line scheduling for Quest Diagnostics’ Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto QuestDiagnostics.com/patient or call 888-277-8772.
- Convenient patient access to more than 195 patient service locations.
- 24/7 access to electronic lab orders, results, and other office solutions through Care360® Labs and Meds.

For more information about Quest Diagnostics lab testing solutions or to establish an account, contact your Quest Diagnostics Physician Representative or call 866-MY-QUEST (866-697-8378).

For physicians and other professional providers located in the HMO capitated lab counties, only the lab services/tests indicated on the Reimbursable Lab Services list will be reimbursed on a fee-for-service basis if performed in the physician’s or other professional provider’s office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician’s or other professional provider’s office will not be reimbursed. You can access the county listing and the 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 BCBSTX provider website. Also, the Drug/Injectable Fee Schedule will be updated on Sept. 1, 2013, Dec. 1, 2013, March 1, 2014 and June 1, 2014.

**Improvements to the medical records process for BlueCard® claims**

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

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

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

**Pass-through billing**

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

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

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

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

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

- **AS modifier:** A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used ONLY if they assist at surgery.)

- **SA modifier:** A supervising physician should use this modifier when billing on behalf of a PA, APN or CRNFA for **non-surgical** services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that DOES NOT include surgery.)
**Contracted physicians and other professional providers must file claims**

As a reminder, physicians and other professional providers must file claims for any covered services rendered to a patient enrolled in a BCBSTX health plan. You may collect the full amounts of any deductible, coinsurance or copayment due and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your physician and other professional provider contract with BCBSTX.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full and directs a physician or other professional provider to not file a claim with the patient's insurer, the physician or other professional provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

**Medical policy disclosure**

New or revised medical policies, when approved, will be posted on the BCBSTX provider website on the 1st or 15th day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted.

To view active and pending medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to active and pending medical policies.

**Draft medical policy review**

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

To view draft medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

**No additional medical records needed**

Physicians and other professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from AIM Specialty Health need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.
Predetermination does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

**Importance of obtaining preauthorization 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 preauthorization 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 serious reportable events.

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

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

Visit the BCBSTX provider website at bcbstx.com/provider to access the [2013 Drug Dispensing Limits list](http://bcbstx.com/provider).

**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.

For the 2013 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: [bcbstx.com/provider/pharmacy/index.html](http://bcbstx.com/provider/pharmacy/index.html) and click on the Preferred Drug Guide offering in the left-side navigation list.

**Are utilization management decisions financially influenced?**

BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

BCBSTX does not specifically reward practitioners or clinicians for issuing denials of coverage, nor is there compensation based on the number or frequency of telephone calls or other contacts that occur with health care providers or members. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

**Contact Us**

Click [here](http://example.com) for a quick directory of contacts at BCBSTX.

**Update your contact information online**

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

If your specialty, practice information/status or board certification is not correct on the BCBSTX Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the “Other” field or contact your Provider Relations office.

Blue Review is published for BlueChoice®, HMO Blue® Texas, Blue Medicare Advantage, Blue Advantage HMO SM and ParPlan contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; email BlueReviewEditor@bcbstx.com.

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

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