BlueCross BlueShield of Texas

BLUE REVIEW℠

A newsletter for physician, professional, facility, ancillary and Medicaid providers

Aug. 3, 2016

Pass-through Billing

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

The performing physician, professional provider or facility and ancillary 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, professional provider or facility and ancillary provider is performed at the place of service of the ordering provider and is billed by the ordering physician or professional provider.
- The service is provided by an employee of a physician, professional provider or facility and ancillary 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 professional provider) and the service is billed by the ordering physician or 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.)

Reminder: New Preauthorization Requirements through eviCore

Blue Cross and Blue Shield of Texas (BCBSTX) has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to provide Utilization Management services for new preauthorization requirements (outlined below).

Effective Oct. 3, 2016, eviCore will manage pre-service authorization for the following specialized clinical services:

- Molecular and genomic testing
- Radiation oncology for all outpatient and office services

These new preauthorization requirements apply to the **Blue Advantage HMO℠ (and Blue Advantage Plus℠ HMO product)** provider networks.

The updated **Blue Advantage HMO and Blue Advantage Plus HMO Preauthorization/Referral Requirements** list has been updated to include the **services listed above that require preauthorization through eviCore, for dates of service beginning Oct. 3, 2016**. The updated preauthorization list will be located on the provider website at bcbstx.com/provider under the Standards & Requirements tab and General Reimbursement Information section. Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.

For all **other** services that require a referral and/or preauthorization, as noted on the Preauthorization/Referral Requirements list, you will continue to use iExchange®. iExchange is accessible to physicians, professional providers and facilities contracted with BCBSTX. For more information or to set up a new iExchange account, please go to bcbstx.com/provider/tools/iexchange.html.

BCBSTX and eviCore will be providing additional information in the coming weeks, on the provider website at bcbstx.com/provider and in *Blue Review*, including:

- Training opportunities/webinars
- How to register with eviCore on their website
- eviCore phone and fax number

You may also contact your Network Management consultant for more information.

Reminder: Use the Correct Place of Service Codes When Billing

Blue Cross and Blue Shield of Texas (BCBSTX) would like to remind all providers to bill with the correct, "original place of service" codes when billing for all services. Billing with the valid place of service is very important and allows claims to be adjudicated more efficiently.

Patient eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership validation, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It's strongly recommended that providers **ask to see the member's ID card for current information and photo ID** to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

Reminder: Corrected Claim Request Change, Effective July 11, 2016

As a reminder, effective July 11, 2016, corrected claim requests for previously adjudicated claims must be submitted as electronic replacement claims, or on the appropriate professional (CMS-1500) or institutional (UB-04) paper claim, and Claim Review form.

Electronic Submission

Electronic replacement claims should be submitted with the appropriate claim frequency code. Frequency code 7 will result in Blue Cross and Blue Shield of Texas (BCBSTX) adjudicating the original claim number (sometimes referred to as a Document Control Number, or DCN) with the corrections. The replacement claim will be issued a new BCBSTX claim number and subsequently deny based on the re-adjudication of the original claim.

Note: Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSTX claim number will not be adjudicated. See below for additional information on claim frequency codes and guidelines to assist you with when and how to use them for making corrections to electronic claims submitted to BCBSTX.

Claim Frequency Codes

Code	Description	Filing Guidelines	Action

5 Late Charge(s)	Use to submit additional charges for the same date(s) of service as a previous claim.	File electronically, as usual. Include only the additional late charges that were not included on the original claim.	BCBSTX will add the late charges to the previously processed claim.
7 Replacement of Prior Claim	Use to replace an entire claim (all but identity information).	File electronically, as usual. File the claim in its entirety, including all services for which you are requesting reconsideration.	BCBSTX will replace the original claim with corrections and the replacement claim will be denied. Refer to the original claim for adjudication.
8 Void/Cancel of Prior Claim	Use to entirely eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."	File electronically, as usual. Include all charges that were on the original claim.	BCBSTX will void the original claim from records, based on request.

Paper Submission
More than 98 percent of the claims BCBSTX receives from providers are submitted electronically. BCBSTX encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer web vendors available to providers. If you are a registered Availity™ web portal user, you have access to submit direct data entry replacement claims electronically, at no additional cost.

As of July 11, 2016, any changes to a claim that are specified **only** on the Claim Review form (or via a letter) will be returned with a notice advising resubmission on the appropriate CMS-1500 or UB-04 paper claim form. Paper claim submitters are required to indicate “corrected claim” on the paper claim form and the accompanying Claim Review form.

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Quality Improvement Program Available to Providers

Blue Cross and Blue Shield of Texas has a Quality Improvement program to better serve our members. The program focuses on preventive health, behavioral health, patient safety and condition management. By collaborating with physicians, providers and health care professionals, the program helps promote safe and appropriate care. It also encourages the efficient use of resources, which ultimately helps reduce health care costs and can improve member satisfaction with their health plan.

The Quality Improvement program includes many activities to develop, review and monitor services provided, including, but not limited to:

- Member complaints and appeals
- Member and provider satisfaction
- Utilization management statistics and systematic measurement of clinical care (e.g., cancer screenings), immunizations, and chronic conditions (e.g., asthma and diabetes)

Member care and service are evaluated on a regular basis to determine whether members are receiving appropriate care and service, and that they are satisfied with their health plan.

Information regarding the Quality Improvement program is available in the Physician and Provider Manuals. These manuals are available at bcbstx.com/provider under Standards & Requirements/Manuals. To receive a written summary of the Quality Improvement program, which includes outcomes, please call the Quality Improvement Programs department at 800-863-9798.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2016

Drug List (Formulary) Changes

Based on the availability of new prescription medications and the Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some revisions were made to the Blue Cross and Blue Shield of Texas (BCBSTX) **Standard drug list** and **Generics Plus drug list** that became effective on July 1, 2016.

Brand Medications Added to the Standard and Generics Plus Drug Lists, Effective July 1, 2016:

Preferred Brand[1]	Drug Class/Condition Used For
Adynovate	Hemophilia
Brilinta	DVT, Stroke and Embolism Prophylaxis
Coagadex	Hemophilia
Depen	Wilson's Disease, Cystinuria
Narcan	Opiate Overdose
Uptravi	Pulmonary Arterial Hypertension

Brand Medications Added to the Generics Plus Drug List, Effective July 1, 2016:

Preferred Brand[1]	Drug Class/Condition Used For
Eliquis	DVT, Stroke and Embolism Prophylaxis

Utilization Management Program Changes

Effective July 1, 2016, several drug categories and/or targeted medications were added to the current Prior Authorization (PA) and Step Therapy (ST) programs for BCBSTX select members on standard pharmacy benefit plans.

Drug Categories Added to the Pharmacy PA Standard Programs, Effective July 1, 2016:

Drug Category	Targeted Medication(s)[1, 2]
Ophthalmic Immunomodulators	Restasis

Targeted Drugs Added to Current Pharmacy PA Standard Programs, Effective July 1, 2016:

Drug Category	Targeted Medication(s)[1, 2]
Therapeutic Alternatives	Kadian, Northera, Onmel, Sporanox, Spritam, Zegerid, Zyflo/Zyflo CR

Drug Categories Added to Current Pharmacy ST Standard Programs, Effective July 1, 2016[3]:

Drug Category	Targeted Medication(s)[1, 2]
Atypical Antipsychotics	Abilify, Abilify Discmelt, Abilify Maintena, Aripiprazole ODT, Aristada, Clozaril, Fanapt, Fazaclo, Clozapine ODT, Geodon, Invega, Invega Sustenna, Invega Trinza, Latuda, Rexulti, Risperdal, Risperdal M-Tab, Risperdal Consta, Saphris, Seroquel, Seroquel XR, Versacloz, Zyprexa, Zyprexa Zydis, Zyprexa Relprevv

For the most up-to-date drug list and list of drug-dispensing limits, visit the Pharmacy Program section of our website at bcbstx.com/provider.

[1]Third party brand names are the property of their respective owners.
[2]These lists are not all inclusive. Other medications may be available in this drug class.
[3]Members on a current drug regimen will be grandfathered from participation in the ST program.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSTX, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Preventive Care, and Medical and Behavioral Health Clinical Practice Guidelines

Blue Cross and Blue Shield of Texas' (BCBSTX) Preventive Care, and Medical and Behavioral Health Clinical Practice Guidelines are published electronically as a resource for network health care providers within the BCBSTX provider website, and in the Physician and Professional Provider Manuals.

The **Preventive Care Guidelines** are based upon recommendations from national organizations, including the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, the American Cancer Society, the American Congress of Obstetricians and Gynecologists, and the American Academy of Pediatrics. The guidelines include recommendations for age and gender-specific preventive care services for infants, children, adolescents, adults and perinatal care. The guidelines are usually reviewed and updated on an annual basis. Please refer to the full Preventive Care Guidelines document (below) for the full list of sources.

Medical and Behavioral Health Clinical Practice Guidelines are reviewed at least every two years. Guideline sources are reviewed monthly and updates may be made sooner than every two years if there have been substantive changes to the sources on which the guidelines are based. Following is a list of a few of the BCBSTX medical and behavioral health clinical practice guidelines and their sources.

Guideline	Source
Asthma	• National Heart, Lung, and Blood Institute
Attention Deficit/Hyperactivity Disorder	• American Academy of Pediatrics
Cardiovascular Disease	• American Heart Association • American College of Cardiology Foundation • United States Preventive Services Task Force • American Society of Hypertension
Depression	• Institute for Clinical Systems Improvement • American Psychiatry Association
Diabetes	• American Diabetes Association
Hypertension	• Eighth Joint National Committee

For a complete list of the Preventative Care Guidelines, and Medical and Behavioral Health Clinical Practice Guidelines, please use the following links:

- Condition-specific Medical Clinical Practice Guidelines
- Behavioral Health Clinical Practice Guidelines
- Preventive Care Guidelines

Preventive Care and Clinical Practice Guidelines are provided for informational and educational purposes only, and are not a substitute for the independent medical judgment of a doctor. Physicians and health care providers are instructed to exercise their own independent medical judgment. The final decision about any medical services or treatment is between the patient and their health care provider.

CDC Guidelines for Prescribing Opioids for Chronic Pain

Part 2 of a 3-part series describing the new CDC guidelines for prescribing opioids. Part 1 was published in the June issue of the Blue Review.

In March of 2016, the Centers for Disease Control and Prevention (CDC) issued new recommendations for prescribing opioid medications for chronic pain, excluding reasons for cancer, palliative and end-of-life care.[1] These recommendations are in response to an increased need for provider education due to a nationwide epidemic of opioid overdose and opioid use disorder.

The CDC has developed 12 recommendations, grouped into three areas of consideration:

1. Determining when to initiate or continue opioids for chronic pain
2. Opioid selection, dosage, duration, follow-up and discontinuation
3. Assessing risk and addressing harms of opioid use

The second area of consideration – opioid selection, dosage, duration, follow-up and discontinuation – is described below. The third area will be discussed in a future issue of *Blue Review*.

Opioid Selection, Dosage, Duration, Follow-Up and Discontinuation

1. According to the new guidelines released in March 2016, the CDC recommends that providers start with prescriptions for immediate-release (IR) opioids, instead of extended-release/long-acting opioids (ER/LA) when initiating treatment for chronic pain.

    - Immediate-release opioids include:

        - Codeine
        - Hydrocodone
        - Hydromorphone
        - Morphine
        - Oxycodone

    - Extended-release/long-acting opioids include:

        - Methadone
        - Transdermal fentanyl
        - ER versions of oxycodone, oxymorphone, hydrocodone and morphine

    - ER/LA medications should be reserved for severe, continuous pain and should only be used in patients who have received IR opioids daily for at least one week.

2. The guidelines also state that providers should start opioid therapy with the lowest effective dosage. Morphine milligram equivalents (MME) more than 50 MME/day should be used with caution, and MME dosages more than 90 MME/day should be avoided when possible, or carefully justified.

    - Opioid therapy lower than 50 MME/day has been associated with reduced risk of overdose.
    - A morphine equivalent dose calculator can be found at agencymeddirectors.wa.gov/mobile.html.

3. Knowing that long-term opioid use often begins with opioid treatment of acute pain, the CDC recommends that providers use the lowest effective dose of an immediate release product when opioids are being used to treat acute pain. For example, three days of opioid treatment for acute pain is often sufficient, but more than seven days may be too much.

    - Evidence has shown that a greater amount of early opioid exposure can be associated with a greater risk of long-term opioid usage.
    - Experts have noted that each day of unnecessary opioid use can increase the likelihood of physical dependence without any additional benefit to the patient.

- Prescribing opioids for fewer days can also help minimize the number of extra medication that may be available for potential misuse.

4. Finally, the guidelines say that providers should follow up with patients to evaluate their pain within one to four weeks of starting opioid therapy for chronic pain, or after a dose increase. Continued opioid therapy should be evaluated at least every three months to determine the benefits or potential harmfulness. If the benefits do not outweigh the harmfulness, providers should consider tapering the opioid dosing and consider other possible therapies.

    - Contextual evidence has found that patients who do not experience pain relief with opioids in one month are unlikely to experience pain relief with opioids at six months.
    - Providers should re-evaluate patients with potential risk of opioid use disorder or overdose more frequently than every three months.

A review on assessing risk and addressing harms of opioid use will be included in next month's *Blue Review*.

[1]Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain- United States, 2016. MMWR Recomm Rep 2016; 65:1-49. DOI: cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

The Operator of BCBSTX Named One of America's Most Community-Minded Companies

The operating company of Blue Cross and Blue Shield of Texas has been recognized as one of America's most community-minded companies, as part of The Civic 50. The Civic 50, an initiative of Points of Light, in partnership with Bloomberg LP, honors the 50 most community-minded companies in the nation each year.

The company was honored for its work to improve health and wellness in its local communities. Of note, the company was recognized for its commitment to improving the quality of life in the communities where it does business, evidenced though the following initiatives:

- Enhancing Care for Children with Asthma: A program in collaboration with the American Lung Association of the Upper Midwest to improve the quality of care for individuals with asthma across our communities. Through our support, the American Lung Association of the Upper Midwest delivers community-based interventions providing asthma patients and health care professionals with the tools and resources to reduce unnecessary hospitalizations and ED visits, while substantially improving health outcomes for individuals with asthma. Since the program's inception in 2012, an estimated 350,000 individuals have been impacted. Initial results from clinic locations in Illinois and New Mexico combined, demonstrate a more than 50 percent reduction in hospitalizations and emergency-related visits on average for participants with asthma who benefited from this program.

- Healthy Kids, Healthy Families®: The company's signature community initiative and ongoing commitment to improve the health and well-being of children and their families across our five states. Through this initiative, the company invests in, and partners with, nonprofit organizations that offer sustainable, measurable programs to reach children and their families in the areas of nutrition, physical activity, disease prevention and management, and supporting safe environments. In 2015, the company invested more than $7 million to outcomes-based programs, impacting more than 3.2 million children.

- Blue Corps℠: The company's employee volunteer program, which promotes and encourages volunteerism across the organization, and provides regular recognition and appreciation activities for volunteers. In 2015, employees volunteered over 107,000 hours to help our

communities, resulting in more than $284,000 in volunteer matching grants to nonprofit community partners.

Created in 2012, The Civic 50 measures corporate civic engagement and recognizes companies that incorporate socially responsible practices and community leadership into their culture. Points of Light, the largest organization in the world dedicated to volunteer service, conducted the survey in partnership with Bloomberg LP. The survey was developed under the guidance of an academic panel of nine experts from leading universities throughout the country. The survey evaluates companies based on several criteria, including how extensively and strategically resources are applied to community engagement, how a community engagement program supports business interests and integrates into business functions.

To view a complete list of The Civic 50 companies for 2015 and to learn more about the importance of civic engagement in corporate America, please visit Civic50.org.

Notices and Announcements

BCBSTX Announces New PPO Contracted Air Transportation Provider for Members

Alacura Medical Transportation will become a Blue Cross and Blue Shield of Texas (BCBSTX) PPO contracted air transportation provider on Aug. 1, 2016. Alacura will provide scheduled, non-emergency medical transportation using fixed-wing (airplane) aircraft services from provider to provider (including connecting ground transportation) for Texas PPO group members. HMO and government program members are excluded from the program.

Non-contracted and/or non-medically necessary air ambulance transports can expose our members to significantly greater out-of-pocket costs and are much costlier for employers. We believe Alacura will greatly benefit our members by assisting them with coordination and servicing of medically appropriate air ambulance transportation.

Facilities should continue to coordinate pre-arranged, non-emergency air ambulance transportation with the assigned BCBSTX nurse (refer to the pre-notify or pre-authorization medical phone number on the back of the member's ID card). BCBSTX will then notify Alacura of the pre-authorized flight for coordination and servicing. Air ambulance coverage is based on current member benefits as well as medical necessity review. Providers may contact Alacura at 844-4ALACURA (844-425-2287) to follow-up on flight coordination.

Member eligibility and benefits should be verified prior to rendering service. Eligibility and benefit quotes include: membership verification, coverage status and other important information, such as an applicable copayment, co-insurance and deductible amounts. We strongly recommend that providers ask to see the member's ID card for current information and photo ID to guard against medical identity theft. When services are not eligible for coverage, members should be notified that they may be billed directly.

Our growing portfolio of product offerings is part of BCBSTX's efforts to meet its goal of increasing access and affordability of health care products to our members and the community that we serve. Making it easier for you and your staff to conduct business with us is equally important. We appreciate your patience, cooperation and support as we work to adapt to this new air ambulance transportation option.

Remittance Viewer Webinars

The remittance viewer offers providers and billing services a convenient way to retrieve, view, save or print claim detail information and help reconcile claim data provided by Blue Cross and Blue Shield of Texas (BCBSTX) in the 835 Electronic Remittance Advice (ERA).

To gain access to the remittance viewer, you must be a registered Availity® user, enrolled to receive the Availity ERA. Online enrollment for ERA may be completed via the Availity web portal. For additional details, view the Remittance Viewer Frequently Asked Questions and the Remittance Viewer Tip Sheet.

Online training sessions have been scheduled to provide an introduction to the remittance viewer. Participants will learn how to gain or grant access, conduct a search, view general and payer-specific information, and save or print results. In addition, a Question and Answer time will be available.

Note: Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSTX claim number will not be adjudicated. For additional information on claim frequency codes and guidelines to assist you with when and how to use them for making corrections to electronic claims submitted to BCBSTX, please refer to Electronic Replacement/Corrected Claim Submission (PDF).

Refer to Remittance Viewer Webinars on our website and select a date and time to attend :

Aug. 10, 2016 – 11 a.m. to 12 p.m. CT
Aug. 17, 2016 – 11 a.m. to 12 p.m. CT
Aug. 24, 2016 – 11 a.m. to 12 p.m. CT
Aug. 31, 2016 – 11 a.m. to 12 p.m. CT

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In Every Issue

The following is information that BCBSTX is required to provide in all published correspondence with physicians, professional providers, and facility and ancillary providers. For the latest updates, visit the News and Updates area of the BCBSTX provider website.

HMO Plans – Importance of Obtaining a Referral and/or Preauthorization and Admitting to a Participating Facility as a Network Provider

HMO Blue TexasSM**, Blue Advantage HMO**SM and **Blue Premier**SM members require a referral from their PCP before receiving services from a specialty care physician or professional provider (except for OBGYNs). The referral must be initiated by the member's PCP, and must be made to a participating physician or professional provider in the same provider network.

If an in-network physician, professional provider, ambulatory surgery center, hospital or other facility is not available in the member's applicable provider network, **preauthorization is required** for services by an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility, through iExchange or call the preauthorization number 1-855-462-1785.

Reminders:

- The **HMO Blue Texas, Blue Advantage HMO and Blue Premier** physician, professional provider, facility or ancillary provider is required to admit the patient to a participating facility, except in emergencies.
- **Additional services may also require preauthorization**. A complete list of services that require preauthorization for **HMO Blue Texas** and **Blue Advantage HMO,** and for **Blue Premier** and **Blue Premier Access**SM, is available on the BCBSTX Provider website. Under the 'Standards and Requirements' tab, click on General Reimbursements (password is 'manual') and scroll down to the “Preauthorization/Notification/Referral Requirements Lists”.

Blue Advantage PlusSM **HMO Point of Service (POS)** is a benefit plan that allows those members to use out-of-network providers. However, it is essential that those members understand the financial impact of receiving services from an out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility. Prior to referring a Blue Advantage Plus enrollee to an out of network provider for non-emergency services, please refer to Section D Referral Notification Program, of the **HMO Blue Texas, Blue Advantage HMO** and **Blue Premier Provider Manual** for more detail including when to utilize the Out-of-Network Enrollee Notification Form.

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 professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or 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.

Implantable Device Versus Medical Supply/Material

We have received a number of questions from providers about billing for implants. To help address the topic, we have provided a reminder about the National Uniform Billing Committee definition of an implant.

National Uniform Billing Committee (NUBC) definition of an implant:

- Revenue Code 274 – Prosthetic/orthotic devices
- Revenue Code 275 – Pacemaker
- Revenue Code 278 – Other Implants

An implantable device is that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Also included is an object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.

Examples of other implants reported under revenue code 278 include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds (not an all-inclusive list).

Supplies that are not implantable should be submitted as supply charges. In conjunction, a device is not a “material or supply furnished incident to a service.” Items used as routine supplies should not be submitted as an implant.
Guide wires, catheters and clips that are used during surgery but do not remain in the body are used the same way as an instrument and are not “implanted” should not be submitted as an implant.

Additional reference and definition of implantable devices, supplies and material can be located in the UB04 Editor and the website of the implantable device’s manufacturer.

Enrollee Notification Form Required for Out-of-network Care for Blue Choice PPO℠ and Blue Advantage HMO℠ (for Blue Advantage Plus)

Effective Jan. 1, an out-of-network care form is required to be completed by the referring network physician for enrollees of **Blue Choice PPO℠** and **Blue Advantage HMO℠ (for *Blue Advantage Plus* point-of-service benefit plan only)**, prior to referring or directing an enrollee to an out-of-network physician, professional provider, hospital, ambulatory surgery center or other facility, for non-emergency services, if such services are available through an in-network provider.

It is essential that **Blue Choice PPO and Blue Advantage Plus** enrollees fully understand the financial impact of an out-of-network referral to a physician, professional provider, hospital, ambulatory surgery center or other facility that does not participate in their BCBSTX provider network. Blue Choice PPO and Blue Advantage Plus enrollees have out-of-network benefits and may choose to use out-of-network providers, however they will be responsible for an increased cost-share under their out-of-network benefits.

Prior to referring or directing a **Blue Choice PPO or Blue Advantage Plus** enrollee to an out-of-network provider for non-emergency services, referring network physicians must complete this form if such

services are also available through an in-network provider. The referring network physician must provide a copy of the completed form to the enrollee and retain a copy in his or her medical record files.

Use of this form is subject to periodic audit to determine compliance with this administrative requirement outlined in the provider manuals.

Hospitals, and Routine Services and Supplies

Routine services and supplies are generally already included by the provider in charges related to other procedures or services. As such, these items are considered non-billable for separate reimbursement. The following guidelines may assist hospital personnel in identifying items, supplies, and services that are not separately billable. This is not an all-inclusive list.

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over-the-counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

Blue Choice PPO℠ Subscribers/Blue Advantage HMO℠ Member Rights and Responsibilities

As a provider for BCBSTX, you are obligated to be aware of subscribers'/members' rights and informed of subscribers' responsibilities. Our health plan subscribers/members may refer to their benefit booklet for a listing of their rights and responsibilities, which are also included below; you can also access these documents on our website at bcbstx.com.

Rights	Responsibilities
Subscriber(s)/Member(s)	**Subscriber(s)/Member(s)**
You have the right to:	**You have the responsibility to:**
• Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities. • Make recommendations regarding the organization's subscribers' rights and responsibilities policy.	• Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.
• Participate with practitioners in making decisions about your health care.	• Follow the plans and instructions for care you have agreed to with your practitioner.
• Be treated with respect and recognition of your dignity and your right to privacy. • A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. • Voice complaints or appeals about the organization or the care it provides.	• Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

HMO Blue Texas Member Rights and Responsibilities

Member Rights – You Have the Right to:

- Receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policy.
- Participate with practitioners in making decisions about your health care.
- Be treated with respect and recognition of your dignity and your right to privacy.
- A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.

Member Rights – You Have the Responsibility to:

- Meet all eligibility requirements of your employer and the Health Maintenance Organization (HMO).
- Identify yourself as an HMO member by presenting your ID card and pay the copayment at the time of service for network benefits.
- Establish a physician/patient relationship with your primary care physician (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OBGyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, in order to care for you. Including changes in your family status, address and phone numbers within 31 days of the change.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Notify your primary care physician or HMO plan within 48 hours or as soon as reasonably possible after receiving emergency care services.
- Communicate complete and accurate medical information to health care providers.
- Call in advance to schedule appointments with your network provider and notify them prior to canceling or rescheduling appointments.
- Read your coverage documents for information about benefits, limitations, and exclusions.
- Ask questions and follow instructions and guidelines given by your provider to achieve and maintain good health.

Understand your health problems and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

Fee Schedule Updates

Reimbursement changes and updates for Blue Choice PPO, HMO Blue Texas (Independent Provider Network only), Blue Advantage HMO and Blue Premier 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. The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule will be updated monthly.

After-hours Access Is Required

BCBSTX requires that primary care physicians, specialty care physicians, professional providers, and facility and ancillary providers provide urgent care, and emergency care or coverage for care 24 hours a day, seven days a week. Providers 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 provider manuals for **Blue Choice PPO℠ Physician, Professional Provider and Facility and Ancillary Provider Manual** (Section B) and **HMO Blue Texas℠ / Blue Advantage HMO℠ / Blue Premier Physician, Professional Provider, Facility and Ancillary Provider Manual** (Section B) available in the Education & Reference section of our provider website. Click on the "Manual" link (note, a password is required).

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:

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.

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 Cross Medicare Advantage (PPO) 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 Cross Medicare Advantage (PPO) 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 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 professional provider and facility or ancillary 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 professional provider reimbursement covers the services, equipment and some of the supplies needed to perform the surgical procedure when a member/subscriber receives these services in the physician's or professional provider's office.

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in a physician's or 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's and 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's or professional provider's reimbursement includes staff and equipment.

AIM RQI Reminder

Physicians, professional providers and facility and ancillary providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPO℠ subscribers when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's, professional provider's or facility or ancillary provider'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 Blue Choice PPO RQI, log into 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. 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 "RQI."

AIM Specialty Health (AIM) is an operating subsidiary of Anthem, Inc.

Notes:

1. *Facilities cannot obtain a RQI from AIM on behalf of the ordering physician, professional provider, facility or ancillary provider.*
2. *The RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.*

Quest Diagnostics, Inc., Is the Exclusive HMO and Preferred Statewide PPO Clinical Reference Lab Provider

Quest Diagnostics, Inc., is the **exclusive** outpatient clinical reference laboratory provider for HMO Blue Texas℠members and Blue Advantage HMO℠ subscribers,* and the ***preferred statewide*** outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO℠ subscribers. 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, professional providers or facility and ancillary 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, professional provider's or facility or ancillary provider's office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician's, professional provider's or facility or ancillary provider's offices will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list in the General Reimbursement Information section located under the Standards and Requirements tab.

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

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 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.

Contracted Providers Must File Claims

As a reminder, physicians, facilities, professional providers and ancillary 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 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 provider to not file a claim with the patient's insurer, the 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 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 our provider website 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, professional providers or facility or ancillary provider who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) 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 a Preauthorization/Referral

A preauthorization/referral is required for certain types of care and services. Although BCBSTX participating physicians, professional providers and facility and ancillary providers are required to obtain preauthorizations/referrals, it is also the responsibility of the member/subscriber to confirm that this action has been taken for services that require a preauthorization/referral.

Preauthorizations/referrals must be obtained for any services provided by someone other than the member's primary care physician (PCP) (i.e., specialist, ambulatory surgery centers, ancillary, etc.). A preauthorization/referral is also needed for an initial stay in a facility and any additional days or services added on.

If a member/subscriber does not obtain a preauthorization/referral for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

A preauthorization/referral does not guarantee payment. All payments are subject to determination of the member/subscriber'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.

If a preauthorization/referral request is received from an out-of-network (OON) provider and the member/subscriber does not have an OON benefit, BCBSTX will contact the ordering provider to discuss network options. However, if a member/subscriber has an OON benefit, OON benefits will apply, which could result in a higher cost sharing.

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, professional providers, facility and ancillary providers is a possible delay, or even denial of services, pending receipt of the required information from the member/subscriber.

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, professional providers, facility and ancillary providers may collect payment from members/subscribers for copayments, co-insurance and deductible amounts. The physician, professional provider, facility or ancillary provider may not charge the member/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, professional provider, facility or ancillary provider must inform the member/subscriber in writing in advance. This will allow the physician, professional, facility or ancillary provider to bill the member/subscriber for the non-covered service rendered.

In no event shall a contracted physician, professional provider, facility or ancillary 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.

Access the 2015 Standard Drug List Dispensing Limits and 2015 Generics Plus Drug List Dispensing Limits documents online.

Prescription Drug Lists

Throughout the year, the BCBSTX Clinical Pharmacy department frequently reviews the prescription drug lists. 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 2015 drug updates, visit Pharmacy Program/Prescription Drug List and Prescribing Guidelines on the BCBSTX provider website.

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, members or subscribers. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Contact Us

View our quick directory of contacts at BCBSTX.

Update Your Contact Information

Accurate provider directories are an important part of providing BCBSTX members/subscribers with the information they need to manage their health. If any of your information has changed, please update your contact information.

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