BlueCross BlueShield of Texas
Blue Review
A Provider Publication

January 2016

(Electronic distribution January 6, 2015)

Blue Advantage HMO℠ and Blue Advantage Plus℠ HMO Provider Webinar Sessions for 2016

The Blue Cross and Blue Shield of Texas (BCBSTX) Network Management Department will be holding four provider webinar training sessions to review information regarding products offered on the Health Insurance Marketplace in 2016.

Webinar Training Dates

Training sessions are being offered on the following dates and times:

- **Jan. 12 from 2 p.m. to 2:50 pm CT**
  https://hcsc.webex.com/hcsc/j.php?RGID=rb4959ac6969aa2ec3b3543e2cf9bef14
- **Jan. 27 from 1 p.m. to 1:50 pm CT**
  https://hcsc.webex.com/hcsc/j.php?RGID=r9c78a476ae2eae93a83c28720316e1a5
- **Feb. 10 from 10 a.m. to 10:50 am CT**
  https://hcsc.webex.com/hcsc/j.php?RGID=r1b6fa146dc12cd76a06c3cffc0a0ae16
- **Feb. 25 from 1 p.m. to 1:50 pm CT**
  https://hcsc.webex.com/hcsc/j.php?RGID=re58c9e63114cd446c1caa1a51763b952

If you have questions please call your network representative.

BCBSTX Provider Relations Office Locations	Telephone Number	Fax Number
Austin	512-349-4847	512-349-4853
Corpus Christi	361-878-1623	361-852-0624
Dallas, East Texas	972-766-8900 / 800-749-0966	972-766-2231
El Paso	915-496-6600, press 2	915-496-6611 915-469-6614
Houston, Beaumont	713-663-1149	713-663-1227
Lubbock, Amarillo	806-783-4610	806-783-4666

Midland, Abilene, San Angelo	432-620-1406	432-620-1428
San Antonio	361-878-1623	361-852-0624

Implementation Reminder: Three New Facility Rules for ClaimsXten™, Effective Feb. 22, 2016

Listed below are details regarding three new facility rules that were originally scheduled to be added to our claims processing system effective Oct. 12, 2015, as an enhancement to our ClaimsXten code auditing tool. **Please note that the deployment of these rules has been postponed to on or after Feb. 22, 2016.** A notice regarding this change in effective date was published in the News and Updates section of the Blue Cross and Blue Shield of Texas (BCBSTX) provider website on Oct. 1, 2015.

Beginning on or after Feb. 22, 2016, Blue Cross and Blue Shield of Texas (BCBSTX) will enhance the ClaimsXten code auditing tool by adding three new outpatient facility rules into our claim processing system. These new rules will apply for claims with dates of service on or after Feb. 22, 2016. We've summarized the new rules below:

Medically Unlikely Edits (MUEs) Multiple Lines Facility Rule
This new facility rule identifies claim lines where the MUE has been exceeded for a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code, reported by the same provider, for the same member/subscriber, on the same date of service.

An MUE is an edit that reviews claims for units of service for a HCPCS or CPT code for services rendered by a single provider/supplier to a single beneficiary on the same date of service.
The ideal MUE is the maximum units of service that would be reported for a HCPCS or CPT code on the vast majority of appropriately reported claims. The maximum allowed is the total number of times per date of service that a given procedure code may be appropriately submitted by the same provider.

Outpatient Code Editor (OCE) CMS CCI Bundling Rule
This new facility rule identifies claims containing code pairs found to be unbundled according to Centers for Medicare & Medicaid Services (CMS) Integrated Outpatient Code Editor (I/OCE). One of the functions of the I/OCE is to edit claims data to help identify inappropriate coding due to the following reasons: The procedure is a mutually exclusive procedure that is not allowed by the Correct Coding Initiative (CCI) and/or the procedure is a component of a comprehensive procedure that is not allowed by the CCI.

Unbundled Pairs Outpatient Rule
This new facility rule identifies the unbundling of multiple surgical codes when submitted on facility claims. This rule detects surgical code pairs that may be inappropriate for one of the following reasons: one code is a component of the other code, or these codes would not reasonably be performed together on the same date of service.

The ClaimsXten tool offers flexible, rules-based claims management with the capability of creating customized rules, as well as the ability to read historical claims data. ClaimsXten can automate claim review, code auditing and payment administration, which we believe results in improved performance of overall claims management.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. For more information on C3 and ClaimsXten, including answers to frequently asked questions, refer to the Education & Reference/Provider Tools/Clear Claim Connection page on our provider website. Information also may be published in upcoming issues of *Blue Review.*

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third-party vendor that is solely responsible for it products and services.

Pharmacy Program Benefit Changes – Effective Jan. 1, 2016

Blue Cross and Blue Shield of Texas (BCBSTX) will be implementing pharmacy benefit changes as of Jan. 1, 2016, for some members with prescription drug benefits administered through Prime Therapeutics.*

Based on claims data, letters will be sent from BCBSTX to alert members/subscribers who may be taking, or who may have been prescribed, a medication that may be affected by the 2016 pharmacy benefit changes. A summary of the changes, as outlined in the member/subscriber letters, is included below for your reference.

Drug List Changes – Some members'/subscribers' plans may now be based on the Generics Plus Drug List. As a result, select medications will move to a higher copay/coinsurance payment tier.

Medication Coverage Exclusions – Most brand-name proton pump inhibitor (PPI) drugs will no longer be covered under the member's/subscriber's pharmacy benefit. Select drug classes and/or brand-name drugs may also no longer be covered under the member's/subscriber's pharmacy benefit. As a reminder, medications that have not received FDA approval are not covered under the BCBSTX pharmacy benefit.

Specialty Drug Changes – Some members'/subscribers' plans may require the member//subscriber to obtain self-administered specialty medications from a specialty pharmacy included in the BCBSTX preferred specialty network. If the member/subscriber does not use the preferred specialty network, they will pay the specialty copay/coinsurance, based on their benefit, plus an out-of-network fee.

Starting Jan. 1, 2016, the BCBSTX preferred specialty network will be expanded to include additional oral oncology and hemophilia specialty pharmacies, including Prime Therapeutics Specialty Pharmacy. For members with an individual benefit plan offered on/off the Texas Health Insurance Marketplace, self-administered specialty medications will move to a coinsurance amount rather than a fixed copay (i.e. $150 in 2015). To help your patients receive the highest level of benefits, be sure their self-administered specialty medications are filled at a BCBSTX preferred specialty pharmacy.

Utilization Management Program Changes – Some members'/subscribers' plans may now be subject to new prior authorization and step therapy programs and/or dispensing limits. Members/Subscribers taking select medications included in these programs may need to meet certain criteria, such as an approval of a prior authorization request, for coverage consideration.

New Preferred Pharmacy Network – For members/subscribers with an individual or employer-offered benefit plan offered on/off the Texas Health Insurance Marketplace, this new pharmacy network will offer the lowest copay/coinsurance amounts. Members/Subscribers filling prescriptions at a non-preferred in-network pharmacy may pay a higher copay/coinsurance amount.

Please note: prescriptions filled at a retail pharmacy for a 90-day supply must be filled at either a pharmacy in this new network or through mail order for coverage consideration.

If your patients have questions about their pharmacy benefits, please advise them to contact the Pharmacy Program number on their member/subscriber ID card. Members/Subscribers also may visit bcbstx.com and log in to Blue Access for Members℠ for a variety of online resources.

**Changes to be implemented, as applicable, based on the member's/subscriber's 2016 plan renewal, or new plan effective date. These changes do not apply to members/subscribers with Medicare Part D or Medicaid coverage.*

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. Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy) is a registered trademark of Prime Therapeutics.

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/Subscribers 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/subscriber and their health care provider.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Jan. 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 effective Jan. 1, 2016.

Brand Medications Added to the Standard and Generics Plus Drug Lists, Effective Jan. 1, 2016

Preferred Brand[1]	Drug Class/Condition Used for
Actimmune	Osteoporosis
Daklinza	Hepatitis C
Ixinity	Hemophilia
Noxafil	Fungal Infections

Brand Medications Moved to a Higher Out-of-pocket Payment Level on the Generics Plus Drug List, Effective Jan. 1, 2016

Non-preferred Brand[1,2]	Condition Used for	Generic Preferred Alternative(s)[2]	Preferred Brand Alternative(s)[1,2]
Synarel	Endometriosis	N/A	N/A
Olysio	Hepatitis C	N/A	Harvoni
Mestinon	Neuromuscular Disorders	pyridostigmine	N/A
Mestinon Timespan	Neuromuscular Disorders	pyridostigmine	N/A
Tobradex Oph Oint	Topical Antibiotic	Tobramycin/Dexamethasone ophthalmic suspension	Zylet

Brand Medications Moved to a Higher Out-of-pocket Payment Level on the Standard Drug List, Effective Jan. 1, 2016

Non-preferred Brand[1,2]	Condition Used for	Generic Preferred Alternative(s)[2]	Preferred Brand Alternative(s)[1,2]
Baraclude	Hepatitis B	entecavir	N/A
Celebrex	Pain	celecoxib	N/A
Cellcept	Transplant Rejection Prophylaxis	mycophenolate mofetil	N/A
Differin	Acne	adapalene	N/A

Epivir	HIV	lamivudine	Emtriva, Truvada, Epzicom
Intuniv	ADHD	guanfacine	Vyvanse
Nexium	GERD	esomeprazole magnesium	N/A
Protopic	Atopic Dermatitis/Eczema	tacrolimus	Zyclara, Elidel
Rapamune	Transplant Rejection Prophylaxis	sirolimus	N/A
Stromectol	Various Infections	ivermectin	Albenza, Biltricide
Synarel	Endometriosis	N/A	N/A
Olysio	Hepatitis C	N/A	Harvoni
Mestinon	Neuromuscular Disorders	pyridostigmine	N/A
Mestinon Timespan	Neuromuscular Disorders	pyridostigmine	N/A
Tobradex Oph Oint	Topical Antibiotic	Tobramycin/Dexamethasone ophthalmic suspension	Zylet
Valcyte	CMV Disease	valganciclovir	N/A
Zyvox	Bacterial Infection	linezolid	N/A

Dispensing Limit Changes
The BCBSTX standard and generics plus prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. Food and Drug Administration (FDA) approved dosage regimens and product labeling.

Effective Jan. 1, 2016, dispensing limits for the following drugs were added to the standard and generics plus list:

Drug Class and Medication[1]	**Product Strength(s)**	**Dispensing Limit**
Afrezza		

Afrezza (insulin human) inhalation powder	4 units/cartridge	19 packs per 30 days (1 pack = 90 cartridges)
Afrezza (insulin human) inhalation powder	4 units and 8 units/cartridge	14 packs per 30 days (1 pack = 60 x 4 unit cartridges, 30 x 8 unit cartridges)
Afrezza (insulin human) inhalation powder	4 units and 8 units/cartridge	12 packs per 30 days (1 pack = 30 x 4 unit cartridges, 60 x 8 unit cartridges)
Antiretrovirals		
Kaletra (lopinavir/ritonavir)	100/25 mg	180 tablets per 30 days
Selzentry (maraviroc)	300 mg	60 tablets per 30 days
Cerdelga		
Cerdelga (eliglustat)	84 mg capsule	60 capsules per 30 days
Diabetes (GLP-1 Receptor Agonists)		
Bydureon (exenatide)	2 mg syringe	4 syringes per 28 days
Fibrates		
Antara (fenofibrate)	30 mg, 43 mg micronized capsules	60 capsules per 30 days
Antara (fenofibrate)	90 mg, 130 mg micronized capsules	30 capsules per 30 days
Fenoglide (fenofibrate)	40 mg tablets	60 tablets per 30 days
Fenoglide (fenofibrate)	120 mg tablets	30 tablets per 30 days
Fibricor (fenofibric acid)	35 mg tablets	60 tablets per 30 days
Fibricor (fenofibric acid)	105 mg tablets	30 tablets per 30 days
Lipofen (fenofibrate)	50 mg capsules	60 capsules per 30 days
Lipofen (fenofibrate)	150 mg capsules	30 capsules per 30 days
Lofibra (fenofibrate)	54 mg tablets	60 tablets per 30 days
Lofibra (fenofibrate)	160 mg tablets	30 tablets per 30 days
Lofibra (fenofibrate)	67 mg, 134 mg, 200 mg micronized capsules	30 capsules per 30 days

Tricor (fenofibrate)	48 mg tablets	60 tablets per 30 days
Tricor (fenofibrate)	145 mg tablets	30 tablets per 30 days
Triglide (fenofibrate)	50 mg tablets	60 tablets per 30 days
Triglide (fenofibrate)	160 mg tablets	30 tablets per 30 days
Trilipix (fenofibric acid)	45 mg delayed-release tablets	60 tablets per 30 days
Trilipix (fenofibric acid)	135 mg delayed-release tablets	30 tablets per 30 days
Lopid (gemfibrozil)	600 mg tablets	60 tablets per 30 days
Fibromyalgia		
Lyrica (pregabalin)	25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg capsule	90 capsules per 30 days
Lyrica (pregabalin)	225 mg, 300 mg capsule	60 capsules per 30 days
Lyrica (pregabalin)	20 mg/mL oral solution	900 mL solution per 30 days
Hetlioz		
Hetlioz (tasimelteon)	20 mg capsule	30 capsules per 30 days
Hypercholesterolemia (HoFH)		
Juxtapid (lomitapide)	5 mg, 10 mg, 20 mg capsule	30 capsules per 30 days
Idiopathic Pulmonary Fibrosis (IPF)		
Esbriet (pirfenidone)	267 mg capsule	270 capsules per 30 days
Ofev (nintedanib)	100 mg capsule, 150 mg capsule	60 capsules per 30 days
Korlym		
Korlym (mifepristone)	300 mg tablet	60 tablets per 30 days
Ophthalmic Prostaglandins		
Rescula (unoprostone)	0.15%	5 mL per 30 days
Opioid Dependence		
Subutex (buprenorphine)	All strengths	15 tabs per 90 days

Oral Immunotherapy		
Grastek (timothy grass pollen allergen extract)	2800 BAU SL tablet	30 tablets per 30 days
Oralair (sweet vernal, orchard, perennial rye, timothy and Kentucky blue grass mixed pollens allergen extract)	300 IR tablet	30 tablets per 30 days
Ragwitek (short ragweed pollen allergen extract)	12 Amb a 1-U SL tablet	30 tablets per 30 days
Oral PAH		
Tyvaso (treprostinil) starter kit	0.6 mg/mL	1 kit per 180 days
Tyvaso (treprostinil) institutional starter kit	0.6 mg/mL	1 kit per 180 days
Tyvaso (treprostinil)	0.6 mg/mL, 4 pack carton	7 packages per 28 days
Tyvaso (treprostinil)	0.6 mg/mL refill kit	1 package per 28 days
Ventavis (iloprost)	10 mcg/mL, 20 mcg/mL	270 ampules per 30 days
Thrombopoietin Receptor Agonists		
Promacta (eltrombopag)	25 mg	30 tablets per 30 days
Promacta (eltrombopag)	75 mg	60 tablets per 30 days
Topical Cancer Treatment		
Picato (ingenol mebutate)	0.015% gel	3 tubes per 90 days
Picato (ingenol mebutate)	0.05% gel	2 tubes per 90 days

Utilization Management Program Changes
Effective Jan. 1, 2016, several drug categories and/or targeted medications will be added to the current Prior Authorization (PA) and Step Therapy (ST) programs for standard pharmacy benefit plans.

Drug categories added to the pharmacy PA standard programs, effective Jan. 1, 2016

Drug Category	Targeted Medication(s)[1]
Afrezza	Afrezza

Cerdelga	Cerdelga
Hetlioz	Hetlioz
Idiopathic Pulmonary Fibrosis (IPF)	Esbriet, Ofev
Korlym	Korlym
Myalept	Myalept
Oral Immunotherapy	Grastek, Oralair, Ragwitek
Topical Antifungal	CNL8, Ciclopirox Kit, Ciclodan Kit, Jublia, Kerydin, Pedipirox, Penlac

Targeted drugs added to current pharmacy PA standard programs, effective Jan. 1, 2016

Drug Category	**Targeted Medication(s)**[1]
Antifungal	Cresemba 186 mg
Doxycycline/Minocycline	Doxycycline 75 mg, Doxycycline 150 mg capsules, Doxycycline Monohydrate 150 mg tablets
Erythropoiesis Stimulating Agents (ESAs)	Mircera 50 mcg, 75 mcg, 100 mcg, 200 mcg
Pulmonary Arterial Hypertension (PAH)	Tyvaso, Ventavis

Targeted drugs added to current pharmacy ST standard programs, effective Jan. 1, 2016[3]

Drug Category	**Targeted Medication(s)**[1, 2]
Atopic Dermatitis	Elidel, Protopic
Diabetes (GLP-1 Receptor Agonists)	Bydureon
Fibrates	Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, Triglide,

Ophthalamic Prostaglandins (Glaucoma)	Lumigan, Rescula, Travatan Z, Travaprost, Xalatan, Zioptan

Targeted mailings were sent to members/subscribers affected by formulary changes per our usual process of member notification prior to implementation. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of the BCBSTX provider website.

[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/Subscribers 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/subscriber and their health care provider.

NOTICES AND ANNOUNCEMENTS

Annual Medical Record Data Collection for Quality Reporting Begins Feb. 1, 2016

Blue Cross and Blue Shield of Texas (BCBSTX) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS®) and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS).

HEDIS is the most widely used and nationally accepted effectiveness of care measurement available and HHS requires reporting of QRS measures. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule and patient authorization for release of information is not required.

To meet these requirements, BCBSTX will be collecting medical records using internal resources and leveraging independently contracted third party vendors, such as Enterprise Consulting Solutions, Inc. (ECS), HealthPort Technologies, LLC and IOD Incorporated. If you receive a request for medical records, we encourage you to reply within seven to 10 business days.

BCBSTX or one of the vendors referenced above may be contacting your office or facility in January or February 2016 to identify a key contact person and to ascertain which data collection method your office or facility prefers (fax, secure email or onsite). Appointments for onsite visits will be scheduled with your staff, if applicable. You will then receive a letter outlining the information that is being requested, and the medical record request list with members' names and the identified measures that will be reviewed.

If you have any questions about medical record requests, please contact BCBSTX at 972-766-6614.

HEDIS is a registered trademark of NCQA.

Enterprise Consulting Solutions, Inc. (ECS), HealthPort Technologies, LLC and IOD Incorporated are independent third party vendors that are solely responsible for the products or services they offer. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions regarding the services they offer, you should contact the vendor(s) directly.

Understanding the Federal Employee Program and OBRA Part A

The Federal Employee Program (FEP) is unique in many ways. The federal government writes the policy that is administered and federal laws apply to the program contracts. While many of these federal laws are not written specifically in the provider contract, they must be complied with.

One such law is the Omnibus Reconciliation Act of 1990 (OBRA '90), which initially included only the Part A component of OBRA. The act was amended in 1993, adding OBRA '93 Part B. OBRA affects patients who are 65 or over who do not have Medicare coverage and are on the plan as a policyholder, annuitant, former spouse or as a covered family member of an annuitant or former spouse. In addition, it limits plan benefits to those to that the patient would have been entitled if they had Medicare coverage. The provider's contracting status with Medicare and with the plan determines the maximum amount for which the patient can be billed.

How Part A and Part B Work

OBRA '90 Part A only applies to inpatient services. The OBRA '90 pricing allowance is calculated based upon Medicare DRG pricing. If the patient has no Medicare and is not employed by an entity that confers with an FEP benefit plan, plan benefits will apply, and the claim will be paid according to the Medicare allowance for the stay. If the patient has Part B coverage, claims for the ancillary services will still need to be submitted to Medicare for payment. The Explanation of Medicare Benefits (EOMB) will also need to be included with the claim. The plan will consider the payment that Medicare made on the claim.

For OBRA '93 Part B, the allowed amount will apply if there is an equivalent Medicare allowable for your service. If there is no Medicare equivalent, the plan allowance will apply. Some Services, such as laboratory, ambulance, and durable medical equipment, are not subject to OBRA '93 pricing. Please keep in mind that if a patient is over 65 and

actively working, OBRA ’90 and OBRA ’93 do not apply. You may consult the plan for a further explanation of how both the Part A and Part B claims are processed.

2015 to 2016 Medicare Part D Formulary Changes

Blue Cross MedicareRx (PDP)℠/Blue Cross Medicare Advantage (HMO)℠/ Blue Cross Medicare Advantage (HMO-POS)℠ /Blue Cross Medicare Advantage (PPO)℠

Based on Centers for Medicare & Medicaid Services (CMS) mandates (e.g., safety concerns, drugs that no longer meet the CMS definition of a “Part D medication,” etc.) and a regular review of changes in the pharmaceutical marketplace, the Blue Cross MedicareRx/Blue Cross Medicare Advantage 2016 Part D plans will have formulary and utilization management changes for 2016.

Members/subscribers were alerted of these changes in late November 2015 via targeted mailings, as well as in the Annual Notice of Change (ANOC) sent to all current members with Blue Cross MedicareRx/Blue Cross Medicare Advantage Medicare Part D plans.

Visit the Pharmacy Program/Medicare Part D Updates sections of the BCBSTX provider website for a quick reference that includes the “Top 30” medications impacted by these formulary changes. Visit the BCBSTX Medicare website for the full 2016 formulary.

Members/subscribers are instructed to ask their doctors about the medications they are prescribed, if any of these formulary, quantity limit or prior authorization changes may impact them and to have a prescription written for a formulary alternative. If the alternative is not appropriate for your patient, please start a coverage determination for the medication needed. Forms are available on our Medicare website under “Drug Information > Utilization Management”.

Blue Cross Medicare Advantage PPO plans are provided by HCSC Insurance Services Company (HISC), and HMO plans provided by GHS Insurance Company (GHS), Independent Licensees of the Blue Cross and Blue Shield Association. HISC and GHS are Medicare Advantage organizations with a Medicare contract. Enrollment in HISC’s and GHS’ plans depends on contract renewal.

Blue Cross MedicareRx is a prescription drug plan provided by HCSC Insurance Services Company HISC, an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC’s plan depends on contract renewal.

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/subscriber’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/subscribers 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/subscriber and their health care provider.

Provider Medicare Enrollment Information

You may have received a message from The Centers for Medicare and Medicaid Services (CMS) if you currently prescribe drugs to Medicare patients, but you are not enrolled in (or validly opted-out of) Medicare. This is a new requirement that CMS will begin enforcing on June 1, 2016.

The new rule requires that all providers who prescribe drugs for Part D patients must enroll in Medicare (or validly opt out, if appropriate). This is important to providers because unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs.

Please also note that if you opt out of Medicare, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services; see 42 CFR 405.440 for details.) Please refer to the attached CMS letter for more information on this requirement for enrollment (or valid opt out). CMS contact information is also included in the letter if you have questions regarding this regulation.

IN EVERY ISSUE

Managing Your Patients' Questions on Their Individual Plans

In light of the open enrollment season, Blue Cross and Blue Shield of Texas (BCBSTX) providers are getting questions from patients about changes to our individual health plans. We recently sent providers an alert to help guide them through these specific changes. Please review the alert.

BCBSTX Announces New Health Insurance Options for Individuals and Small Businesses

Individual Network Options

In anticipation of the upcoming open enrollment season, BCBSTX has introduced 2016 individual and small group health insurance coverage. Texas residents now can choose from coverage options that best fit their varying needs.

BCBSTX will again offer its **Blue Advantage (BAV) HMO℠** to individual members both on and off the Health Insurance Marketplace. Individual members are those who buy their own insurance that is not provided by an employer or through a government program (Medicare, Medicaid or CHIP). We will also offer the new **Blue Advantage Plus℠ HMO** plan with added Point of Service (POS) benefits to individual members both on and off the Health Insurance Marketplace.

Get the details and get started today.

Enrollee Notification Form Required for Out-of-network Care

Effective Jan. 1, an out-of-network care form will be required by the referring network physician for members/subscribers enrolled in Blue Choice PPO℠ and Blue Advantage HMO℠ (for *Blue Advantage Plus* point-of-service benefit plan) prior to referring to an out-of-network provider 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 impact of an out-of-network referral to a provider, hospital, ambulatory surgery center (ASC) or other facility that does not participate in their BCBSTX provider network.

Prior to referring a Blue Choice PPO or Blue Advantage Plus enrollee to an out-of-network provider for non-emergency services, 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.

Claims with More Than One Unit Count for Drug Test Codes

BCBSTX periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our member's/subscriber's benefit plan and meet BCBSTX's guidelines. Some providers are submitting claims with more than one unit count for drug test codes 80337 and 80338, which should be a single date of service.

Effective **Feb. 1, 2016**, the following two codes will allow only one unit on a single date of service: 80337 and 80338. Services should be provided in the most cost-effective manner and in the least costly setting required for the appropriate treatment of the member.

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.

Two New Products for 2016: Blue Premier and Blue Premier Access

In 2016, BCBSTX will offer two new HMO products to our employer groups under the names of **Blue Premier**SM and **Blue Premier Access**SM. We will continue to offer our **HMO Blue Texas**SM product as well. These two new product offerings reflect our commitment to offer more choices and to increase access to affordable and quality health care services for our members.

Below is a look at our rollout process for Blue Premier and Blue Premier Access effective **Jan. 1, 2016:**

Blue Premier and Blue Premier Access Members Must Live or Work Within the Network Coverage Area to Enroll in this Product:
Austin **Bell, Hays, Travis and Williamson counties**
Dallas/Fort Worth **Collin, Dallas, Denton, Ellis, Johnson, Rockwall and Tarrant counties**
Houston and Beaumont **Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery and Orange counties**
San Antonio **Atascosa, Bandera, Bexar, Comal, Guadalupe and Kendall counties**

Blue Premier

Blue Premier offers its members access to a select set of hospitals and providers within the county coverage area listed in the grid above. With this product, members must select a primary care physician (PCP), and referrals are required to see a specialist.

This product has a geographic restriction where the member has to live or work within the network coverage area (listed in the grid above) to enroll into the Blue Premier product.

Blue Premier Access

Blue Premier Access provides the same county coverage (listed in the grid above) as Blue Premier, but gives its members the freedom to choose their care without having to select a PCP or get a referral when seeing an in-network provider.

Like the Blue Premier product, Blue Premier Access has a geographic restriction where the member has to live or work within the network coverage area (listed in the grid above) to enroll in the Blue Premier Access product.

Blue Premier and Blue Premier Access will appear on our Provider Finder® under their respective product names. There is a geographic restriction with this product, so a member must live or work within the network coverage area to enroll in this product.

	HMO Blue Texas	Blue Premier	Blue Premier Access
PCP required	Yes	Yes	No
Referrals required	Yes	Yes	No
Preauthorization required	Yes	Yes	Yes
Out-of-network benefits	No	No	No

How to Identify Blue Premier and Blue Premier Access Members
We understand and recognize that this is a new product for you and our members. Here are some tips to assist your staff when scheduling appointments for these members:

- **Ask for the name of the product**
  The product name, *Blue Premier* or *Blue Premier Access*, appears on the front of the ID card in the lower left corner. You are considered an in-network provider for this patient if you are contracted with Blue Premier (HMH).

- **Ask for the three-letter network code**
  This code is in red in the lower left on the front of the ID card. The network code for Blue Premier is HMH

- **Alpha prefix code**
  Blue Premier – ZGW
  Blue Premier Access – VCE

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit quotes include membership verification, 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.

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 all work to adapt to new product options.

If you have questions about Blue Premier in the defined member counties listed above, please call your network representative in those counties at the applicable number below:

Network Management Office Locations	Telephone Number	Fax Number
Austin	512-349-4847	512-349-4853
Dallas	972-766-8900/ 800-749-0966	972-766-2231
Houston, Beaumont	713-663-1149/ 800-637-0171	713-663-1250
San Antonio	361-878-1623	361-852-0624

BCBSTX Implements Changes in Maximum Allowable Fee Schedule

BCBSTX implemented changes in the maximum allowable fee schedule used for Blue Choice PPO℠, HMO Blue Texas℠, Blue Advantage HMO℠ (Independent Provider Network and THE Limited Network only), and ParPlan effective Nov. 1, 2015.

The changes to the maximum allowable fee schedules used for the Blue Cross Medicare Advantage PPO℠ and Blue Cross Medicare Advantage HMO℠ effective Jan. 1, 2016.

- The methodology used to develop the maximum allowable fee schedule for Blue Choice PPO, HMO Blue Texas and Blue Advantage HMO will be based on 2015 CMS values posted on the CMS website as of Jan. 16, 2015, for those services for which the BCBSTX reimbursement is based on CMS values.
- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.
- Blue Choice PPO, HMO Blue Texas, Blue Advantage HMO and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility).
- 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 continue to be updated monthly.

BCBSTX provides general reimbursement information policies, request forms for allowable fees and fee schedule information. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. If you would like to request a sample of maximum allowable fees or if you have any other questions, please contact your Network Management office.

Reimbursement changes will be posted under "Reimbursement Changes and Updates" in the Reimbursement Schedules section on the BCBSTX provider website. 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.

Blue Choice PPO℠ Subscriber(s) / 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	• 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 & 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) and Blue Advantage HMO 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 and 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 provider manuals for **Blue Choice PPO℠ Physician and Professional Provider** (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 (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 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 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 the 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 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 reimbursement includes staff and equipment.

AIM RQI Reminder

Physicians and professional 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 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."

Notes*:*
1) *Facilities cannot obtain a RQI from AIM on behalf of the ordering physician.*
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.*

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

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 and 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 professional provider's office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician's or professional provider's office 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 and professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians and 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.*

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 professional provider requests and bills for a service, but the service is not performed by the ordering physician or professional provider.

The performing physician or 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 professional 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 or 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 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.)

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 and professional providers 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 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.

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 team 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 the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html and click on the Rx List/Prescribing Guides 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, members or subscribers. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Contact Us

Access a directory of BCBSTX contacts.

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.

To update your contact information, please submit your correspondence via:

- fax: 972-231-9664
- mail: P.O. Box 650267, Dallas, TX, 75265-0267

You should submit all changes at least 30 days in advance of the effective date of 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, please contact your Network Management office.

In addition, BCBSTX periodically identifies providers who have not submitted claims for a period of one year. We make an effort to contact each provider to confirm their information. If the provider does not respond, we will initiate a network termination. Similarly, BCBSTX will inactivate any tax identification numbers (TINs) under which there have been no claims submitted for a period of one year.

Blue Review is published for Blue Choice PPO℠, HMO Blue Texas℠, Blue Cross Medicare Advantage (PPO)℠, Blue Cross Medicare Advantage (HMO)℠, Blue Advantage HMO℠, Blue Premier and ParPlan contracting physicians and other health care providers. To contact the editor, email BlueReviewEditor@bcbstx.com.

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

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