BlueCross BlueShield of Texas
Blue Review
A Provider Publication

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ICD-10: Quick Facts and Resource Reminders

The U.S. Department of Health and Human Services published a final ruling in early August 2014, confirming an Oct. 1, 2015, mandated transition to ICD-10. As of this compliance deadline, all Health Insurance Portability and Accountability Act covered entities **must** use ICD-10 on claims and other health care transactions.

- ICD-10-CM will replace ICD-9-CM for diagnosis coding in all health care settings. ICD-10-PCS will replace ICD-9-CM for inpatient procedure coding.
- Outpatient and professional ICD-10 coding is based on date of service; inpatient institutional ICD-10 coding is based on date of discharge.
- Outpatient and professional claims will need to be split if services dates span the compliance date.
- Use of other codes, such as Current Procedural Terminology (CPT®), HCPCS and Revenue Codes will not be impacted by the transition to ICD-10.

There are many industry resources available to assist providers with making the transition to ICD-10. The Centers for Medicare & Medicaid Services offers training modules for Continuing Education Units (CEUs) and helpful resources for small and medium provider practices, such as the Road to 10 site and new Quick Start Guide.

Please refer to the Standards and Requirements/ICD-10/Stay Informed section of the Blue Cross and Blue Shield of Texas (BCBSTX) provider website for additional links to helpful external sites and educational resources. You'll also find links to BCBSTX resources, such as answers to frequently asked questions.

It's Not Too Late to Enroll for ICD-10 Testing with BCBSTX

If you submit electronic claims, confirming ICD-10 readiness with your software vendor, billing service and/or clearinghouse is just the first step. End-to end or "round-trip" testing with payers is necessary to help ensure your claims will make a successful journey from start to finish.

The best place to encounter issues is within the test environment while there is still time to resolve them. The testing process also offers you and your staff the opportunity to practice coding with ICD-10.
The Blue Cross and Blue Shield of Texas (BCBSTX) ICD-10 Testing Program is currently in progress. Participants are submitting "twin" claims for testing – one with ICD-

9 codes and the other with ICD-10 codes. BCBSTX is processing both claims with the intention of taking all submitted and accepted test claims to a finalized status. For each finalized test claim, BCBSTX is returning an 835 Electronic Remittance Advice (835 ERA). Participants also receive testing summary results for each set of twin claims.

If you are interested in testing with BCBSTX, you may enroll online using the ICD-10 Testing Enrollment form. Within three to five days after your request is received, BCBSTX will email you an enrollment kit with a brief survey and testing agreement. Upon approval, you will receive a welcome letter with instructions and next steps.

For details on upcoming webinars and other educational resources, visit the ICD-10 page in the Standards and Requirements section of the BCBSTX provider website. You may also find webinar listings in the Notices and Announcements section of this newsletter. If you have questions or need additional information, send an email to icd@bcbstx.com. Or, contact your assigned Network Management Representative for assistance.

Tips to Help Your Patients Improve Medication Adherence

Using the GuidedHealth® clinical rules platform to review Blue Cross and Blue Shield of Texas (BCBSTX) claims data, patients with BCBSTX pharmacy benefits are identified as potentially non-adherent to an antiviral, cholesterol, diabetes, depression, hypertension and/or respiratory prescription drug. Informational letters are sent on a quarterly basis to prescribing providers of these identified members to help increase awareness and promote patient safety.

According to *Script Your Future*, a national campaign to raise awareness about medication adherence, nearly three out of four Americans do not take their medications as directed.* For patients with a chronic condition, non-adherence with prescriber instructions may lead to adverse events that may not be immediate but could be harmful over time. There are many reasons people do not take their medications, such as inconvenience, cost or side effects.

BCBSTX is increasingly looking at medication adherence as a quality measure. Listed below are some suggestions that may help your patients improve their medication adherence:

- Simplify the drug regimen by adjusting the timing, frequency, amount and/or dosage of the medications prescribed.
- Encourage honesty when screening your patients for medication adherence. Open communication and trust can lead to uncovering perceived barriers your patients may be facing that you can then help address.
- Explain the consequences of not taking the medication and provide clear, written instructions for taking their medications.
- Offer to prescribe a 90-day supply for home delivery pharmacy services or consider prescribing generics or other less expensive alternatives, if cost is an issue.
- Recommend that your patients set a routine/daily alert by using a pillbox or some other reminder system.
- Collaborate with all of your patient's health care providers to deliver patient-centered complete care. Reach out to the patient's caregiver as well, if appropriate.

GuidedHealth is a registered trademark of Prime Therapeutics LLC (Prime), a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management and other related services. BCBSTX, as well as several other Blue Cross and Blue Shield Plans, has an ownership interest in Prime. BCBSTX makes no endorsement, representations or warranties regarding GuidedHealth. If you have any questions about this product or services, you should contact Prime Therapeutics directly.

**Script Your Future, National Community Pharmacists Association and Pharmacists for the Protection of Patient Care Adherence Survey, 2006.*

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage. 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.

Pharmacy Program Update: Formulary Changes Effective July 1

Standard 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 effective July 1, 2015.

Brand Medications Added to the Drug List, Effective July 1, 2015

Preferred Brand[1]	Drug Class/Condition Used For
Stelara	Autoimmune
Simponi	Autoimmune
Eliquis	Anticoagulant
Toujeo	Diabetes
Ibrance	Cancer
Incruse Ellipta	COPD

Utilization Management Program Changes

Effective July 1, 2015, the Idiopathic Thrombocytopenic Purpura (ITP) specialty prior authorization (PA) program changed its name to: Thrombopoietin Receptor Agonists. The Familial Hypercholesterolemia specialty PA program also changed its name to: Hypercholesterolemia. All targeted medications and program criteria for both programs remains the same.

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.*

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.

Modifier 25 Reminders

The Current Procedural Terminology (CPT®) codebook defines Modifier 25 as a "significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service."

When you submit a Blue Cross and Blue Shield of Texas (BCBSTX) Provider Review form requesting review of a previously submitted claim that contained Modifier 25, we will perform a retroactive audit to determine if the services rendered warrant use of this modifier. If we receive a request to add Modifier 25 to a previously submitted claim, medical records are required to complete our review. If appropriate documentation is not included, the Provider Review form will be returned to you along with a request to include medical information explaining the reason for adding the modifier to a claim that was originally sent without one.

Remember these tips when using Modifier 25:

- Documentation must support significant and separately identifiable preoperative and/or postoperative work, above and beyond the usual care associated with the performed procedure.
- Documentation must support that the patient's symptom, problem or condition required a separately identifiable E/M service.
- The reported E/M service must meet the key components (history, examination and complexity of medical decision making) of the selected E/M service.
- The E/M service must be distinct from the service performed.
- Modifier 25 should only be appended to E/M services and not procedures.
- Modifier 25 is not used to report an E/M that resulted in the decision to perform surgery. Refer to Modifier 57 guidelines for an E/M service which results in a decision for surgery.
- Procedures include preoperative evaluation services necessary prior to performing a procedure or other service. This may include, but is not limited to assessing the site/condition, explaining the procedure, and obtaining informed consent.

Please refer to the CPT codebook for additional details.

As a reminder, BCBSTX actively participates in inquiries and investigations to accurately identify and appropriately address potential fraudulent activities through our Special

Investigations Department (SID). The SID is committed to reducing health care costs and helping to protect the integrity of the BCBSTX independently contracted provider network. To learn more about SID, we welcome you to view the SID Fraud Awareness Tutorial on the BCBSTX provider website in the Education and Reference/Related Resources section.

Claim Status Option to Exit Automated Phone System, Effective July 13, 2015

As announced previously, effective July 13, 2015, claim status will no longer be available through the Blue Cross and Blue Shield of Texas (BCBSTX) interactive voice response (IVR) phone system.

The IVR system will continue to prompt callers for the type of request (eligibility and benefits, claims, preauthorization or other services). The claims menu will include two options (adjust a claim and claim mailing address). As of July 13, 2015, the claims menu will no longer include options for claim status or claim number.
We've provided FAQs on the BCBSTX provider website to further assist you in this migration from the IVR to Web channels for determining your claims status.

Claim status information will continue to be available electronically through your preferred vendor portal. Among other advantages, using a vendor portal can help save your staff time by offering faster, more efficient returns on claim status requests and other inquiries.

Online claim status options offer the same real-time information formerly provided by the phone system, and more. For example, registered Availity™ Web Portal users may access the Claim Research Tool, which allows searches by member ID, group number or DCN. You can check status of multiple claims in one view, view claims for a particular date range and obtain detailed line item information, such as amount paid, ineligible reason code and description for each service line.

Availity users also may access a remittance viewer tool to help view and interpret claim payment details on the 835 Electronic Remittance Advice (835 ERA) from BCBSTX. For more information on the Claim Research Tool and remittance viewer, visit the Education and Reference/Provider Tools section of the BCBSTX provider website. Also watch the Education and Reference section of our website for upcoming webinars.

NOTICES AND ANNOUNCEMENTS

ICD-10: It's Really Happening

The transition to ICD-10 is federally mandated. The compliance deadline is Oct. 1, 2015. As of the compliance deadline, claims without valid ICD-10 codes, as required, will not be accepted by Blue Cross and Blue Shield of Texas (BCBSTX). Use of ICD-10 also affects eligibility and benefits requests, preauthorization, electronic health records, referrals and other processes.

Are you ready? Are you sure?
Take action now. Visit the Standards and Requirements/ICD-10 section of the BCBSTX provider website for readiness tips and educational resources.

Join Us for a Webinar: Using ICD-10 in Online Benefit Preauthorization Requests

BCBSTX will be offering educational webinars through September 2015 to demonstrate the differences you may encounter when using ICD-10 codes in iExchange®, our online benefit preauthorization and referral tool. Select a date from the list below to register now for an iExchange ICD-10 Enhancements webinar.

July 22, 2015 – 2 p.m. to 3 p.m., CT
Aug. 12, 2015 – 11 a.m. to noon, CT
Sept. 16, 2015 – 2 p.m. to 3 p.m., CT

Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized/pre-certified, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

IN EVERY ISSUE

Blue Choice PPO℠ Subscriber(s) Rights and Responsibilities

As a provider for Blue Cross and Blue Shield of Texas (BCBSTX), you are obligated to be aware of subscribers' rights and informed of subscribers' responsibilities. Our health plan subscribers 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)	**Subscriber(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/Blue Advantage HMO Member Rights & Responsibilities

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.

After-hours Access Is Required

BCBSTX requires that primary care physicians and 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℠ Physician and Professional Provider** (Section B) available on our provider website at bcbstx.com/provider. Click on the "Education & Reference" tab, then click on "Manuals" and enter the password.

BCBS Medicare Advantage PPO Network Sharing

What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO℠ network sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

What does the BCBS MA PPO network sharing mean to me?

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

If you are not a contracted BCBS MA PPO provider with BCBSTX and you provide services for any BCBS MA PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?
You can recognize a BCBS MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

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

Thank you for your cooperation!

Technical and Professional Components

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

Note: When a physician or 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 members and HMO Blue Texas members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's office, a professional provider's office, the outpatient department of a hospital or a freestanding imaging center:

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

To obtain a Blue Choice PPO or HMO Blue Texas RQI, log in to AIM's provider portal at aimspecialtyhealth.com and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive a RQI. 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*$_{SM}$ uses the term "Order" rather than "RQI."

Notes*:*

1. *HMO Blue Texas physicians or professional providers who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group regarding outpatient high-tech diagnostic imaging services.*
2. *Facilities cannot obtain a RQI from AIM on behalf of the ordering physician.*
3. *The RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX PPO or HMO coverage are included in the program.*

AIM Specialty Health (AIM) is an operating subsidiary of WellPoint, 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^{SM} and Blue Advantage HMO^{SM} members* and the **preferred statewide** outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO^{SM} members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

Quest Diagnostics Offers:

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

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

For physicians and 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 at bcbstx.com/provider under 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.

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.

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 bcbstx.com/provider and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing

to the disclaimer, you will then have access to view any draft medical policies, if available.

No Additional Medical Records Needed

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

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

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

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

Billing for Non-covered Services

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

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

In no event shall a contracted physician or professional provider collect payment from the subscriber for identified hospital acquired conditions and/or serious reportable events.

Dispensing QVT (Quantity Versus Time) Limits

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

Visit the BCBSTX provider website at bcbstx.com/provider to access the 2015 Standard Drug List Dispensing Limits and 2015 Generics Plus Drug List Dispensing Limits.

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

Contact us

Click here for a quick directory of contacts at BCBSTX.

Update your contact information

Accurate provider directories are an important part of providing BCBSTX members with the information they need to manage their health.

To update your contact information, please submit your correspondence via fax to 972-231-9664 or mail to 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 Advantage HMO℠ 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.

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