BlueCross BlueShield of Texas
Blue Review
A Provider Publication

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Using ICD-10 in Online Benefit Preauthorization and Referral Requests; Join Our Webinars

Blue Cross and Blue Shield of Texas will be offering educational webinars in the upcoming months 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.

June 10, 2015 – 11 a.m. to noon, CT
July 22, 2015 – 2 p.m. to 3 p.m., CT
Aug. 12, 2015 – 11 a.m. to noon, CT

Checking eligibility and/or benefit information is not a guarantee of payment. 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.

Weighing in Against Obesity: How BCBSTX Helps Communities and Members

At Blue Cross and Blue Shield of Texas (BCBSTX), we are as concerned about the health of our members as our community. Obesity is a public health crisis that dramatically impacts people's health and well-being, along with health care costs. Estimates suggest that the U.S. annually spends nearly $200 billion on obesity-related health care expenses.

Recently **Dr. Derek Robinson**, vice president of Quality and Accreditation for the operator of BCBSTX, joined **U.S. Surgeon General Dr. Vivek H. Murthy** and other leaders at a national obesity prevention forum in Washington, D.C. Dr. Robinson talked about our company's holistic approach to addressing obesity, including community partnerships and intervention programs. The forum was sponsored by the Healthcare Leadership Council. This coalition brings together chief executives in health care to create policies, plans and programs to help achieve affordable, high-quality care that is accessible to all Americans. **(*Dr. Robinson (R) with Dr. Murthy)***

"Obesity is one our nation's most concerning diseases and public health concerns," stated Dr. Robinson. "We understand that to win the fight against obesity, we must take a holistic approach to the problem by engaging with the community on outreach

initiatives centered on preventive education, chronic disease management, physical activity programs and nutrition education."

Our Community Commitment
BCBSTX supports nonprofit groups that help prevent health problems, promote healthy behaviors and lessen the impact of chronic conditions. We invest in programs to help reduce health care disparities and meet social needs that lead to good health. We also provide wellness resources to members that help them live healthier lives.

Examples include:

- Healthy Kids, Healthy Families® (HKHF): One in three U.S. kids is overweight or obese. This puts them at greater risk for diabetes, heart disease and cancer. HKHF invests in local programs focusing on nutrition, physical activity, preventing and managing disease, and supporting safe settings. We build playgrounds, help create safe places to play and support classes to teach healthy cooking.

- We work with reputable weight management programs that help our members make smart and healthy choices.

- BCBSTX offers members resources and discounts that promote healthy eating, being active and staying motivated. Members can use online tools to help manage diabetes and heart disease, conditions often linked to obesity. Employer groups can take advantage of wellness and condition management programs that address the health concerns of their employees.

The obesity fight must take place on many levels to win positive, long-term results. That's why BCBSTX actively supports members, works with community partners and takes part in national programs.

Sleep Study Medical Policy Update

Previously, we notified you of revisions to the Blue Cross and Blue Shield of Texas (BCBSTX) Medical Policy, Diagnosis and Medical Management of Sleep Related Breathing Disorders (MED205.001). The updated policy is effective for services rendered on or after May 1, 2015.

Effective immediately, and to allow sufficient time to adjust to recent changes, we are implementing a period of voluntary compliance with BCBSTX Medical Policy MED205.001, Diagnosis and Medical Management of Sleep Related Breathing Disorders. While BCBSTX will not perform clinical review for approval or denial of benefit predetermination requests at this time (except for codes 95807 and 95808), it is requested that you will follow the guidelines in the policy.

BCBSTX will provide notice regarding when this voluntary compliance period will end. As we transition toward enforcement of the updated policy, we will keep you informed about when we will begin processing benefit predeterminations. We want to thank providers who submitted voluntary predetermination requests in the days since the policy took effect and we apologize for any inconvenience this change may have caused.

The BCBSTX Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to

exercise their own clinical judgment based on each individual patient's health care needs. Some benefit plans administered by BCBSTX, such as some self-funded employer plans or governmental plans, may not utilize BCBSTX Medical Policies. Members should contact their local customer service representative for specific coverage information.

2013 HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Results

As noted on the NCQA website, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of health plans in the United States to measure performance on important areas of care and service. Collectively, HEDIS consists of 75 measures across eight categories of care.

HEDIS measurements that are specific to Behavioral Health services include, but are not limited to:

- Antidepressant medication management (AMM)
- Initiation and engagement in treatment following a substance abuse diagnosis (IET)
- Seven and 30-day follow up after a mental health hospitalization (FUH)
- Follow-up care for children prescribed ADHD medication (ADD)

The IET HEDIS metric includes the percentage of adolescent (13-plus years) and adult members with a new episode of alcohol or other drug dependence who received the following services:

- Initiation of Alcohol and Other Drug Dependence (AOD) Treatment – Treatment was initiated by members through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- Engagement of Alcohol and Other Drug Dependence (AOD) Treatment – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

The goal of this measurement is to help ensure that members who receive an AOD diagnosis pursue and engage in treatment after the initial diagnosis.

On an annual basis, HEDIS measurements are calculated and compared to national averages. The 2013 national average for the IET Initiation was 40.15 and the 2013 national average for the IET Engagement was 14.06. In 2013, the average IET initiation for Blue Cross and Blue Shield of Texas (BCBSTX) members was 37.99 and the IET Engagement was 11.46.

What is BCBSTX doing to help increase member participation?

BCBSTX has implemented a formal Quality Improvement Program (QIP) to help increase the number of members initiating and engaging in alcohol or other drug dependence treatment. Programs will be implemented to facilitate coordination with facilities and providers to identify members admitting with a diagnosis of alcohol or other drug dependence, as well as to assist members with setting up post discharge follow-up care.

What can you do to help?
You may identify patients during the initiation of treatment for substance dependence and encourage them to seek ongoing treatment to prevent future relapse. You may assist your patients by discussing treatment options and facilitating follow-up care. If you feel that a patient may need counseling or psychiatric referrals, you also have the option to refer them to the BCBSTX Behavioral Health Case Management Program by calling the number on the back of the member's ID card.

To share feedback or learn more, visit the Clinical Resources/Behavioral Health Care Management Program section of the BCBSTX provider website.

HEDIS is a registered trademark of the NCQA.

Notices and Announcements

ICD-10: Put Your Claims to the Test

It's time to face the facts: The transition to ICD-10 is happening. There's a lot you need to do to prepare, and no one can do it for you. Blue Cross and Blue Shield of Texas (BCBSTX) is nearing completion of updates to all applicable systems in preparation for the wide variety of scenarios that may occur related to processing of ICD-10 codes. Testing is critical to help identify possible issues so they can be fixed well before the Oct. 1, 2015, ICD-10 compliance date.

If you are interested in testing your electronic claims with us, please contact your assigned Network Management Representative. Or, send an email to icd@bcbstx.com – please include "ICD-10 TESTING REQUEST" in the subject line of your email. Provider ICD-10 testing at BCBSTX started in May 2015 and we want to start testing with **you**.

How Will ICD-10 Impact Your Practice?
The transition to ICD-10 is huge! It will affect all aspects of your practice. For a visual representation of the potential impact to various departments in a provider office, refer to the Provider Office Changes Map. Also visit the ICD-10 page in the Standards and Requirements section of the BCBSTX provider website for additional information and related resources.

Venipunctures for Hospitals and ASCs

Effective Sept. 1, 2015, BCBSTX will no longer pay a separate fee for CPT codes 36415 and 36416 for hospitals and ambulatory surgery centers (ASC). This change affects all BCBSTX commercial business, including all existing and future commercial networks. Currently, this includes Blue Choice PPO℠, HMO Blue Texas℠, Blue Advantage HMO℠ and ParPlan.

CPT Code	Maximum Allowable Fee Effective 9/1/2015
36415	$0
36416	$0

Blue Advantage HMO

Blue Advantage HMO has no out-of-network benefits. As such and for all provider types, except for emergency services, claims will be denied for any out-of-network services for which Blue Advantage HMO has not approved an out-of-network referral.

Claim Status No Longer Available Through Automated Phone System, Effective July 13

As noted in last month's *Blue Review* and also on our provider website, effective Monday, July 13, claim status will no longer be available via the Blue Cross and Blue Shield of Texas (BCBSTX) Interactive Voice Response (IVR) phone system. BCBSTX Customer Advocates will remain available to assist your office with claim adjustments; however, document control numbers (DCNs) – claim numbers – will be required.

We encourage you to prepare now for this change. Rather than calling BCBSTX and using the IVR, you or your billing service will need to conduct online claim status requests (ANSI 276 transactions) using an electronic vendor portal, such as Availity™. Conducting online claim status requests will give you real-time responses with detailed results, such as received date, processed date, adjudication outcomes and finalized dollar amounts.

If you are a registered Availity Web Portal user, you also have access to additional online tools at no cost, such as the Claim Research Tool, which offers enhanced claim status information in a user friendly format. Results can be saved electronically or printed for your records.

For More Information

To learn more about the Claim Research Tool and other electronic options available to providers, visit the Education and Reference/Provider Tools section of our website at bcbstx.com/provider. Also watch the News and Updates on our Provider website for dates and times of upcoming webinars. If you have questions or need assistance, email our Provider Education Consultants at pecs@bcbstx.com.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

In Every Issue

After-hours Access is Required

Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians and specialty care physicians and 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)SM 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 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℠ and Blue Advantage HMO℠ members* and the **preferred statewide** outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO℠ 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 Drug Dispensing Limits list.

Preferred Drug List

Throughout the year, the BCBSTX Clinical Pharmacy Department team frequently reviews the preferred drug list. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

For the 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 Preferred Drug Guide offering in the left-side navigation list.

Are Utilization Management Decisions Financially Influenced?

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

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

Contact Us

Click here 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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