BlueCross BlueShield of Texas
Blue Review
A Provider Publication

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BCBSTX's 2014 Social Responsibility Report highlights our community commitment

The Blue Cross and Blue Shield of Texas (BCBSTX) 2014 Social Responsibility Report shows how our company as a whole, and employees across our five states, are giving their time, money and support in unprecedented ways to strengthen our communities. Available online, the report uses videos, graphics and unscripted member narratives to tell the story.

The numbers in the corporate report reveal:

- **More than 86,000 employee hours spent volunteering**, double last year's total
- **Over 13 million children reached to date through our Healthy Kids, Healthy Families® initiative**, in the areas of nutrition, physical activity, disease prevention and management, and supporting safe environments
- **More than 8 million health care services provided**, including mammograms and wellness visits, enabled by our offering of insurance through the Affordable Care Act in all our communities

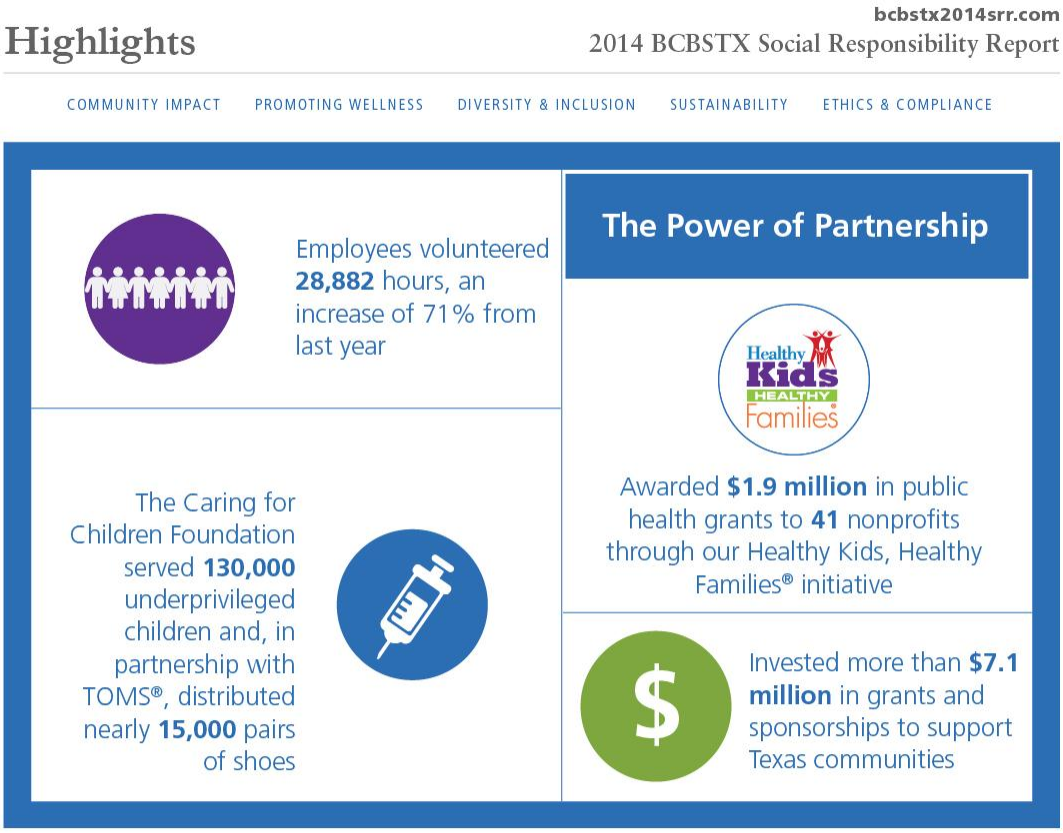
Beyond the numbers, some of the most compelling stories are told by members, in their own voices, including:

- **Caitlin**, who after suffering a potentially fatal head injury in Malawi, was flown 1,200 miles to South Africa and successfully treated, thanks to her Blue Cross and Blue Shield coverage
- **Denise**, who has hypertension, diabetes and heart disease and credits her nurse case manager with saving her life
- **Marcelino**, who was uninsured for several years after becoming unemployed, but can now breathe easy, knowing he has Blue Cross and Blue Shield coverage through the Affordable Care Act

The report shows how we live our commitment to social responsibility. Through corporate and employee giving, diversity and inclusion, sustainability, ethics and compliance, and promoting wellness, we align our community investments with our business objectives. BCBSTX partners with local organizations to serve at-risk communities and address chronic health disparities.

BCBSTX Highlights

This chart shows a few key outcomes at BCBSTX. For the full details, please review our report and share it with your colleagues and clients.



ICD-10: Be a part of the solution

ICD-10-CM diagnosis codes will be required on all professional and outpatient claims with dates of service on or after the compliance date of Oct. 1, 2015, as established by the U.S. Department of Health and Human Services (HHS).

Both ICD-10-CM diagnosis and ICD-10-PCS procedure codes will be required on all inpatient institutional claims with discharge dates on or after Oct. 1, 2015. Service dates or discharge dates prior to Oct. 1, 2015, will require ICD-9 codes. Use of other codes, such as Current Procedural Terminology (CPT®), HCPCS and Revenue Codes will not be impacted by this change.

The bottom line: The transition to ICD-10 is happening and there is a lot you need to do to prepare. Here are four ways you can take action, right now.

1. Talk to your software vendor, billing service or clearinghouse

Your focus is caring for your patients, but your claims also need your attention. To prepare for ICD-10 you need to consider how your claims are submitted and by whom. If you use an Electronic Health/Medical Record (EHR/EMR) system, Practice Management

System (PMS) or Health Information System (HIS), have you contacted your software vendor to confirm that all necessary updates will be completed and ready for you by the compliance deadline? Or, if you use a billing service or clearinghouse, have you contacted them to make sure they are ready to submit compliant claims on your behalf?

2. Start adding ICD-10 to referrals and orders for future services likely to occur Oct. 1, 2015, and later
The provider receiving your referral or order often relies on your diagnosis for their own billing. If you are not sure when the future service will occur, include both ICD-9 and ICD-10 codes on your request.

3. Ask about testing with us
Testing is important to help identify possible issues well before the Oct. 1, 2015, ICD-10 compliance date.

Blue Cross and Blue Shield of Texas (BCBSTX) began provider ICD-10 testing in April 2015. If you are interested in testing with us, please contact your assigned Network Management Consultant. Provider ICD-10 testing at BCBSTX is scheduled to run through Sept. 15, 2015. Or, send an email to icd@bcbstx.com and please include 'ICD-10 Testing Request' in the subject line of the email. Provider ICD-10 testing at BCBSTX is scheduled to run through Sept. 15, 2015.

4. Take our ICD-10 readiness assessment
We encourage you to complete our brief online ICD-10 Readiness Assessment. Survey responses will help us understand what types of communication materials and resources you and your staff need to help you achieve compliance. A link to the ICD-10 Readiness Assessment will be available on the home page of the BCBSTX provider website through **May 27, 2015.** General results will be shared in an upcoming issue of our provider newsletter. All individual provider responses and contact information will be kept confidential.

Questions? Please email us at icd@bcbstx.com, and we will be happy to assist.

New videos on patient support and palliative care: What every physician should know

Blue Cross and Blue Shield of Texas (BCBSTX) is expanding its efforts to encourage early member referrals to palliative care by releasing two new videos on the topic. The videos feature Martha L. Twaddle, MD**,** FAAHPM, who has helped to facilitate the growth and development of palliative and hospice care on the national level.

Dr. Twaddle is currently an associate professor of medicine at Northwestern University Feinberg School of Medicine. A former president of the American Academy of Hospice and Palliative Medicine (AAHPM), she also served on the steering committee for the National Consensus Project for Palliative Care.

Please take a moment to watch these brief videos.

- "Palliative Care: Supporting Your Patients through Serious Illness"
- "Sam's Story: Patient Support through Palliative Care"

BCBSTX encourages the early referral of patients to palliative care, which unlike hospice care, can be provided along with curative therapy. The goal of palliative care is to improve the quality of life for members and their families – whatever their diagnosis.

Palliative care helps members with serious illnesses to better control pain and other symptoms, which may help improve quality of life and reduce emergency room visits, hospitalizations and re-hospitalizations.

To provide more information on palliative care to your patients (our members), use this resource to download a *Palliative Care Frequently Asked Questions* document written for members. Members may use the Provider Finder® on Blue Access for Members℠ to find palliative care providers in their network.

CMS replaces modifier 59 with new "X" modifiers

Effective Jan. 1, 2015, the Centers for Medicare & Medicaid Services (CMS) added four new modifiers to replace modifier 59 when submitted with Current Procedural Terminology (CPT®)/HCPCS codes. Modifier 59 was previously used to report that a service was a *distinct procedural service*. The new modifiers and their descriptions are:

X Modifier	Description
XE Separate Encounter	A service that is distinct because it occurred during a separate encounter
XS Separate Structure	A service that is distinct because it was performed on a separate organ/structure
XP Separate Practitioner	A service that is distinct because it was performed by a different practitioner
XU Unusual Non-Overlapping Service	The use of a service that is distinct because it does not overlap usual components of the main service

Beginning on or after April 20, 2015, Blue Cross and Blue Shield of Texas (BCBSTX) will enhance the ClaimsXten code auditing tool by adding the first quarter 2015 codes and bundling logic into our claim processing system. Currently, BCBSTX will accept the new modifiers when submitted.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may use 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 for additional information on gaining access to C3.

For more details regarding 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 its products and services.

NOTICES AND ANNOUNCEMENTS

Women's contraceptive drug list reminder

Under the Affordable Care Act, certain U.S. Food and Drug Administration approved women's contraceptives are covered with no member cost share when in-network providers and pharmacies are used. The list of women's contraceptives covered by Blue Cross and Blue Shield of Texas (BCBSTX) for eligible benefit plans was updated this year to include dosage strengths for some drugs.

Eligible members with prescription drug coverage through Prime Therapeutics may find the Women's Contraceptive Drug List in the Member Services/Prescription Drug Plan section of the BCBSTX member website. If members have questions, they may contact the number on the back of their ID card for assistance.

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. 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.

Claim status availability to change in automated phone system

Effective Monday, July 13, claim status requests will no longer be available within the BCBSTX Interactive Voice Response (IVR) phone system. You may continue to use the IVR phone system to obtain eligibility and benefits information and Customer Advocates will remain available for other inquiries, such as claim adjustments.

Electronic transactions are available to help you streamline administrative processes and minimize time spent by your staff on unnecessary phone calls. You will need to direct claim status requests electronically through your Web vendor of choice. The Availity™ Claim Research Tool provides enhanced claim status at no cost by going to availity.com.

Additional information regarding the above-referenced change will be published in upcoming issues of *Blue Review* as well as on our provider website.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the

member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

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)℠ 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 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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