BlueCross BlueShield of Texas
Blue Review
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ICD-10: Important Dates and Resource Reminders

As mandated by the U.S. Department of Health and Human Services (HHS), all Health Insurance Portability and Accountability Act (HIPAA) covered entities must use ICD-10 codes on claims and other health care transactions as of the Oct. 1, 2015, compliance deadline.

Blue Cross and Blue Shield of Texas (BCBSTX) will begin accepting ICD-10 codes as of Sept. 21, 2015, for benefit preauthorization requests for services that will be rendered on or after Oct. 1, 2015. Valid ICD-10 codes must be included on claims submitted to BCBSTX for dates of service or inpatient discharge dates on or after Oct. 1, 2015. Claims without valid ICD-10 codes, as required, will not be accepted by BCBSTX.

For additional information, such as claim submission tips and resource reminders, refer to the Standards and Requirements/ICD-10 section of the BCBSTX provider website. If you have ICD-10 questions, email us at icd@bcbstx.com, or contact your assigned Network Management Representative.

Health Summary Now Available in iExchange®

We are continuing to make enhancements to iExchange, our online benefit preauthorization tool. For example, you can use this tool to obtain a Health Summary, which is a modification of the Patient Clinical Summary offered previously.

The Health Summary is derived from claims and other data and may include member details, chronic and acute conditions, health status measures, medications, lab tests/procedures and visits. Compared to the Patient Clinical Summary, the Health Summary offers you a more updated view, with enhanced information that is delivered in near real-time.

To learn more about the Health Summary, as well as using ICD-10 in online benefit preauthorization requests, please join us for an iExchange ICD-10 Enhancements webinar. Select your preferred date and time from the list below to register now.

- Sept. 16 – 2 to 3 p.m., CT
- Sept. 30 – 11 a.m. to noon, CT
- Oct. 7 – 2 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.

Seasonal Flu Vaccines Save Lives and Reduce Unnecessary Hospitalizations

According to the Centers for Disease Control (CDC), although most persons who become infected with influenza viruses will recover without sequelae, influenza can cause serious illness and death.

Complications are particularly common among those 65 years or older or under 2 years old. Complications are also common among those with medical conditions that confer high risk for complications from influenza.

Estimated influenza-associated deaths range from 3,000 to 49,000 annually in the United States. Annual influenza vaccination is the primary means of preventing influenza and its complications.

The most complete information about influenza vaccination rates nationally is for Medicare fee-for-service beneficiaries. For the 2014-2015 flu season, the national rate was 50 percent, indicating that half of the Medicare fee-for-service beneficiaries did not receive a flu shot. In some areas of the country, the influenza vaccination rate was much lower.

Seniors are often the population with the highest influenza vaccination rates, so information about Medicare patients is useful in demonstrating the need to focus on flu shots. This interactive map shows 2014-2015 flu shot rates by county and zip code.

Flu Vaccine for 2015-2016

This season, the flu vaccines are designed to protect against the flu viruses expected to be the most common:

- an A/California/7/2009 (H1N1)pdm09-like virus
- an A/Switzerland/9715293/2013 (H3N2)-like virus
- a B/Phuket/3073/2013-like virus

In addition, some of the 2015-2016 flu vaccine is quadrivalent, and also protects against B/Brisbane/60/2008-like virus.

According to the CDC, the 2015-2016 vaccines are available in formulations for four routes of administration:

- **Intramuscular (IM)**: Trivalent and quadrivalent formulations are available for IM administration. High dose vaccines will all be trivalent this season.
- **Jet Injector**: One trivalent vaccine is available for administration by jet injector for those 18 through 64 years old.
- **Nasal spray**: The nasal spray vaccines are all quadrivalent.
- **Intradermal vaccine:** These vaccines are all quadrivalent.

The CDC provides many influenza vaccination patient education materials, including brochures, fact sheets, posters, stickers, podcasts and videos.

Patients win when they are immunized for the flu as they can reduce their risk of being sick, missing work and the need for hospitalization. By increasing the percentage of

citizens who receive influenza vaccine, physicians and other health care providers can help reduce the burden of influenza and its complications.

The Impact and Benefits of Palliative Care

This is the second in a series of three articles.

Years of research and patient accounts tell us that the care of patients with serious illness – both during ongoing treatment and at the end of life – may be fraught with unmet needs. Pain, shortness of breath and delirium are frequently under-recognized or under-treated.

People facing serious illness often receive care in the last phase of life in places and in ways not consistent with their wishes.[1] Higher-intensity and higher-cost health care actually correlates with worse quality of life at the end of life.[2] Moreover, families and loved ones often feel lost, confused or unsupported during these difficult events.

There is a better way. With emphasis on symptom management, communication, advance care planning, coordinated care by the interdisciplinary team and family/caregiver support – palliative care helps address many of those unmet needs and aims to buttress a complicated and sometimes dysfunctional care delivery system.

Palliative Care Helps Patients

Those who receive it usually experience:

- Care consistent with patients' preferences and values
- Better pain and other symptom control
- Less emotional and psychological suffering
- Better support in making difficult decisions that enable patients to work toward their goals in the course of their illness or condition
- Greater satisfaction with the care experience
- Smoother and safer transitions to other appropriate care settings

Palliative Care Works in All Settings and Can Prolong Life

Though studies all vary to some degree, the effects have been shown in hospital,[3, 4] ambulatory[5] and home[6] settings. For patients at the end of life, hospice care often leads to greater satisfaction with care, enhanced patient and family support – all without a decrease in life expectancy compared with similar patients who do not receive hospice support.[1,7] The benefits usually tend to be more pronounced at the end of life, but palliative care helps throughout care of life-threatening disease.

As Temel and colleagues showed in a landmark 2010 study, patients with metastatic lung cancer who received concurrent palliative and anti-cancer care at diagnosis reported better quality of life, less depression, better prognostic understanding of their illness and lived longer.[8]

Palliative Care Helps Families

Finally, patients and families facing serious illnesses is a public health issue, and palliative care can help improve overall outcomes. When communication about a patient's illness is promoted early and regularly, families and loved ones providing care have better self-reported health outcomes and less depression themselves.[9]

Moreover, this added layer of support, whether through palliative care or home hospice programs, can be provided with overall cost savings to the health care system – especially in the last phases of life when the cost of care tends to increase significantly.[9-12]

Palliative Care is Becoming Available

Fortunately, hospitals, health care systems, professional societies and national quality guidelines have increasingly advocated for integration of palliative care across the continuum of care. More than half of the hospitals with at least 50 beds in this country (and over 85 percent of the larger hospitals with over 300 beds) now have palliative care programs of some type.[13]

The challenge remains how to most effectively and efficiently integrate these services earlier in the care of patients and families facing serious, life-limiting illnesses. We have a ways to go, but as long as patients, families and providers increasingly demand the support, information and care they need, concurrent palliative care will become an expected part of care, rather than an "extra," novel idea.

References
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Dr. Eytan Szmuilowicz, Director of the Section of Palliative Care at Northwestern University Feinberg School of Medicine, has provided this information about palliative care for Blue Review readers.

Medicare Marketing Guidelines for Providers

The 2016 Centers for Medicare & Medicaid Services (CMS) Annual Election Period for beneficiaries is fast approaching. For those providers who are independently contracted with Blue Cross and Blue Shield of Texas (BCBSTX) to provide services to our Blue Cross Medicare Advantage (PPO)[SM] members, it's important to keep in mind the rules established by CMS when marketing to potential new members.

You may not be planning specific marketing activities, but what if a patient asks for information or advice? Remaining neutral when assisting with enrollment decisions is essential.

Below, you'll find a partial listing of additional "Dos" and "Don'ts" for providers, as specified within the CMS Medicare Marketing Guidelines (MMG) for contract year 2016 (section on Provider-Based Activities).

DO:

- Provide the names of Plans/Part D Sponsors with which you contract and/or participate (see MMG section 70.11.2 for additional information on provider affiliation).
- Provide information and assistance in applying for the LIS*.
- Make available and/or distribute plan marketing materials in common areas
- Refer [your] patients to other sources of information, such as SHIPs** plan marketing representatives, [the] State Medicaid Office, local Social Security Office, CMS' website or 800-MEDICARE.
- Share information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" or other documents that were written by or previously approved by CMS.

DON'T:

- Accept Medicare enrollment applications.
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Plans/Part D Sponsors.
- Offer inducements (e.g., Free Health Screenings, Cash, etc.) to persuade beneficiaries to enroll in a particular plan or organization.
- Accept compensation directly or indirectly from the plan for enrollment activities.
- Distribute materials/applications within an exam room setting.

The above lists provide just a sampling of important points for your convenience. For a more in-depth review of the guidelines that are applicable to providers, please refer to the Provider Medicare Marketing Guidelines Excerpt located in the of the BCBSTX provider website.

If you have questions about these guidelines or are planning marketing activities, please refer to the Managed Care Marketing page located under Health Plans, in the Medicare section of the CMS website.

**LIS refers to low-income subsidy*
***SHIPs are Senior Health Insurance Assistance Programs*

Help Your Patients Keep Their Health on Track with Our Healthy Family App

Healthy Family is an app that tells users, like your patients, which preventive services are recommended for themselves and their familes. The app lets them know about important wellness screenings and immunizations, so they can take charge of their health and have informed conversations with you, their doctor.

With the Blue Cross and Blue Shield of Texas Healthy Family app, your patients can:

- Get recommendations for themselves and families based on age and gender
- Store past test information

- Set reminders for upcoming tests and add notes
- Available in English and Spanish

To get the Healthy Family app, text* FAMILY to 33633 or download it on the App Store or Google Play.

Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

NOTICES AND ANNOUNCEMENTS

Claims with More Than One Unit Count for Drug Test Codes

Blue Cross and Blue Shield of Texas (BCBSTX) periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our member's benefit plan and meet BCBSTX's guidelines. Some providers are submitting claims with more than one unit count for drug test codes (80300, 80301, 80303, 80320-80328 and 80345-80377) which should be a single date of service.

Effective Jan. 1, 2016, the following range of codes will allow only one unit on a single date of service: 80300, 80301, 80303, 80320-80328 and 80345-80377. Services should be provided in the most cost effective manner and in the least costly setting required for the appropriate treatment of the member.

Important Notice Regarding Category II Codes

BCBSTX periodically reviews procedures to ensure that benefits provided are for services that are included in our member's benefit plan and meet BCBSTX's guidelines.

Effective Dec. 15, 2015, the performance measurement/demonstration Category II codes listed below will no longer be reimbursed by BCBSTX.

CATEGORY II CODES – F CODES					
C0500F	C1035F	C3014F	C3046F	C3288F	C4025F
C0501F	C1100F	C3015F	C3048F	C3330F	C4035F
C0503F	C1111F	C3017F	C3049F	C3331F	C4037F
C0518F	C1123F	C3023F	C3050F	C4000F	C4040F
C1003F	C1124F	C3025F	C3060F	C4001F	C4050F
C1022F	C1157F	C3027F	C3061F	C4004F	C4124F
C1030F	C1158F	C3044F	C3062F	C4008F	C4140F
C1034F	C3011F	C3045F	C3210F	C4013F	C4144F

Online Predetermination of Benefits Coming Soon

Beginning in early 2016, iExchange® will support submission of online requests for predetermination of benefits, along with all required documentation. Watch the *Blue Review/Capsule News* for further information, including dates and times for educational webinars.

Using DSM-5 to Identify ICD-10 Codes

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), was published in May 2013 by the American Psychological Association (APA). This manual represents the industry standard used by health care providers for the classification and diagnoses of behavioral health disorders.

Here is a description from the APA website:

DSM-5 contains the standard criteria and definitions of mental disorders now approved by the American Psychiatric Association (APA), and it also contains both ICD-9-CM and ICD-10-CM codes (in parentheses) selected by APA. Since DSM-IV only contains ICD-9-CM codes, it will cease to be recognized for criteria or coding for services with dates of service of October 1, 2015, or later. Updates for DSM-5 criteria and their associated ICD-10-CM codes (identified by APA) can be found at DSM5.org.

To view a brief tutorial on using DSM-5 in the transition to ICD-10, go to http://psychiatry.org/psychiatrists/practice/dsm/icd-10.

Note: This material is provided for informational purposes only and is not an endorsement of any particular site or resource. The owners/operators of each website are solely responsible for the content on their respective websites.

Considering Mobile Apps for ICD-10?

Mobile apps downloaded to smart phones and tablets may be a great way to bring ICD-10 to your fingertips at the point of care. However, like all mobile apps, ease of use and quality can vary significantly.

While BCBSTX cannot endorse any particular vendor product, we wanted to offer some quick tips, if you are considering using mobile apps to assist in your transition to ICD-10:

- Look for an app that provides key word search capability.
- Make sure the app is using 2015 or 2016 ICD-10 codes.
- Look for an app that helps you look up ICD-10 codes directly, without always requiring you to first enter an ICD-9 code to get a similar ICD-10.
- Look at both free and for-purchase apps. Be aware that some apps have a free trial period, with a monthly or annual subscription fee required after the trial period ends.
- Be wary of elaborate registration processes – some vendors may use the information gathered at registration to try to sell you other products later.
- Visit the parent company's website to verify credibility – look for a vendor that employs certified coders and has a large user base.

IN EVERY ISSUE

BCBSTX Implements Changes in Maximum Allowable Fee Schedule

Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule used for Blue Choice PPO℠, HMO Blue Texas℠, Blue

Advantage HMO℠ (Independent Provider Network and THE Limited Network only), and ParPlan effective Nov. 1, 2015.

Changes will be implemented in the maximum allowable fee schedules used for the Blue Cross Medicare Advantage PPO℠ and Blue Cross Medicare Advantage HMO℠ effective Jan. 1, 2016.

- The methodology used to develop the maximum allowable fee schedule for Blue Choice PPO, HMO Blue Texas and Blue Advantage HMO will be based on 2015 CMS values posted on the CMS website as of Jan. 16, 2015, for those services for which the BCBSTX reimbursement is based on CMS values.

- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.

- Blue Choice PPO, HMO Blue Texas, Blue Advantage HMO and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility).

- The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year.

- The NDC Fee Schedule will be updated monthly.

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

Reimbursement changes will be posted under "Reimbursement Changes and Updates" in the Reimbursement Schedules section on the BCBSTX provider website. The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted.

Blue Choice PPO℠ Subscriber(s) / Blue Advantage HMO℠ 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 Member Rights & Responsibilities

Member Rights – You Have the Right to:

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

Member Rights – You Have the Responsibility to:

- Meet all eligibility requirements of your employer and the Health Maintenance Organization (HMO).
- Identify yourself as an HMO member by presenting your ID card and pay the copayment at the time of service for network benefits.
- Establish a physician/patient relationship with your primary care physician (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OBGyn.

- Provide, to the extent possible, information that the HMO and practitioner/providers need, in order to care for you. Including changes in your family status, address and phone numbers within 31 days of the change.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Notify your primary care physician or HMO plan within 48 hours or as soon as reasonably possible after receiving emergency care services.
- Communicate complete and accurate medical information to health care providers.
- Call in advance to schedule appointments with your network provider and notify them prior to canceling or rescheduling appointments.
- Read your coverage documents for information about benefits, limitations, and exclusions.
- Ask questions and follow instructions and guidelines given by your provider to achieve and maintain good health.
- Understand your health problems and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

Fee Schedule Updates

Reimbursement changes and updates for Blue Choice PPO, HMO Blue Texas (Independent Provider Network only) and Blue Advantage HMO practitioners will be posted under Standards and Requirements / General Reimbursement Information / Reimbursement Schedules and Related Information / Professional Schedules section on the BCBSTX provider website at bcbstx.com/provider.

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule will be updated monthly.

After-hours Access Is Required

BCBSTX requires that primary care physicians 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[SM] 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[SM] 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 Cross Medicare Advantage (HMO)℠, Blue Advantage HMO℠ and ParPlan contracting physicians and other health care providers. To contact the editor, email BlueReviewEditor@bcbstx.com.

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