Using National Drug Codes (NDCs) on professional/ancillary claims

Currently, Blue Cross and Blue Shield of Texas (BCBSTX) requires inclusion of National Drug Codes (NDCs) and related NDC data (qualifier, unit of measure, number of units, and price per unit), along with the applicable HCPCS or CPT code(s) on claim submissions for unlisted or “Not Otherwise Classified” (NOC) physician-administered/supplied drugs.

Inclusion of NDCs is already business-as-usual for many Home Infusion Therapy (HIT) and Specialty Pharmacy providers. Changes are on the horizon in 2013, and including NDC data on claims will play a significant role. We would like to encourage all providers – in addition to HIT and specialty pharmacy providers – to begin using NDCs and related data when drugs are billed under the medical benefit on professional electronic (837P) and paper (CMS-1500) claims.

For general information to assist you with using NDCs on electronic (837P) and paper (CMS-1500) claims, please refer to the Billing with National Drug Codes (NDC) information in the Claims and Eligibility/Submitting Claims section of the BCBSTX provider website at bcbstx.com/provider. Also watch the News and Updates section of our provider website for NDC announcements, key dates and related resources.

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Properly completing items number 21 and 24E on the CMS-1500 is critical for ensuring payment

We are seeing a number of situations where adjustments are needed when routine exams, such as annual physicals, are billed.

It is important to remember that the primary reason for the patient’s visit indicates the primary diagnosis code pointer that should be used on the claim. Diagnosis code pointers are used to indicate the appropriate order of importance in relation to the service being performed. The first pointer designates the primary diagnosis for the service line. Remaining diagnosis pointers indicate declining level of importance to service line.

For additional information about properly completing the form, view the CMS-1500 Instructions on the National Uniform Claim Committee (NUCC) website. The information below is excerpted from the NUCC site for your convenience.
**Item Number 21**
**Title:** Diagnosis or Nature of Illness or Injury (relate items 1, 2, 3, or 4 to 24E by line)

**Instructions:** Enter the patient’s diagnosis/condition. List no more than four ICD-9-CM diagnosis codes. Relate lines 1, 2, 3, 4 to the lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this field.

When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g., E codes), enter the fourth digit above the period.

**Description:** The “Diagnosis or Nature of Illness or Injury” refers to the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

**Field Specification:** This field allows for the entry of 3 characters prior to the period, 1 character above the period, and 4 characters after the period in each of the four line areas.

**Example:**

<table>
<thead>
<tr>
<th>Item Number 21</th>
<th>Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 998 . 59</td>
<td>3. V18 . 0</td>
</tr>
<tr>
<td>2. 780 . 6</td>
<td>4. E878 . 8</td>
</tr>
</tbody>
</table>

**Item Number 24E**
**Title:** Diagnosis Pointer [lines 1–6]

**Instructions:** In 24E, enter the diagnosis code reference number (pointer) as shown in Item Number 21 (refer to description above) to relate the date of service and the procedures performed to the primary diagnosis. When multiple diagnoses are related to one service, the reference number for the primary diagnosis should be listed first, other applicable diagnosis reference numbers should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained. ICD-9-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.

Enter numbers left justified in the field. Do not use commas between the numbers.

**Description:** The “Diagnosis Pointer” refers to the line number from Item Number 21 that relates to the reason the service(s) was performed.

**Field Specification:** This field allows for the entry of 4 characters in the unshaded area.

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Consider becoming a Bridges to Excellence recognized physician for asthma, diabetes care

Blue Cross and Blue Shield of Texas (BCBSTX) has teamed up with the Health Care Incentives Improvement Institute (HCI3) to launch a new Bridges to Excellence (BTE) program for Asthma Care. In an effort to improve asthma care, BTE rewards physicians
who gain recognition for the Asthma Care BTE program. Asthma Care recognized physicians will receive enhanced reimbursement of CPT code 99367 from BCBSTX.

Additionally, to further reward and recognize the value that physicians who treat diabetes bring to our members, BCBSTX increased the physician incentive amount effective Jan. 1, 2013, for BTE Diabetes Care recognized physicians. The incentive amount increased from $100 per patient per year to $150 per patient per year.

Would you like to become an Asthma Care or Diabetes Care or Cardiac Care recognized physician? Visit the HCI3 Web site at www.hci3.org. For additional information about the BCBSTX BTE initiative, go to bcbstx.com/provider/training/bridges_excellence.html.

Keeping your ICD-10 conversion on track
The ICD-10 conversion is a significant undertaking for small and large practices alike. Without a focused and clear plan, some providers may run the risk of missing the U.S. Department of Health and Human Service’s Oct. 1, 2014, deadline, which could lead to delays in claims payments. The ability of multiple business teams, including but not limited to the Information Technology (IT) team, to manage the threat of “scope creep” is crucial to converting to ICD-10 on time and within budget.

“Scope creep” may be defined quite literally – when the scope of one’s project creeps beyond its original time and budget boundaries, line item, by line item. Scope creep often goes unnoticed until deadlines and expenses are impacted.

Make a plan
A comprehensive plan with a clear vision and buy-in from the necessary stakeholders is one of the best defenses against scope creep. Everyone working on the implementation should be able to use the plan to make key decisions.

Assess your vendors
Your health information technology vendors may be assisting you with hardware purchasing and installation, maintenance, support services and infrastructure needs. Communicate your ICD-10 conversion plan to your vendors so they understand your goals. Ask your vendor to commit to detailed deliverables and a defined resolution process. If you have signed a contract without precise specifications, request an addendum.

Communication is key
Ensure your team knows the goals and the limitations of your plan. Engage stakeholders from the beginning and provide frequent updates about accomplishments and challenges. A well-communicated plan that engages your health care organization as well as your vendors can help guard against scope creep to keep your ICD-10 implementation plan on time and within budget.

For additional information on ICD-10, visit the Standards and Requirements/ICD-10 section of the Blue Cross and Blue Shield of Texas (BCBSTX) provider website at bcbstx.com/provider. Our ICD-10 webinars are also a great resource. We also encourage you to complete our ICD-10 Provider Readiness Assessment Survey, which
is available in the Standards and Requirements/ICD-10 section of our website at bcbstx.com/provider.

Blue MedicareRx Medicare Part D Formulary changes 2012 to 2013


Some of the changes were mandated by CMS (safety concerns, drugs that no longer meet CMS’ definition of a ‘Part D medication’, etc.) but others were a result of dynamic changes in the pharmaceutical marketplace. The Blue MedicareRx 2013 Part D formulary changes include the addition of new drug therapies as well as the migration to some important generic equivalents (e.g. BONIVA tablets, LIPITOR, MAXALT, and TRICOR) that have and/or will become available in 2013.

A copy of 2012 to 2013 formulary changes (i.e. drug removals and new Prior Authorization and Step Therapy utilization management programs) will be included in the Annual Notice of Change (ANOC) that is sent to all current members of HISC’s Medicare Part D plans. In addition, individual member letters were mailed in mid-November 2012, alerting them of 2013 formulary changes (removals, tier changes, new utilization management programs, etc.) affecting them. Finally, a copy of the 2013 formulary is already available on the BCBSTX website, bcbstx.com, in time for the start of the Medicare Part D OEP.

The list below is a handy reference to the Top 30 medications that will be impacted by a change to the 2013 formulary and, therefore, the medications on the list have the most potential to affect current members. Coverage determinations for changes, when applicable, can be submitted by the prescribing physician after Dec. 1, 2012, with an effective date of Jan. 1, 2013.

**Blue MedicareRx - Top 30 Formulary Changes from 2012 into 2013**

<table>
<thead>
<tr>
<th>Affected Drug(s)</th>
<th>Description of Change</th>
<th>Formulary Alternative, if Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>amphetamine/dextroamphetamine tabs</td>
<td>Is not covered on our 2013 formulary</td>
<td>amphetamine/dextroamphetamine ER capsule or Adderall XR capsule</td>
</tr>
<tr>
<td>ANDROGEL</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may newly apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>ATRIPLA</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>Drug Name</td>
<td>Formulary Status</td>
<td>Additional Information</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AVONEX kit, AVONEX PEN</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may apply.</td>
<td></td>
</tr>
<tr>
<td>BONIVA tabs</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>ibandronate</td>
</tr>
<tr>
<td>BRILINTA</td>
<td>Is not covered on our 2013 formulary</td>
<td></td>
</tr>
<tr>
<td>CARBATROL</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>carbamazepine SR</td>
</tr>
<tr>
<td>carbinoxamine liquid, tabs, Arbinoxa</td>
<td>Is not covered on our 2013 formulary</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>COPAXONE</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>cyproheptadine syrup, tabs</td>
<td>Is not covered on our 2013 formulary</td>
<td>levocetirizine tabs</td>
</tr>
<tr>
<td>DERMOTIC</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>fluocinolone acetonide (otic) oil 0.01%</td>
</tr>
<tr>
<td>diphenoxylate/atropine tabs, Lonox, Lofene</td>
<td>Is not covered on our 2013 formulary</td>
<td>loperamide capsule</td>
</tr>
</tbody>
</table>

Check with your doctor
<table>
<thead>
<tr>
<th>Drug</th>
<th>Formulary Status</th>
<th>Generic Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMARA</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>Ietrozole</td>
</tr>
<tr>
<td>flunisolide nasal spray</td>
<td>Is not covered on our 2013 formulary</td>
<td>fluticasone, triamcinolone acetonide, or Nasonex nasal spray</td>
</tr>
<tr>
<td>guanfacine</td>
<td>Is not covered on our 2013 formulary</td>
<td>clonidine or Intuniv</td>
</tr>
<tr>
<td>haloperidol concentrate, tabs</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>hydroxyzine pamoate caps</td>
<td>Is not covered on our 2013 formulary</td>
<td>Levocetirizine tabs</td>
</tr>
<tr>
<td>ISENTRESS</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>LIPITOR</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>Atorvastatin</td>
</tr>
<tr>
<td>LODOSYN</td>
<td>Is not covered on our 2013 formulary</td>
<td>Carbidopa/levodopa, amantadine, Apokyn, bromocriptine, Comtan, pramipexole, ropinirole, or selegiline</td>
</tr>
<tr>
<td>MAXALT, MAXALT-MLT</td>
<td>Is not covered on our 2013 formulary</td>
<td>Naratriptan or sumatriptan tablets</td>
</tr>
<tr>
<td>meprobamate</td>
<td>Is not covered on our 2013 formulary</td>
<td>Buspirone</td>
</tr>
<tr>
<td>MESTINON TIMESSPAN</td>
<td>Is not covered on our 2013 formulary</td>
<td>Pyridostigmine regular release tablet</td>
</tr>
<tr>
<td>NORVIR caps, solution, tabs</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>Drug</td>
<td>Description</td>
<td>Prior Authorization/Authorization</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>olanzapine</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>PERPHENAZINE/AMITRIPTYLINE</td>
<td>Is not covered on our 2013 formulary</td>
<td>quetiapine, risperidone, ziprasidone</td>
</tr>
<tr>
<td>quetiapine</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>REVATIO tabs</td>
<td>Is not covered on our 2013 formulary</td>
<td>Adcirca, Letairis, or Tracleer</td>
</tr>
<tr>
<td>SEROQUEL</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>SUBOXONE</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>TESTIM</td>
<td>Is not covered on our 2013 formulary</td>
<td>Androderm, Androgel or Fortesta</td>
</tr>
<tr>
<td>testosterone cypionate</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may newly apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>TRACLEER</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>TRICOR</td>
<td>Is not covered on our 2013 formulary</td>
<td>fenofibrate, Lipofen, or TriLipix</td>
</tr>
<tr>
<td>TRUVADA</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>VALTURNA</td>
<td>Has been discontinued by the manufacturer</td>
<td>eprosartan, irbesartan, or losartan</td>
</tr>
</tbody>
</table>

**Ranbaxy Pharmaceuticals recalls specific lots of atorvastatin**

On Nov. 9, 2012, Ranbaxy Pharmaceuticals announced that it was initiating a voluntary recall of its popular cholesterol lowering medication atorvastatin, which is the generic version of Pfizer’s Lipitor. The reason for Ranbaxy’s recall was due to the possibility of small (less than 1 mm) glass particles in its product. It also reported that the probability of an adverse event is low, but that it could not be ruled out. Presently, Ranbaxy has not received any reports of adverse events.

Interestingly enough, the recall only affects the 10, 20, and 40 mg strengths of atorvastatin calcium (i.e. it does NOT include the 80 mg strength). In addition, Ranbaxy
reported that the recall includes 41 specific lots of atorvastatin. A list of the recalled lot numbers can be found at: http://www.ranbaxyusa.com/newsdisp281112.aspx. Ranbaxy has notified its distributors and retailers of the recall and affected lots are no longer being distributed\(^2\).

Patients that are experiencing adverse effects from taking the affected medication should contact their health care provider immediately. Patients with atorvastatin prescriptions from Ranbaxy should contact their pharmacist or Ranbaxy’s Customer Coordinator at 866-266-7623 to find out if their prescription is affected.

Generic Lipitor is currently manufactured by five pharmaceutical companies: Apotex Inc., Dr. Reddys Labs, Mylan Pharmaceuticals, Sandoz Inc. and Teva Pharmaceuticals\(^3\). There is no anticipated drug shortage for the 10, 20, 40 mg strengths of atorvastatin. Patients taking affected Ranbaxy atorvastatin should have their medication substituted seamlessly by their pharmacist. The substituted medication may look different. Patients with questions about product identification should contact their pharmacist for clarification.

**The FDA recall process**

Drugs may be recalled from the market by three methods; (a) the manufacturer can perform a voluntary recall, (b) the FDA can request the manufacturer to perform a recall, or (c) the FDA can mandate a recall.\(^4\) Each recalled drug has an individual classification of Class I-III, which are explained below:\(^1\)

- **Class I recall**: a situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.
- **Class II recall**: a situation in which use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
- **Class III recall**: a situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.

As an example, the recall of Ranbaxy’s atorvastatin 10, 20, and 40 mg is a voluntary recall with a classification of Class II.\(^5\) The recalled medication should be sequestered by the pharmacy and the distributor and sent back to the manufacturer for destruction. The FDA may monitor and audit any step of the process. Recalls protect public health by removing potentially harmful products from the market.

**References**


2. Ranbaxy Pharmaceuticals. Ranbaxy Issues Voluntary Nationwide Recall of 41 lots of Atorvastatin Calcium Tablets 10 mg, 20 mg and 40 mg Due to Potential Presence of Foreign Substance. Available at
3. Food and Drug Administration. Approved Drug Products with Therapeutic Equivalence Evaluations 32


Notices and Announcements

Blue Advantage HMO®

Blue Cross and Blue Shield of Texas (BCBSTX) is pleased to announce the development of a new cost-effective network designed to provide affordable quality health care services to the uninsured and underinsured. Blue Advantage HMO affords members medical benefits at a lower cost whenever they access care through a participating Blue Advantage HMO network provider.

BCBSTX extends an invitation for you to participate as a provider in Blue Advantage HMO as your participation helps ensure the program’s success. Our long-standing history in providing affordable health care coverage to the people of Texas and our strong brand recognition make BCBSTX an excellent choice for members seeking cost-effective health care.

Please note that additional credentialing is not required for those providers already credentialed in the BlueChoice PPO or HMO Blue Texas networks and whose credentialing is current.

Below are answers to frequently asked questions regarding Blue Advantage HMO.

Q: What is Blue Advantage HMO?
A: Blue Cross and Blue Shield of Texas (BCBSTX) is developing a new cost-effective network to make quality health care services affordable to the uninsured and underinsured, and would like to extend the opportunity for you to participate as a provider in the network. Blue Advantage HMO affords benefits at a lower cost for members whenever they access care through a participating network provider. We believe that our long-standing history in providing affordable health care coverage to
the people of Texas and our strong brand recognition make BCBSTX an excellent choice for members seeking new cost effective health coverage opportunities. We need your network participation for this program to be successful.

**Q: If I choose not to participate in Blue Advantage HMO, will this affect my participation in other BCBSTX provider networks?**

A: No. Participation in Blue Advantage HMO is optional. Accepting or declining the invitation in no way impacts a provider’s participation in any other BCBSTX networks.

**Q: Why should I participate in Blue Advantage HMO?**

A: As the health care environment continues to evolve, a large number of people will become insured or seek new products that are more cost effective. We feel it is critical to offer new alternatives as an opportunity to build and retain customers that will stay with BCBSTX in the future. It is an opportunity for you to attract patients for the long-term, retaining them as patients as their health needs change. You may see reimbursement opportunities for serving those patients who were uninsured or underinsured in the past and were seen on a “no cost” basis.

**Q: Will the same claims and membership system used for our other commercial plans be used for administering the Blue Advantage HMO plan?**

A: Yes.

**Q: If I am already participating in the BlueChoice PPO and/or HMO Blue Texas network, is any additional credentialing required?**

A: Additional credentialing is not required if you are already credentialed in the BlueChoice PPO or HMO Blue Texas networks and if your credentialing is current.

**Q: Who are the target markets for BCBSTX’s Blue Advantage HMO network?**

A: **Employees/Individuals**
- Employees who cannot afford their employer sponsored plans for themselves and/or their dependents
- Employees whose employers are not offering an employer-sponsored plan
- Employees of small businesses
- Individuals

**Employers**
- Small businesses with 2-50 employees

**Q: Why did BCBSTX decide to create a new network?**

A: We expect to attract a new population – many who were formally uninsured or enrolled in Medicaid – and to retain existing business. In order to keep costs low, we have to develop a new cost effective network.

**Q: How can I learn more about this program?**

A: Please contact your local Professional Provider Network office.
**AIM national program launch Jan. 1, 2013**

Effective Jan. 1, 2013, AIM Specialty Health℠ (AIM®) will be implementing a national product for more than 65 employer groups. The program will reach all 50 states and touch approximately 3 million lives. The marketing name of the 2013 national product is Integrated Imaging Management Program.

There are two primary components included in the Integrated Imaging Management Program described below.

1. **Prospective Case Review and Education**
   - Clinical review of outpatient CT, MRI, Nuclear Cardiology, PET and Echocardiography exams.
   - Please contact Customer Service utilizing the phone number on the back of the subscriber’s ID card to determine if the RQI program applies.

2. **Provider / Patient Transparency**
   - Blue Cross Blue Shield Association’s National Consumer Cost Transparency (NCCT*) data set will be utilized for transparency purposes. This data is updated twice per year.
   - Outbound phone calls may be made to subscribers to inform them of the imaging facility options available.

It is important to note that subscribers will not be denied access to services if they do not choose the lower-cost option and that outreach will exclude pediatric and cancer patients. The goal of this program is to provide subscribers with information to make informed choices.

*NCCT Cost Data: Each facility’s cost of care is calculated using the average allowed amount for a specific procedure. The average allowed amounts are derived from Blue Plans’ claims data through the National Consumer Cost Tool® (NCCT®). NCCT is the same tool that Blue Plans use on a nationally consistent basis to provide consumers with transparent cost information about the average allowed cost of typical cases for certain treatment categories at the facility level and includes facility, professional and related costs. Cost estimates are developed under the NCCT methodology, using 12 months of claims data, based on Blue negotiated arrangements for all in-network facilities in nearly every U.S. ZIP code.

**In Every Issue**

**After-hours access is required**

Blue Cross Blue Shield of Texas (BCBSTX) requires that primary care physicians and specialty care physicians and other 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 BlueChoice® Physician and Other Professional Provider Manual (Section B) and the HMO Blue® Texas Physician and Other Professional Provider Manual (Section B), available on the BCBSTX 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 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 (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 Availity, or RealMed 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 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 PPO 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 Medicare Advantage 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 Medicare Advantage 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 other 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 other professional provider reimbursement is all-inclusive.

Our payment covers all of the services, supplies and equipment needed to perform the surgical procedure when a member receives these services in the physician’s or other professional provider’s office. Please note the physician and other 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, supplies and equipment.
AIM RQI/Preauth reminder
Physicians and professional providers must contact AIM Specialty HealthSM, formerly American Imaging Management® (AIM®), first to obtain a Radiology Quality Initiative (RQI) number (for BlueChoice members) or a Preauthorization (for 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 BlueChoice RQI number or an HMO Blue Texas Preauthorization, 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 number or Preauthorization (whichever is applicable). 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 ProviderPortalSM uses the term “Order” rather than “Preauth” or “RQI.”

Note: Facilities cannot obtain an RQI number or Preauthorization from AIM on behalf of the ordering physician. Also, the RQI and Preauthorization program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS or HMO coverage are included in the program.

AIM Specialty Healthy (AIM) is an operating subsidiary of WellPoint, Inc.

Quest Diagnostics, Inc., is the exclusive HMO and preferred statewide PPO/POS clinical reference lab provider
Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for HMO Blue® Texas members* and the preferred statewide outpatient clinical reference laboratory provider for BCBSTX BlueChoice (PPO/POS) 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 other 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 other professional provider’s office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician’s or other 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 & other professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians & 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 BlueChoice and HMO Blue Texas (Independent Provider Network only) 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. Also, the Drug/Injectable Fee Schedule will be updated on March 1 and June 1 in 2013.

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

The performing physician or other 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 other professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician or other professional provider.

• The service is provided by an employee of a physician or other 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 other professional provider) and the service is billed by the ordering physician or other 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 physicians and other professional providers must file claims**

As a reminder, physicians and other professional 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 physician and other professional 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 physician or other professional provider to not file a claim with the patient's insurer, the physician or other professional 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 portal on the 1st or 15th day of each month. Those policies requiring disclosure will become effective 90 days from the posting date. Policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each policy that is posted.

To view active and pending policies go to [bcbstx.com/provider](http://bcbstx.com/provider), click on the Policies link toward the bottom of the page and then click on the Medical Policies link. After reading
and agreeing to the disclaimer, you will 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 our provider portal and provide your feedback online. The 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 policies go to [bcbstx.com/provider](http://bcbstx.com/provider), click on the Policies link toward the bottom of the page and then click on the Draft Medical Policies link.

**No additional medical records needed**

Physicians and other professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from AIM Specialty Health, formerly American Imaging Management, 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 preauthorizations for initial stay and add-on days**

Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and other professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or other professional provider obtains preauthorizations 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 other
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 other professional providers may collect
payment from subscribers for copayments, co-insurance and deductible amounts. The
physician or other 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 BCBS TX determines that a proposed service is not a covered service,
the physician or other professional provider must inform the subscriber in writing in
advance. This will allow the physician or other professional provider to bill the subscriber
for the non-covered service rendered.

In no event shall a contracted physician or other professional provider collect payment
from the subscriber for identified hospital acquired conditions and/or never 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 BCBS TX provider website at bcbstx.com/provider to access the 2012 QVT list.

Preferred drug list
Throughout the year, the BCBS TX 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 2013 drug updates, visit the BCBS TX provider website under the Pharmacy
Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html.
Are utilization management decisions financially influenced?
BCBSTX is dedicated to serving its customers through the provision of health care coverage and related benefit services. Our mission calls for us to respond to our customers with promptness, sensitivity, respect and dignity.

In support of this mission, BCBSTX encourages appropriate utilization decisions; it does not allow or encourage decisions based on inappropriate compensation. Physicians, other professional providers or BCBSTX staff do not receive compensation or anything of value based on the amount of adverse determinations, reductions or limitations of length of stay, benefits, services or charges. Any person(s) making utilization decisions must be especially aware of possible underutilization of services and the associated risks.

This topic has been addressed in the Blue Review provider newsletter and in previous BCBSTX employee communications as a requirement of our Utilization Review Accreditation Commission accreditation. This serves as a reminder for all physicians and other professional providers in the BCBSTX provider network.

Contact us
Click here for a quick directory of contacts at BCBSTX.

Update your contact information online
To update your contact information, go to bcbstx.com/provider, click on the Network Participation tab and follow the directions under Update Your Contact Information. This process allows you to electronically submit a change to your name, office or payee address, email address, telephone number, tax ID or other information. You should submit all changes at least 30 days in advance of the effective date of the change.

If your specialty, practice information/status or board certification is not correct on Blue Cross and Blue Shield of Texas Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the “Other” field or contact your local Professional Provider Network office.

Blue Review is published for BlueChoice®, ParPlan and HMO Blue® Texas, Blue Medicare Advantage and Blue Advantage HMO contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; 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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