On track with ACA: Preventive care services
This month we will spotlight the Affordable Care Act (ACA) provision for coverage of certain preventive care services without cost-sharing (e.g., coinsurance, deductibles or copayments).

The requirement:
- Became effective for the first plan/policy year beginning on or after Sept. 23, 2010
- Does not apply to grandfathered health plans
- Applies to fully insured and self-insured ERISA plans, non-federal government plans and church plans
- Can be limited to in-network services

New recommendations or guidelines regarding preventive services that are adopted by the Department of Health and Human Services (HHS) must be added, but there is a one-year period to implement, following the adoption date.

Billing guidelines for office visits
Here are some guidelines to help you determine when to apply copayments and deductibles for preventive care services.

Cost sharing should not be applied when:
- The primary purpose of an office visit is for a recommended preventive service

Cost sharing should be applied when:
- The recommended preventive service is billed separately from the office visit; and/or
- A patient receives a recommended preventive service that is not billed separately from the office visit, but the primary purpose of the visit was not to receive the preventive service

We invite you to visit the Provisions of the Affordable Care Act page on our website at bcbstx.com/affordable_care_act/provisions.html for more information on these guidelines and other existing ACA provisions. You will also find there links to external resources regarding health care reform.

This material is for informational purposes only and is not legal advice. If you have any questions regarding these laws, you should consult with your legal advisor.
Poll gauges provider preparedness for implementing the ICD-10 conversion

In May 2012, Blue Cross and Blue Shield of Texas (BCBSTX) conducted provider webinars on ICD-10. For those unable to attend one of these webinars, a recording is now available. Look for the ICD-10 webinars link in the Standards and Requirements section of the BCBSTX provider website at bcbstx.com/provider. Returning users can access the recorded sessions from the “On Demand” tab. New users will need to register first.

The May webinars included a series of poll questions to help gauge provider readiness and identify strategic trends for ICD-10 conversion. More than 250 providers responded to the questions. Results of this preliminary assessment show a considerable range in progress and approach:

- Thirty-eight percent of respondents answered “no” when asked if they were familiar with ICD-10.

- Sixty-five percent of respondents said they do not have a clinical “champion” leading ICD-10 preparation efforts.

- Sixty percent of respondents indicated they were not sure of their organization’s status with respect to ICD-10 preparations, and only nine percent of respondents indicated they were in any of the three active stages (design/development, internal testing or external testing).

- Nineteen percent of respondents said they were conducting a gap analysis, and 12 percent stated they were defining requirements.

- Fifty percent of respondents said they were not sure how they plan to generate ICD-10 codes.

- Approximately 80 percent of respondents were unsure when they would begin internal and external testing and 79 percent indicated they still plan to meet the Oct. 1, 2014, deadline.

The Centers for Medicare & Medicaid Services recommends that providers start internal system testing for ICD-10 conversion no later than Oct. 1, 2013, to meet the proposed extended deadline of Oct. 1, 2014. However, before testing can begin, a well-organized strategic plan and management approach must be established. Staff training, change and process management, evaluation of software tools and many other factors must also be considered. For additional information, please visit the Standards and Requirements/ICD-10 section of the BCBSTX provider website at bcbstx.com/provider.

What are hospitals doing to prepare?
To promote exchange of actionable ideas, BCBSTX will be sponsoring panel discussions about real-world ICD-10 conversion projects. Panel members will include hospital information and practice management system vendors, hospital executives, physicians and other health care providers. Dates and times will appear in future Blue Review articles. We invite you to email your topic suggestions to us at icd@bcbstx.com for consideration.
What else can you do right now?
Ask your technical lead or ICD-10 project manager to complete our online ICD-10 Provider Readiness Assessment Survey, which is available in the Standards and Requirements/ICD-10/Related Resources section of the BCBSTX provider website at bcbstx.com/provider. Also, don’t miss the next round in our continuing series of ICD-10 webinars! View September session dates and times and register online now.

Fee schedule update
Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule used for BlueChoice®, HMO Blue® Texas (Independent Provider Network and THE Limited Network only), and ParPlan effective Nov. 1, 2012. Please review these updates:

- The methodology used to develop the maximum allowable fee schedule will continue to be based on 2011 CMS values for those services for which the Blue Cross and Blue Shield of Texas reimbursement is based on CMS values.
- Reimbursement percentages for the modifiers 53, 54, 55, 56, 73, 74, 80, 81, 82 and AS will be revised.
- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.
- HMO Blue Texas, BlueChoice, and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility).

BCBSTX provides general reimbursement information policies, request forms for allowable fees and fee schedule information under the General Reimbursement tab on its provider website, bcbstx.com/provider. If you would like to request a sample of maximum allowable fees or if you have any other questions, please contact your local Professional Provider Network office.

Reimbursement changes will be posted under the Reimbursement Changes/Updates link in the Professional 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.

Teen driving: Be Smart. Be Well.® spotlight
Each year, about 3,000 teens are killed in motor-vehicle crashes, making it the leading cause of death for teens. The summer months, from Memorial Day to Labor Day, are considered the deadliest for teen drivers. And more than 350,000 teens are treated in emergency departments each year for injuries suffered in a crash*. Our newest topic on the free health and wellness website BeSmartBeWell.com, teen driving, offers safety reminders and related resources for your teen or adult patients.
The Be Smart. Be Well. team interviewed teens and parents about the responsibilities and potential risks of driving. The video, *Teen to Teen*, is available on [BeSmartBeWell.com](http://BeSmartBeWell.com) and is an honest and engaging look at how teens are working to become better drivers.

In addition, the site includes a video interview with teen driving safety expert Erin Sauber-Schatz, Ph.D., M.P.H., of the Centers for Disease Control and Prevention (CDC), who provides tips for both teens and parents to help them become safe and aware drivers. She states that when it comes to safe driving, parents have more influence over their teens’ behavior than they might expect. “Parents play a key role in preventing teen crashes. When asked whose opinions they listen to, teens most often said their parents,” she says.

The Be Smart. Be Well. site also offers tips on how parents can start safe driving conversations and give their teens the driving experience they need to be safe behind the wheel. Parents and teens will also find sample driving contracts or agreements, reputable resources and links for more information, and a quiz about the risks to teen drivers.

Be Smart. Be Well. is a free health and wellness website available to Blue Cross and Blue Shield of Texas (BCBSTX) members as well as the general public. The goal of the site is simple: help your patients stay healthier and safer through increased awareness and easy-to-follow tips.

*cdc.gov/Motorvehiclesafety/Teen_Drivers/teendrivers_factsheet.html*

**Process reminders for self-administered drugs**

For those medications that are self-administered, Blue Cross and Blue Shield of Texas (BCBSTX) members are required to use their pharmacy benefit and acquire the medication through a pharmacy provider. Please note that self-administered drugs can include oral, topical and injectable products.

In January 2013, BCBSTX will implement a system edit that will deny services submitted on physician claims for self-administered drugs that are covered under the member’s prescription drug benefit. For your patients to receive benefit coverage, the covered self-administered drugs must be provided under their pharmacy benefit and not dispensed through the physician’s office.

To help you determine the correct path for medication fulfillment and ensure that the correct benefit is applied, a Specialty Pharmacy Program Drug List will be available in the Pharmacy Program/Specialty Pharmacy section of the BCBSTX provider website at [bcbstx.com/provider](http://bcbstx.com/provider). This list will identify those drugs that are approved for self-administration and, therefore, covered under the patient’s pharmacy benefit.

As a reminder, Triessent Specialty Pharmacy is the preferred specialty pharmacy for most BCBSTX members. Please check the member’s ID card to confirm the member’s pharmacy provider. With an extensive inventory of specialty medications in stock and pharmacists available by phone 24/7, Triessent Specialty Pharmacy also provides alerts for patient non-adherence issues, coordination of medication refills, information on patient assistance organizations and other support services.
To obtain specialty medications through the Triessent Specialty Pharmacy Program, follow these steps:

1. **Collect Patient and Insurance Information**
   Use the [Triessent Specialty Pharmacy fax form](bcbstx.com/provider/pdf/intake_form.pdf) or your own prescription form, along with your office’s fax cover sheet. Be sure to include the physician’s signature and any clinical data that may support the approval process.

2. **Fax Signed Forms to 866-203-6010**
   Triessent Specialty Pharmacy’s team of pharmacists and benefit specialists will handle the details, from checking eligibility to coordinating delivery.

Triessent Specialty Pharmacy provides safe and efficient delivery of specialty medications and integrated management across medical and pharmacy benefits. As a service to your patients, Triessent Specialty Pharmacy can deliver those drugs that are approved for self-administration directly to the patient’s home or alternate location. Please note that Triessent is also available for those specialty medications that are covered under the member’s medical benefit.

For more information, visit the Pharmacy Program/Specialty Pharmacy section of our website at [bcbstx.com/provider](bcbstx.com/provider).

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member’s certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

**ANSI v5010 update: Interpreting the PLB segment on the 835 ERA**
You may have noticed changes on your electronic remittance advice (ERA) from Blue Cross and Blue Shield of Texas (BCBSTX) as a result of new ANSI Version 5010A1 835 requirements specified in the Technical Report Type 3 (TR3). As a reminder, the TR3 is available for purchase on the Washington Publishing Company (WPC) website at [wpc-edi.com](http://wpc-edi.com).

There are reversals and corrections when claim adjudication results have been modified from a previous reporting. The method for revision is to reverse the entire claim and resend the modified data. Provider level adjustments are reported in the PLB segment within the ERA.

Adjustments in the PLB segment can either decrease the payment (a positive number) or increase the payment (a negative number). You should alert your practice management software vendor, as the information in the PLB segment must be taken into consideration for auto-posting of payments to your patient accounts.
Information for your vendor
Included below are additional details regarding the adjustment codes you may see in the PLB segment, in accordance with the TR3. Please share this important information with your practice management software vendor, and/or your billing service or clearinghouse, if applicable. Questions may be directed to our Electronic Commerce Center at 800-746-4614.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WO</td>
<td>Overpayment Recovery</td>
</tr>
<tr>
<td>72</td>
<td>Authorized Return</td>
</tr>
<tr>
<td>B2</td>
<td>Rebate</td>
</tr>
<tr>
<td>CS</td>
<td>Adjustment</td>
</tr>
<tr>
<td>C5</td>
<td>Temporary Allowance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>WO</td>
<td>This is the recovery of a previous payment. An identifying number must be provided in PLB03-02. (See notes on codes 72 and B2 for additional information about balancing against a provider refund.) Example: PLB<em>154837NN82</em>20121231<em>WO:0201209NN08956B0X.5520NN142</em>1156</td>
</tr>
<tr>
<td>72</td>
<td>This is the provider refund adjustment, acknowledging a refund received from a provider for a previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment. Referring to the original refund request or reason for balancing purposes, the amount related to this adjustment reason code must be directly offset.</td>
</tr>
<tr>
<td>B2</td>
<td>This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 and offset by the amount with code WO. The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider. Example: PLB<em>154837NN82</em>20121231<em>72:020120NN5076B180X00.5520NN794</em>-9281.11<em>WO:020120NN5076B180X00.5520NN794</em>9281.11<em>B2:020120NN5076B180X00.5520NN794</em>-9281.11</td>
</tr>
<tr>
<td>CS</td>
<td>Provide supporting identification in PLB03-2. Example: PLB<em>15483NN082</em>20121231<em>CS:020120NNN0C85890X00.55NN82101</em>-1156</td>
</tr>
<tr>
<td>C5</td>
<td>This is a tentative adjustment used to convey to the provider information for debit or credit transactions. This is used in situations where there is a reduction in payment under $50. Example: PLB<em>15483NN082</em>20121231<em>C5:020120NNNQ3980X00.55NN30940</em>-2</td>
</tr>
</tbody>
</table>

Balancing procedure
The amounts reported in the 835, if present, must balance at three different levels, as follows:
1. Service Line – Record the BPR02 (the total actual payment to the provider for this 835). This is the check or Electronic Funds Transfer (EFT) amount.
2. Claim Level – Sum the CLP04 (Claim Payment Amount).
3. Transaction Level – Summarize any PLB adjustments, if any, and reverse the sign of the value.

The sum of all claim payments (CLP04) minus the sum of all provider level adjustments (PLB) equals the total payment (BPR02).

WPC is an independent, third-party vendor that is solely responsible for its products and services.
Notices and Announcements

Predetermination request reminders
A predetermination of benefits is a voluntary, written request for review of treatment or services, including those that may be considered experimental, investigational or cosmetic.* Prior to submitting a predetermination of benefits request, you should always check eligibility and benefits first to determine any pre-service requirements. A predetermination of benefits is not a substitute for the pre-certification process.

To submit a predetermination of benefits request, use the Predetermination Request Form. Please note that predetermination requests must be sent to the Blue Cross and Blue Shield (BCBS) Plan that holds the patient’s policy.

Faxing your information may help expedite the review process. For Blue Cross and Blue Shield of Texas (BCBSTX) members, fax your completed Predetermination Request Form to BCBSTX at 888-579-7935, along with any supporting documentation. Approvals and denials are usually based on provisions in our medical policies. BCBSTX will notify you when the outcome has been reached.

For out-of-area BCBS members, an online "router" tool is available to help you locate Plan-specific pre-certification/preauthorization and medical policy information. When you enter the Alpha Prefix from the member’s ID card, you will be redirected to the appropriate BCBS Plan’s website for more information.

* For Federal Employee Program members, a Predetermination of Benefits review is required for the following services: Outpatient/Inpatient surgery for Morbid Obesity; Outpatient/Inpatient surgical correction of Congenital Anomalies; and Outpatient/Inpatient Oral/Maxillofacial surgical procedures needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

Please note: Regardless if a guideline is available for any given treatment or a service or treatment has been pre-certified or pre-determined for benefits, these do not guarantee 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.

Reminder: Licensed free-standing emergency medical facilities
The Uniform Billing Editor is listing a newly created Bill Type for the UB04 for Licensed Free Standing Emergency Medical Facilities. The new Bill Type is 078X, which should be used on any claims filed after July 1, 2012.

In Every Issue

Medical record requests: Include our letter as your cover sheet
When you receive a letter from Blue Cross and Blue Shield of Texas (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 reminder**

Physicians and professional providers must contact AIM Specialty Health SM, formerly American Imaging ManagementSM (AIMSM), first to obtain an RQI number 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 PPO RQI number, 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 an RQI number. 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 from AIM on behalf of the ordering physician. Also, the RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS 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](http://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](http://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](http://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 Sept. 1 and Dec. 1 in 2012 and 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 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, 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, 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 BCBSTX 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 BCBSTX provider website at bcbstx.com/provider to access the 2012 QVT list.

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

For the 2012 drug updates, visit the BCBSTX 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.

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