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Availity's new claims research tool offers speed, accuracy

Availity's new online Claims Research Tool (CRT) provides your office staff greater claims accuracy and increased office efficiency in managing your account receivables. The CRT gives your staff fast, real-time access to enhanced Blue Cross and Blue Shield of Texas claim status information, with features that include:

- Status of multiple claims in one view.
- Member ID and claim (DCN) number lookups.
- Patient account and group number information.
- Detailed line-level information including reason codes and descriptions.
- Related copay, deductible and coinsurance amounts.

The CRT also ends the need for time-consuming phone calls and is offered at no cost to you. An online tip sheet is provided to help you with this new and easy tool.

To view the Claims Research Tool, go to www.bcbstx.com/provider. Under Electronic Commerce, click Online Transaction Tip Sheets and scroll down to CRT Tip Sheet, or go to http://www.bcbstx.com/provider/ec/online_trans_tip_sheets.htm.

Reminder! New plan years have begun, verify member ID cards

With the new year, many of your patients may receive new member ID cards. To help ensure prompt and accurate claims processing, we encourage you to make sure you have a copy of the patient's current ID card to use when submitting claims.

You may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in your patient's file.
- Make copies of the front and back of the member's ID card and pass this key information to your billing staff.
- Blue Plan members' ID cards include a three-digit alpha prefix in the first three positions of the member's ID number. This alpha prefix identifies the member's Blue Plan and is critical for eligibility/benefits verification and claims processing. This may be followed by up to 14 additional characters, in any combination of letters and numbers. When filing the claim, always enter the identification number exactly as it appears on the member's card, including the alpha prefix.

  Examples of ID numbers:

ABC1234567	ABC1234H567	ABC12345678901234
Alpha Prefix	Alpha Prefix	Alpha Prefix

Special note about Walmart patients and their ID cards
New ID cards, effective Jan. 1, 2010, have been issued to Walmart associates. Some ID cards will include a new alpha prefix as part of the member's ID number. To ensure claims are processed correctly:

- Verify the ID card to make sure you have the correct one on file.
- File claims to Blue Cross and Blue Shield of Texas (BCBSTX) using the exact ID card number, including the alpha prefix. Do not add, omit or alter any characters from the member ID number.
- To check eligibility, benefits and precertification requirements, send an electronic eligibility inquiry to BCBSTX or call 800-676-BLUE (2583) and provide the three-letter alpha prefix.

Newly designed public Web site launched

More than ever, it is important for your patients to understand their health insurance. Our www.bcbstx.com Web site redesign, launched in early December, focuses on providing this guidance and support.

In addition to secure access to customized information through Blue Access® for Members, patients now also have access to publicly available tools and resources to help them navigate the often complex world of health insurance.

New features and enhancements include:

- Searching for a doctor is now easier. The Find a Doctor section is more prominently located in the center of the homepage.
- The Glossary section provides definitions of health insurance words and phrases.

- The Getting Started tutorial makes health insurance easy to understand, with articles, shopping guidelines and tips on how your patients can get the most out of their health plan.
- The Health and Wellness section provides informative articles on coping with illnesses, preventive care, exercise, diet, behavioral health and more.
- The Plans For Different People section is a guide that helps your patients identify health care coverage that best matches their needs.
- New, straightforward content helps make health insurance more understandable.

Early testing results from members and health care consumers have been overwhelmingly positive. More than 90 percent of users were able to complete tasks easily and with confidence. Most users felt comfortable with the new site architecture. Feedback on the new consumer education areas revealed that the information was trusted and that it would be helpful when making a decision about health insurance.

These changes represent our commitment to help consumers as they shop for health insurance and add value for our members who use online tools and resources. As always, we value your opinion. Go to www.bcbstx.com, browse the Web site and click on Feedback to let us know what you think.

Important provider information on new wellness initiatives for federal employees under the Service Benefit Plan

Beginning Jan. 1, 2010, the Blue Cross and Blue Shield Service Benefit Plan began rewarding federal plan members when they complete either the adult Blue Health Assessment or a child's body mass index (BMI) assessment. The intent of these programs is to encourage wellness and prevention and aim to remove barriers to care.

The member reward will be enhanced benefits. If an adult member completes the Blue Health Assessment (our Health Risk Assessment), the copayment for his/her subsequent annual physical examination or an individual preventive counseling visit will be waived. The member will receive a certificate that entitles them to a preventive visit at no charge and the member will be directed to present the certificate to the physician at the time of care. The member must complete the Blue Health Assessment and present a certificate of completion in order for the provider to waive the copayment for the visit.

The second incentive targets children who complete a BMI assessment. Once the BMI assessment is complete, the member will receive a certificate to present at the time of care. The copayments for up to four nutritional counseling visits will be waived. This incentive is limited to children ages 5 through 17 whose BMI falls in the 85th percentile or higher, according to standards established by the Centers for Disease Control and Prevention (CDC). Only those children who meet these requirements will be presented with a certificate. The member must complete the child BMI assessment and present a certificate of completion for the provider to waive the copayment for the visit.

The certificates for both programs will include the member's name, contract ID number, effective date and expiration date. Following this article are copies of the certificates for your reference.

How does it affect my office?

The directions for providers can be found on the certificates, but we are also providing them here for your convenience.

1. If a Service Benefit Plan member presents a certificate, please do not collect the copayment amount from the member at the time of the visit. The reimbursement from Blue Cross and BlueShield of Texas (BCBSTX) for these visits will include the payment of the copayment.
2. If a member presents a certificate and an office visit copayment is collected in error for these types of visits, providers will be required to refund this amount to the member upon receiving payment from BCBSTX.
3. To ensure correct reimbursement, the claim must be filed with the correct evaluation/management procedure code and diagnosis to reflect that the visit was primarily a routine/annual examination for adults, or the correct medical nutrition therapy/nutritional counseling codes and diagnosis to reflect that the visit was primarily a nutritional counseling visit for children.
4. Providers may retain the certificate for their records; you need not submit it with the claim.
5. The child certificate encompasses four visits, so providers are asked to sign and date the certificate when presented by the member in order for the member to track usage of visits.
6. For questions about the certificate or the process, please contact BCBSTX.

Members will be told they do not have to pay copayments for these visits, so we want to ensure our members do not get charged copayment amounts for these visits. Please follow these important directions and do not charge a copayment when a member brings in a certificate. Reimbursement for this visit will be 100 percent of the plan allowance, including payment of the copayment amount.

What action do you need to take?

1. Please ensure the entire office staff is aware of these programs and the process, especially those that normally collect member copayments and arrange appointments. If the patient is a Service Benefit Plan member, you may want to ask if they have a certificate to waive the copayment amount.
2. Follow the directions on the certificate when a Service Benefit Plan member presents one to ensure a positive member experience with your office and the patient's health coverage.

We hope these programs will encourage wellness and prevention. We appreciate your support of these programs that encourage good health practices for our Service Benefit Plan members.

About the BlueCross and BlueShield Service Benefit Plan

Local Blue Cross and Blue Shield Plans underwrite and administer the Blue Cross and Blue Shield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) program. Sixty percent of all federal employees and retirees who receive their health care benefits through the government's FEHB program are members of the Service Benefit Plan.

MyBlue Wellness Certificate

Sample A. Sample

XXXXXXXXXXXXXX

This certificate entitles the above Service Benefit Plan member to:

Four (4) Nutritional Counseling Visits with no member cost-share at a BlueCross BlueShield Plan Preferred Provider upon presentation of this certificate. Valid from XX/XX/XXXX to XX/XX/XXXX.

Visit #1 Acknowledgement:

Visit #2 Acknowledgement:

Visit #3 Acknowledgement:

Visit #4 Acknowledgement:

Provider Information and Instructions

MyBlue Wellness Certificate

Sample A. Sample

XXXXXXXXXXXXXX

This certificate entitles the above Service Benefit Plan member to:

One (1) Free Annual Physical Examination or Individual Preventive Counseling Office Visit at a BlueCross BlueShield Plan Preferred Provider. Valid from XX/XX/XXXX to XX/XX/XXXX.

Provider Information and Instructions

BLUE HEALTH ASSESSMENT

Texas amends age limit for autism spectrum disorder benefits

The 2009 Texas Legislature amended the current autism spectrum disorder (ASD) mandate, extending the age limit from age six to age 10 for generally recognized services prescribed in relation to ASD.

Blue Cross and Blue Shield of Texas (BCBSTX) currently provides benefits for all generally recognized services prescribed in relation to ASD by primary medical care physicians/providers of covered members between the ages of birth and **six** years.

To comply with the new mandate, these benefits now will be available for members from birth up to age **10**.

After the covered member's 10th birthday, benefits for eligible expenses for the treatment of ASD will be available as otherwise covered under the member's group benefit plan.

The provisions of the new law will go into effect on the group's next contract renewal/effective date beginning in 2010.

Exception: The state mandate does not apply to self-funded groups; however, during the benefit renewal period, these groups do have the opportunity to elect coverage options mirroring the state-mandated benefits.

Medical offices are gaining the paperless advantage …

Sign up today to receive the Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS) and help keep your office ahead of the game with increased efficiency, accuracy and security of your account reconciliation processes. Even though you may not be submitting your claims electronically at this time, you are still eligible to enroll in ERA and EPS.

The ERA is a HIPAA-compliant electronic file that explains claim payment and remittance information. You or your designated billing service or clearinghouse will receive the ERA the day after claim finalization. The information can then be automatically posted to your patient accounting system; check with your software vendor, billing service or clearinghouse to confirm the appropriate ERA-compatible software is in place.

Once you enroll, you will receive your ERA file based on your payment cycle. The enrollment process establishes an electronic mailbox where Availity® will place ERAs received from all payers, such as Blue Cross and Blue Shield of Texas. Your ERA will be delivered to an electronic mailbox on Availity's Web portal. You or your billing agent will use an assigned ERA receiver ID to retrieve your ERA, along with your EPS.

The EPS is an electronic print image of the provider claim summary (PCS). It provides the same payment information as a paper PCS. It is received in your office the same day your ERA is delivered, the day after claim finalization. You can archive the information electronically for quick retrieval, rather than maintaining paper files.

The downloadable ERA enrollment form is available in the Electronic Commerce section of our Web site at www.bcbstx.com/provider. Just fax or mail your completed ERA form to Availity, as indicated on the form. Once you enroll for ERA, you are automatically enrolled for EPS.

Not yet enrolled for Electronic Funds Transfer (EFT)? Eliminate the risk of lost or stolen checks. Sign up for EFT and have your claims payments transferred electronically to the financial institution and account of your choice.

For more information, visit the Electronic Commerce section of our Provider Web site for answers to frequently asked questions about EFT, ERA and EPS. You can also contact our Electronic Commerce Center at 800-746-4614 for assistance.

Are you using paper claims to bill unlisted procedure codes for drugs and injections?

Providers often file unlisted procedure codes on paper claims in order to include the descriptions of the services rendered. Are you interested in filing your unlisted procedure codes for drugs and injections electronically, but unsure how?

Availity's electronic format system for filing claims includes a descriptive field for each line of service, allowing you to include the description of services rendered, even for unlisted procedure codes. This helps reduce the unnecessary filing of paper claims.

In the past, services for not-otherwise-classified (NOC) "J Codes" required narrative descriptions and/or submission using paper claims. The fields below provide the additional information required by the Blue Cross and Blue Shield of Texas (BCBSTX) adjudication system to process these services electronically. The addition of these fields will expedite processing and ensure accuracy. The following table defines the new fields and the location of the elements in the professional electronic claim format.

Field name	**Field description**	**ANSI (loop 2410) reference description**
NDC UNITS	National Drug Code Units. This field identifies the number of units administered of the prescription drug.	CTP04
NDC UNIT OF MEASURE	National Drug Code Unit of Measure. This field identifies the unit of measure of the drug	CTP05-I

	administered. Values: F2 = international unit GR = gram ML = milliliter UN = unit	
NATIONAL DRUG CODE	National Drug Code. National code assigned to the drug administered.	LIN02 = "N4" LIN03 = the NDC code
NDC UNIT PRICE	Unit Price. Price per unit of measure for the administered drug.	CTP03

(The NDC number is sent on an electronic ANSI 837 ANSI (4010A1) in the LIN segment of the 2410 loop. The LIN 02 houses the qualifier and the LIN03 houses the actual descriptive field. The 2410 loop is a situational loop that may not always appear on the electronic 837 claim file. The loop is included only if the billing party has to report drug information.)

You may need to modify provider billing systems or notify billing vendors of these changes. Please contact your software vendor to ensure your software will support these data elements. If you have any questions, contact Availity Client Services at 800-AVAILITY (800-282-4548).

BCBSTX Medicare Part D formulary changes for 2010

The Medicare Part D annual six-week open enrollment period ended Dec. 31, 2009. In mid-October, the 2010 Blue Cross and Blue Shield of Texas (BCBSTX) Medicare Part D formulary was approved by the Centers for Medicare and Medicaid Services (CMS). As with all Medicare Part D drug plans, you can expect some changes for 2010.

Some of the changes were mandated by CMS (safety concerns, drugs that no longer meet CMS's definition of a Part D medication) but others were a result of dynamic changes in the pharmaceutical marketplace. BCBSTX's 2010 Medicare Part D formulary includes the addition of some new drug therapies as well as the migration to some important generic equivalents that became available in 2009.

A copy of the 2010 formulary will be included in the annual notice of change (ANOC) sent to all current members of BCBSTX's Medicare Part D plans. In addition, individual member letters were mailed in late November 2009, alerting them to the 2010 formulary changes (removals, tier changes, new utilization management programs) affecting them.

A copy of the 2010 formulary is currently posted on the BCBSTX (www.bcbstx.com) Web site. Please refer to our list below for a handy reference to the top medications impacted by changes to the 2010 formulary that have the most potential to affect current members.

#	Formulary change	2009 tier	2010 tier	Description of formulary change	Formulary alternative if applicable
1	Omeprazole CAP 20 MG	1	1	Is on our formulary; however quantity limits may apply	On formulary, quantity limits may apply
2	FLOMAX CAP 0.4 MG	2	3	Is on our formulary, but will be covered in a higher cost tier	On formulary, higher tier

3	TOPROL XL TAB 25, 50, 100, 200 MG	3	Not on formulary	Is not covered on our 2010 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 • Less expensive	Not on formulary, generic(s) available
4	Propoxyphene - N/APAP TAB 50/325, 100/500, 100/650 MG	1	Not on formulary	Is not covered on our 2010 formulary CMS – High-Risk Medication	ibuprofen, naproxen, acetaminophen w/ codeine, hydrocodone/acetaminophen
5	COZAAR TAB 25, 50, 100 MG	2	3	Is on our formulary, but will be covered in a higher cost tier	On formulary, higher tier
6	COMBIVENT AER	2	Not on formulary	Is not covered on our 2010 formulary	Check with your doctor
7	COSOPT SOL 2-0.5%OP	3	Not on formulary	Is not covered on our 2010 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 • Less expensive	Not on formulary, generic(s) available
8	HYZAAR TAB 50-12.5, 100-12.5, 100-25 MG	2	3	Is on our formulary, but will be covered in a higher cost tier	On formulary, higher tier
9	Carisprodol TAB 350 MG, ASA/COD TAB	1	Not on formulary	Is not covered on our 2010 formulary CMS – High-Risk Medication	cyclobenzaprine, methocarbamol, tizanidine
10	LUMIGAN SOL 0.03%	3	Not on formulary	Is not covered on our 2010 formulary	Travatan, Travatan Z, Xalantan
11	Colchicine TAB 0.6 MG	1	Not on formulary	Is not covered on our 2010 formulary	Colcrys
12	ARIMIDEX TAB 1 MG	2	3	Is on our formulary, but will be covered in a higher cost tier	On formulary, higher tier
13	DEPAKOTE TAB 125, 250, 500 MG DR; SPR CAP 125 MG	3	Not on formulary	Is not covered on our 2010 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	Not on formulary, generic(s) available

				• Less expensive	
14	KEPPRA TAB 250, 500, 750, 1000 MG; SOL 100 MG/ML	2	Not on formulary	Is not covered on our 2010 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 • Less expensive	Not on formulary, generic(s) available
15	TOPAMAX TAB 25, 50, 100, 200 MG	3	Not on formulary	Is not covered on our 2010 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 • Less expensive	Not on formulary, generic(s) available
16	ALPHAGAN P SOL 0.15%	3	Not on formulary	Is not covered on our 2010 formulary	brimonidine 0.2% ophthalmic
17	NULYTELY SOL	2	Not on formulary	Is not covered on our 2010 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 • Less expensive	Not on formulary, generic(s) available
18	FEMARA TAB 2.5 MG	2	3	Is on our formulary, but will be covered in a higher cost tier	On formulary, higher tier
19	Dicyclomine TAB 20 MG, CAP 10 MG, SOL 10 MG/5 ML	1	Not on formulary	Is not covered on our 2010 formulary CMS – High-Risk Medication	Check with your doctor
20	XOPENEX HFA AER	2	Not on formulary	Is not covered on our 2010 formulary	PROAIR HFA, VENTOLIN HFA
21	ACULAR LS SOL 0.4%; SOL 0.5% OP	2	3	Is on our formulary, but will be covered in a higher cost tier	On formulary, higher tier

22	TOBRADEX SUS OP	2	Not on formulary	Is not covered on our 2010 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 • Less expensive	Not on formulary, generic(s) available
23	VALTREX TAB 500 MG, 1 GM	2	3	Is on our formulary, but will be covered in a higher cost tier	On formulary, higher tier
24	TRUSOPT SOL 2% OP	2	Not on formulary	Is not covered on our 2010 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 • Less expensive	Not on formulary, generic(s) available

La Cruz Azul and U.S. Virgin Island claims run-out period

Triple-S Management Corporation, the Blue Shield licensee in Puerto Rico, signed a definitive agreement to acquire certain managed care assets of La Cruz Azul de Puerto Rico, Inc. (Blue Cross of Puerto Rico). All La Cruz Azul membership was enrolled with Triple-S effective July 1, 2009.

The La Cruz Azul licensee operates under Plan Code 470 and has active alpha prefixes ZTA, ZTB, ZTC and ZTD. Because of the acquisition, providers should no longer accept Blue ID cards with these alpha prefixes.

Claims run-out period for La Cruz Azul

The claims par/host and control/home licensee run-out period for La Cruz Azul ended Dec. 31, 2009.

Institutional services incurred in Puerto Rico on or before June 30, 2009 will be processed through BlueCard by La Cruz Azul. Professional and Institutional services incurred in Puerto Rico on or after July 1, 2009, will be processed through BlueCard by Triple-S. Members will continue to use the BlueCard Program for access to professional and institutional Puerto Rico providers supported by Triple-S. Provider information remains available through both the Blue National Doctor & Hospital Finder and 800-810-BLUE.

La Cruz Azul members who have received services from providers outside of the Puerto Rico service territory but within another Blue Plan's service territory on or before June 30, 2009 will

be processed through BlueCard. Any claim received on or after Jan. 1, 2010, regardless of the date of service, will not be processed through ITS.

Claims run-out period for U.S. Virgin Islands
Effective July 1, 2009, Triple-S assumed responsibility for processing U.S. Virgin Islands host claims. The claims run-out period is July 01, 2009 to Jan. 31, 2010. Services incurred in U.S. Virgin Islands on or before June 30, 2009 will be processed through BlueCard by Independence Blue Cross just as they are today. Services incurred in U.S. Virgin Islands on or after July 01, 2009 will be processed through BlueCard by Triple-S.

Medicare Part D pharmacy updates: dose optimization

Today, health care organizations are being tasked with the job of providing costly new technologies, expanding services and improving quality of care while still trying to hold the line on escalating medical and pharmaceutical costs.

One cost-saving measure that is simple to implement and well accepted by providers and patients alike is called dose optimization. Dose optimization is the practice of identifying patients who take multiple units (tablets or capsules) of a lower strength, once-daily maintenance medication. The physician consolidates or optimizes the dosing regimen to an equivalent daily dosage of the same medication given as a single unit. Dose optimization is particularly successful for those medications available in a number of different strengths with parity or near-parity pricing.

For example, let's take a look at America's best-selling brand-name medication, Lipitor. The average wholesale prices of both the 20-mg and 40-mg strengths of Lipitor are $4.77 a tablet. A simple conversion from two 20-mg tablets to one 40-mg tablet could save an estimated $1,717 over 12 months.

An extreme example of dose optimization would be switching a patient taking five 5-mg Revlimid tablets to a single 25-mg tablet daily, which could save the health care system $486,131.52 annually. Even drugs like Azor, which do not have parity pricing, can lead to significant cost savings when considered over an extended period of time. In addition to the cost savings, simplifying the dosage schedule is likely to improve patient compliance and possibly lower out-of-pocket costs.

If the savings are so significant and the switch would appear to be a rather simple exercise, why don't providers do a better job of optimizing their patient drug regimens? Several factors may contribute to this phenomenon, including a lack of clinician awareness, inappropriate drug titration and drug sampling. Physicians are often unaware a medication is available in multiple dosage strengths and even less aware of the pricing differences among those dosages. In addition, because patients may start at a lower dosage strength, it is common for providers to instruct their patients to utilize some multiple of their current prescription instead of writing a new one. Lastly, samples are often used to test patient tolerability and provide a supply of medication through the titration phase of therapy. Once the patient exhausts the sample supply, many providers simply provide a prescription for the same multiple-units-per-day regimen to continue their therapy.

The table below lists once-daily medications that have multiple dosage strengths with either parity or near-parity pricing. This list is certainly not exhaustive; many more examples likely exist. When in doubt, remember to contact your local retail pharmacist to determine what

strengths of a medication are available and if the pricing for these different strengths are the same or similar.

Generic (brand name)	Dosage strengths	Average wholesale price (AWP)	Estimated annualized savings
Amlodipine/olmasartan (Azor)	5/20 mg, 5/40 mg, 10/20 mg, 10/40 mg	5/20 mg = $2.91 10/40 mg = $4.18	$457.20
Armodafinil (Nuvigil)	50 mg, 150 mg, 250 mg	50 mg = 3.73 250 mg = $11.23	$2,671.20
Atorvastatin (Lipitor)	10 mg, 20 mg, 40 mg, 80 mg	20 mg = $4.77 40 mg = $4.77	$1,717.20
Desvenlafaxine (Pristiq)	50 mg, 100 mg	50 mg = $4.26 100 mg = $4.26	$1,533.60
Escitalopram (Lexapro)	5 mg, 10 mg, 20 mg	10 mg = $3.37 20 mg = $3.52	$1,159.20
Fesoterodine (Toviaz)	4 mg, 8 mg	4 mg = $4.78 8 mg = $4.78	$1,720.00
Lansoprazole (Prevacid)	15 mg, 30 mg	15 mg = $6.25 30 mg = $6.25	$2,250.00
Lenalidomide (Revlimid)	5 mg, 10 mg, 15 mg, 25 mg	5 mg = $371.13 15 mg = $404.85	$238,069.44
Rosuvastatin (Crestor)	5 mg, 10 mg, 20 mg, 40 mg	5 mg = $3.97 10 mg = $3.97	$1,429.10
Thalidomide (Thalomid)	50 mg, 100 mg, 150 mg, 200 mg	50 mg = $136.58 150 mg = $237.05	$62,168.40
Venlafaxine (Effexor XR)	37.5 mg, 75 mg, 150 mg	75 mg = $4.42 150 mg = $4.82	$1,879.20

References

Calabrese, D. and S. Baldinger. 2002. Dose-Optimization Intervention Yields Significant Drug Cost Savings. JMCP 8(2): 146–151.
Dose Optimization Program. BlueCross BlueShield Wellmark Web site. http://www.wellmark.com (accessed Sept. 23, 2009).

Evidence Based Measures results posted on secure provider portal

Blue Cross and Blue Shield of Texas (BCBSTX) has evaluated physicians in the BlueChoice® network in certain specialties annually over the past four years for performance on Evidence Based Measures (EBM). This year's evaluation is under way. BCBSTX will mail communication materials with results of this year's evaluation to affected physicians, along with instructions for accessing individual EBM Performance Reports through a newly-developed secure on-line portal (if applicable). This year's evaluation will include the measures from last year's evaluation. For information on the current list of Evidence Based Measures and the specialties measured, visit bcbstx.com/provider/ebi_2010.htm.

Notices and announcements

Upcoming changes regarding specialty medications

These changes became effective Jan. 1, 2010:

30-day supply limit for specialty medications

Coverage for specialty medications will be limited to a 30-day supply. Members with claims history for specialty medications are being notified of this change by mail.

Members obtaining specialty medications through PrimeMail

Specialty medications will no longer be available through PrimeMail, as coverage will no longer be available for an extended supply. A communication is now being included with medication shipments to notify these members. This notice also provides members instructions for transitioning their medication to the Triessent® specialty pharmacy program. This change applies **only** for specialty medications.

Walmart behavioral health benefit announcement

Effective Jan. 1, 2010, Walmart has chosen New Directions as their behavioral health vendor. Walmart members will continue to use Blue Cross and Blue Shield of Texas (BCBSTX) behavioral health physicians, behavioral health professional providers and behavioral health facilities.

Preauthorization will be required from New Directions for behavioral health services rendered in facilities for both ambulatory and inpatient services. In addition, behavioral health office visits will need preauthorization upon the ninth visit per benefit year (which is the calendar year). You can contact New Directions online at www.ndbh.com or by phone at 877-709-6822.

AIM ProviderPortal enhancement

An AIM enhancement of their ProviderPortal℠ on Oct. 5, 2009 provided script bundling when a user attempts to add a multiple-exam type of abdomen CT and pelvis CT. The system now verifies this as a valid combination. Users will need to confirm indication is the same as the previous request and autopopulate clinical data into the second exam. Abdomen CT and pelvis CT are the only valid combinations as of the October release.

Are you billing for services performed on yourself or a family member?

Please be advised that any services rendered or supplies provided by a person who is related to the patient by blood or marriage will be considered a benefit exclusion and will not be covered. Services rendered or supplies provided by a provider on him/herself are also excluded and will not be covered.

New HRA benefit for Kohler employees

Effective Jan. 1, 2010, Kohler Company, a national account administered by Blue Cross and Blue Shield of Alabama (BCBSAL) with a plant located in Brownwood, Texas, will add the Provider Paid Health Reimbursement Arrangement (PPHRA) benefit to their employees' coverage. The difference between a PPHRA and an HRA is that a PPHRA reimburses the provider.

Member identification (ID) cards for Kohler will have a member contract number that begins with KHB. The cards will include Provider Paid HRA logos in the lower right-hand corners to indicate the benefit is included in their coverage. If you have questions about any of these members' benefits, call BlueCard® Eligibility at 800-676-BLUE (2583).

Here is a summary of the benefits BCBSAL's PPHRA will offer providers:

- PPHRA funds and payments from the medical plan will both be included in your remittance advice as medical plan payments.
- Since reimbursement is based on your contractual allowances, you don't have to collect any money differences between what you collected and the actual payment.
- Once the PPHRA funds are exhausted for each member, you can collect the remaining copays, deductible and coinsurance amounts.

Step Therapy and Prior Authorization programs

Step Therapy and Prior Authorization at Blue Cross and Blue Shield of Texas (BCBSTX) are clinical programs that apply to certain prescription medications. These programs are designed to encourage appropriate use of medication and help manage the rising cost of prescription drugs.

Effective for the 2010 renewal of BCBSTX Fully Insured groups, Step Therapy for Biologic Immunomodulators (Rheumatoid Arthritis/Psoriasis) and Prior Authorization for Growth Hormone have been included as standard provisions for Fully Insured pharmacy benefits.

Individuals currently on a biologic immunomodulator or growth hormone, under a BCBSTX Fully Insured group health plan in 2010, will be "grandfathered" to continue that medication. This will assure no disruption in their current therapy.

Physician fax forms are available to download at http://www.bcbstx.com/provider/pa_step_therapy.htm.

Medical policy disclosure

New or revised medical policies, when approved, will be posted on our Provider Portal on the first or the 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 pending policies, go to the General Reimbursement section at www.bcbstx.com/provider and click on Medical Policies. After reading the disclaimer, click on I Agree to advance to the medical policy page. The policies can be accessed by clicking the View Pending Policies tab.

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 first and the 15th of each month with a review period of approximately two weeks.

To view draft policies, go to the General Reimbursement Information section of our Provider Portal at www.bcbstx.com/provider and click on Draft Medical Policies. After reading the disclaimer, click on I Agree to advance to the Medical Policy page.

Urgent versus standard predeterminations

At times, a predetermination for services may need to be handled as priority.

Urgent predetermination requests include, but are not limited to:

- Procedures and/or drugs needed to relieve pain.
- Acute medical conditions.
- Continuities of care in a chronic condition.
- Treatments that need to be given within one week of the date the request is received.

Cosmetic procedures and bariatric surgery would not be considered urgent.

In order for a predetermination request to be processed as priority, please check the box marked “URGENT” located at the top of the completed predetermination form and indicate the anticipated date of service. Urgent predetermination requests only should be faxed to 888-579-7935.

Please note that photographs will not be accepted via fax. They should be placed in a sealed envelope with the words “Request for Predetermination — Original Photos — Do Not Bend” written on both sides and sent to the appropriate address found on the form.

Remember, all predetermination requests are considered standard and should be mailed to the appropriate address found on the form if treatment is to be given later than one week.

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) number from American Imaging Management (AIM) need not submit additional medical records to Blue Cross and Blue Shield of Texas (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.

Importance of obtaining preauthorizations for initial stay and add-on days

Preauthorization is required for certain types of care and services. It is the responsibility of the insured person to confirm that their 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

BlueCross BlueShield of Texas receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our 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 thru 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.

Nonliability and hold harmless reminders: billing for non-covered services

As a reminder, contracted providers may collect payment from subscribers for supplemental charges, copayments, coinsurance and deductible amounts. The 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 Blue Cross and Blue Shield of Texas (BCBSTX) determines that a proposed service is not a covered service, the provider may inform the subscriber in writing in advance. This will allow the provider to bill the subscriber for the non-covered service rendered.
In no event shall a contracted provider collect payment from the subscriber for identified hospital acquired conditions and/or never events.

QVT (quantity versus time) limits

To help minimize health risks and to improve the quality of pharmaceutical care, QVT limits have been placed on select prescription medications. The limits are based upon the FDA (Federal Drug Administration) and medical guidelines as well as the drug manufacturer’s package insert.

The Blue Cross and Blue Shield of Texas Clinical Pharmacy Department is currently working on updating the QVT list for 2010. Please visit www.bcbstx.com for an update and detailed list under the Pharmacy section.

Preferred drug list

Throughout the year, the Blue Cross and Blue Shield of Texas 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.

The 2010 drug guide updates are posted at www.bcbstx.com under the Pharmacy section.

PrimeMail utilizers for specialty medications (all groups)

Effective Jan. 1, 2010, specialty medications will no longer be available through PrimeMail. After Jan. 1, these medications will be delivered through the Triessent specialty pharmacy program. PrimeMail will no longer be filling prescriptions for specialty medications. Triessent staff will assist members with their transfer from PrimeMail to Triessent when they call 888-216-6710. To see a complete list of specialty drugs, go to www.bcbstx.com/member/pdf/specialty_druglist.pdf.

A notice will also be sent to members utilizing specialty medications informing them that effective Jan. 1, 2010, a 90-day supply of these specialty medications will no longer be available. Specialty medications will be limited to a one-month supply at a time.

AIM RQI reminder

Physicians and professional providers must contact American Imaging Management (AIM) 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 www.americanimaging.net 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 provider portal 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 Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program.

Outpatient clinical reference laboratory for HMO Blue Texas

Laboratory Corporation of America (LabCorp) is the exclusive outpatient clinical reference laboratory provider for HMO Blue Texas members (see note below for exceptions). To find the closest LabCorp Patient Service Center, call LabCorp's automated phone system toll free at 888-LABCORP or visit their Web site at www.labcorp.com. Both systems will prompt you for your ZIP code and will provide those service centers nearest that ZIP code location.

You can find a complete list of participating providers by using the Provider Finder search tool at www.bcbstx.com/provider. For physicians located in certain 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 office for HMO Blue Texas members. Please note that all other lab services/tests performed in the physician's office will not be reimbursed.

You can access the county listing and the revised Reimbursable Lab Services list, which will become effective Nov. 1, 2009, at www.bcbstx.com/provider under the General Reimbursement Information section.

Note: Physicians who are contracted/affiliated with a capitated IPA/medical group and physicians 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.

BlueChoice Solutions Large Employer Group List As of December 2009	
A.H. Beck Foundation Co., Inc.	Mass Group Marketing Inc.
Air Force Villages Inc.	MHMR Services of Texoma
Alamo Iron Works Inc.	Mike Calvert Toyota
Bert Ogden Olds, Nissan & BMW Inc.	Naegeli Transportation Inc.
Blue Cross and Blue Shield of Texas	Odyssey Aerospace Components, LLC
Career Point Institute	Reef Industries, Inc.
Centaurus Property Management, LLC	Research Analysis & Maintenance Inc.
City of Sanger	Six Day Dental & Orthodontics-North TX, P.A.
Community Hospice of Texas	Southwest Ford, Inc.
Crestview RV	SXSW, Inc.
DCTA	Taylor & Hill
Epic Medstaff Services Inc.	TEI & Associates, LLC
First Co.	The Care Group of Texas
Gabriel Holdings, LTD	The City of Glenn Heights
Good Fulton & Farrell	The CMI Group Inc.
Guido Management Services Inc.	The Spencer Company
Health Services Management of Texas, LLC	United Graphics
Hi-Tech Plastics	VLSIP Technologies Inc.
John L. Wortham & Son, LP	Wal-Mart
Lantern Drilling Company	Yantis Company
M. Hanna Construction Co. Inc.	

Fee schedule updates

As you have already been notified, the ParPlan, BlueChoice® and HMO Blue® Texas (Independent Provider Network only) maximum allowable fees for practitioners will be updated to reflect 2010 CMS values.

Geographic practice cost indices (GPCIs) will not be applied to the relative values, so relative values will not differ by Medicare locality. ParPlan, BlueChoice and HMO Blue Texas relative values will consider the site where the service is performed (facility or non-facility).

The drug/injectable fee schedule will be updated on the following dates: June 1, 2010; Sept. 1, 2010; Dec. 1, 2010; March 1, 2011; and June 1, 2011.

Blue Cross and Blue Shield of Texas provides general reimbursement information policies, request forms for allowable fees and fee schedule information at www.bcbstx.com/provider. To view this information, visit the General Reimbursement Information section on the Web site.

To request a sample of maximum allowable fees or if you have any other questions, contact your local Professional Provider Network office.

Reimbursement changes will be posted under Reimbursement Changes/Updates in the Professional Reimbursement Schedules section on the Web site. 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.

Improvements to the medical records process for BlueCard claims

Blue Cross and Blue Shield of Texas 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 Blue Cross and Blue Shield of Texas if needed for claims processing.

If you receive requests for medical records from other Blue Plans before rendering services, as part of the pre-authorization process, please submit them directly to the requesting Plan.

Pass-through billing

Blue Cross and Blue Shield of Texas (BCBSTX) does not permit pass-through billing. Pass-through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider.

The performing provider should bill for these services unless otherwise approved by BCBSTX.

BCBSTX does not consider the following scenarios to be pass-through billing:

1. The service of the performing provider is performed at the place of service of the ordering provider and is billed by the ordering provider.
2. 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 provider) and the service is billed by the ordering provider.

Reminder — Contracted providers must file claims

As a reminder, providers must file claims for any covered services rendered to a patient enrolled in a Blue Cross and Blue Shield of Texas (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.

Change your information online

Click the Change Your Information icon at www.bcbstx.com/provider to electronically submit a change to your name, office or payee address, e-mail 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 (BCBSTX) 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.

About Blue Review

Blue Review is published for BlueChoice®, ParPlan and HMO Blue® Texas contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; e-mail BlueReviewEditor@bcbstx.com.

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