



Issue 5, 2010

When requesting claims status, the Web trumps the telephone

Our automated, customer service telephone system provides a valuable service. But when it comes to determining the status of a claim, there's nothing faster and more efficient than using specialized Web tools to stay on top of the information you need.

Occasionally when you call our Provider Customer Service, our automated system will let you know that your claim has been 'pending.' This simply means your claim is still in process and that additional information is not yet available.

But with the Availity^{®*} Claim Research Tool (CRT), the information you need is at your fingertips. Registered Availity users can use the CRT—at no additional charge—for **up-to-the-minute** electronic transactions that are secure, unlimited and printable. To keep checking on the status of your claim, simply log on. Availity is just one of a number of electronic connectivity vendors who offer Web tools capable of keeping you in touch with the claims process.

As of July our automated system no longer offers the option to speak with a Customer Advocate if the claim in question has been in process for less than 21 days.

Note: To learn more and register with Availity, visit availity.com or call 800-AVAILITY (800-282-4548) for assistance.

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Electronic Refund Management tool is an excellent alternative to submitting a paper refund request

Our Electronic Refund Management (eRM) tool offers a flexible, convenient and user-friendly alternative to the paper refund request and payment process. The eRM tool is available to all independently contracted Blue Cross and Blue Shield of Texas (BCBSTX) physicians and other professional providers. You must be registered with Availity^{®*} or RealMed^{®***} to be able to gain access to the eRM application.

Here are some of the benefits of eRM:

- It's easy to use! There's a three-step status bar on every page in eRM. For every transaction, you have the opportunity to review your selection or data before you submit the information to BCBSTX. Webinars are ongoing to assist new users (see below).

- Instead of receiving the paper request for a claim refund (RFCR) letter, you can opt to receive a daily or weekly e-mail summarizing overpayment requests from BCBSTX. Once you receive an electronic notification of overpayment, you can choose to deduct from a future payment or pay by check.
- If you have any questions, inquiries can be made right through the eRM system. No need to call BCBSTX — you'll receive a response electronically.
- If there's a need to appeal or dispute a request, you can upload your documentation directly to the eRM system. If you need to fax your information, the system will generate a cover sheet with a bar code to ensure your documentation is matched with the appropriate refund.
- You may also use the system to view transactional history for each request or generate a report related to multiple new, outstanding and/or closed refund requests that contain an NPI related to your office/facility.

Training and Support

We offer free, ongoing webinar sessions to help you learn about eRM. Webinars feature a live demo of the tool as well as a presentation on how to get started. Visit the BCBSTX provider website at bcbstx.com/provider for a listing of the eRM Webinars. View the webinars as many times as you like. If you have any questions or need assistance, send an e-mail to eRM@hcsc.com.

You must be registered with Availity or RealMed to gain access to the BCBSTX eRM tool. To register with Availity, visit their website at availity.com or call 800-AVAILITY (800-282-4548). For information on RealMed registration, call the RealMed Customer Service Center at 877-REALMED (877-732-5633).

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EFT, ERA and EPS: Beyond the Basics, Part 2

In July, we shared feedback from physicians and other professional providers who expressed interest, but needed more information prior to enrolling for Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS). The first *Beyond the Basics* article focused primarily on enrollment details and prerequisites. The collection of questions included in this month's article examines how you will receive your payment and remittance information, as well as how EFT, ERA and EPS work better when utilized together.

1. How often will the electronic checks be deposited?

Upon enrollment for EFT, you have a choice between daily and weekly payments, or you can remain on your current payment cycle. If no option is selected on the EFT enrollment form, the default is weekly. Once your EFT enrollment is processed, you

will receive a letter from our Electronic Commerce Services department with your effective date and related information.

2. ***How does ERA work?***

The ERA is just one of many electronic solutions that can help you streamline the administrative process and bring each claim full circle as quickly and easily as possible. The ERA is a HIPAA-compliant electronic file that contains claims payment reconciliation data. The purpose of the ERA is to support automated posting of payments to your patient accounts. Once you enroll for ERA, you will also receive the EPS — an electronic companion file that replaces your paper PCS. The EPS file contains the same information as the PCS, including individual claim details on each patient, along with the total amount of the payment you are due. The big advantage of the ERA and EPS files is that you receive them *the day after claim finalization*. This means that, if you are also enrolled for EFT, you will be able to reconcile your patient accounts *prior* to receiving your payment from Blue Cross and Blue Shield of Texas (BCBSTX).

3. ***How do I retrieve the ERA?***

You must be registered with Availity®* prior to enrolling for ERA. Once your ERA enrollment process is completed, you or your billing agent will use an assigned Receiver ID to obtain your ERA and EPS information, which is delivered to your electronic mailbox on Availity's online provider portal. If you currently have a Submitter ID for Electronic Media Claims (EMCs), the same Submitter ID may be used to retrieve the ERA. If your software is ERA-capable, you can transfer an ERA to your computer. Some software also offers the option to print the ERA data for review. If you have designated a billing agent (billing service or clearinghouse) to receive the ERA and EPS on your behalf, it's a good idea to contact your billing agent directly with any questions about how they will utilize the information and/or pass it along to you.

4. ***In what format will I receive the EPS?***

The EPS is delivered by BCBSTX as a text file so that you can receive it in conjunction with your ERA. You can either save the EPS as an electronic file for future retrieval or select and print some or all of the document. The EPS contains the same information as your paper PCS. You can even make the electronic document look like the paper PCS by opening the file in Microsoft Word or a similar application, setting the page layout as landscape and selecting 8-point Courier New for the font. If you use a billing agent or clearinghouse, check with them to make sure they are aware of your formatting preferences.

5. ***Do I need to have a person with advanced computer skills to set up and use the ERA?***

No. You don't need a technical person on your staff, but you do need to consult your software vendor to ensure that your practice management system can accept and "translate" the electronic data. This is because the ERA, also known as the ANSI 835, is a HIPAA-compliant transaction that must be configured according to specific regulations and guidelines. These regulations and guidelines are available for your vendor to access on the BCBSTX website at bcbstx.com/provider. Ask your vendor if there is any additional charge for ERA-compatible or auto-posting software. A partial listing of ERA-compatible software vendors is available on the Availity website at

availity.com: click on “Info for Providers,” then select “View Availity technology company partners.”

Ready to move on to the next level?

Watch for our next *EFT, ERA and EPS: Beyond the Basics* article, which will continue to address recent questions and concerns from physicians and other professional providers. Meanwhile, we invite you to visit the BCBSTX provider website at bcbstx.com/provider for the Electronic Options Tutorial, EFT and ERA enrollment forms, and a schedule of upcoming webinars and other learning opportunities available to BCBSTX physicians & other professional providers. If you have questions about EFT and ERA enrollment, contact our Electronic Commerce Center at 800-746-4614.

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‘Hospital Acquired Conditions’ and ‘Never Events’

Effective Dec. 1, 2010, Blue Cross and Blue Shield of Texas (BCBSTX) will apply the following principles and guidelines for review and determination of Hospital Acquired Conditions (identified by CMS) and Never Events (identified by National Quality Forum), to determine whether reimbursement to a physician or other professional provider should be reduced for the additional costs related to the event:

- The error or event must be preventable
- The error or event must be within control of the physician or other professional provider
- The error or event must be a result of a mistake by the physician or other professional provider
- The error or event must result in significant harm
- Identification of non-payable events will incorporate case-by-case review and determination by a BCBSTX medical director, except when self reported and without dispute

If medical records are required to complete a review of a Hospital Acquired Condition/Never Event, the minimum defined record set will include: Discharge Summary, Admission History and Physical, Operative Reports, Consultation Reports, Physician Progress Notes, Emergency Department records (if admitted via the ER), and other documentation as determined by the medical director.

If adjustment of claims is determined applicable, the physician or other professional provider will be notified. The physician or other professional provider may appeal a decision made by BCBSTX for the Hospital Acquired Condition/Never Event and appeal instructions will be included in the notification letter.

Hospital Acquired Conditions

As defined by CMS, Hospital Acquired Conditions are those conditions that are acquired by a patient while they are in the inpatient hospital setting and were not present upon admission to the hospital.

The following Hospital Acquired Condition represents a potential area of responsibility and will be reviewed by a BCBSTX medical director on a case-by-case basis:

- Foreign Object Retained After Surgery

Never Events

As defined by the National Quality Forum (NQF), Never Events are adverse events that are serious, but largely preventable and of concern to both the public and health care providers for public accounting purposes. Never Events earned that name because these events should never happen in medical practice.

The following Never Events represent potential areas of responsibility and will be reviewed by a BCBSTX medical director on a case by case basis:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- The wrong surgical procedure performed on a patient

Should you have any questions, contact your local Professional Provider Network office.

Copayments, coinsurance and some benefits change for HealthSelect plan

For the HealthSelectSM of Texas plan,* Sept. 1, 2010, marks the beginning of a new plan year. It also will bring about changes to copayments, coinsurance and some benefits.

Below is a summary of the changes:

- In-network only:
 - PCP office visit and Retail Health Clinic copays increase to \$25
 - Specialist office visit copay increases to \$40
 - ER visit copay increases to \$150
 - Copay for Urgent Care Clinic/Center benefit (effective June 1, 2010) is \$50.
- Inpatient facility copay increases to \$150 (per day), with a \$750 copay max per admission, \$2,250 calendar year inpatient copay max
- Calendar year out-of-pocket coinsurance maximums increase to \$2,000 (in-network), \$7,000 (non-network) and \$3,000 (out-of-area)
- New \$100 copay for high-tech radiology (CT scans, MRI, Nuclear Medicine) (waived if performed during ER visit or inpatient admission)
- Chiropractic care coverage will be limited to 30 visits per calendar year, per participant, with a benefit maximum of \$75 per visit

For more information, contact Blue Cross and Blue Shield of Texas Provider Customer Service at 800-451-0287.

** HealthSelectSM of Texas is administered by BCBSTX for the Employees Retirement System of Texas (ERS) for state of Texas and certain higher education employees, retirees and their dependents.*

NOTICES AND ANNOUNCEMENTS

Electronic claims with NPI-related errors set to reject Aug. 1, 2010

In June 2008, we published a complete listing of electronic claim edits that were implemented in support of an NPI-Only claims processing environment. This document provided the three-digit error code along with a defining message indicating the severity level of the error and the resulting impact on the claim – “W” for Warning and “R” for Rejection.

An updated NPI-only Electronic Claim Submission Edits listing has been posted in the Electronic Commerce “Alerts” section of the BCBSTX website at bcbstx.com/provider. **Please be advised that most of the edits/error listings that were formerly set at the Warning level will be set to Reject as of Aug. 1, 2010.** The only two error types that will continue to remain at the Warning (“W”) level are as follows:

Error Code	Message	Status
BA6	Rendering NPI is not on file (Claim Level Error Message)	W
CA6	Rendering NPI is not on file (Service Line Level Error Message)	W

If you are currently receiving Warning message(s) on your electronic claim reports denoting a lack of NPI-related information, it is imperative that you make the necessary correction(s) immediately, as most of these claims will reject commencing Aug. 1, 2010.

It is important to ensure that you and/or all of your electronic trading partners (billing services, clearinghouses and software vendors) are aware of and responsive to these messages. If you have any questions on these edits, please contact our Electronic Commerce Center at 800-746-4614.

If your office refers to a printed copy of the 2008 NPI-only Electronic Claim Submission Edits listing, please replace it with the updated version posted in the Electronic Commerce “Alerts” section of the BCBSTX website at bcbstx.com/provider.

Supervision of Physician Assistant, Advanced Practice Nurse or Certified Registered Nurse First Assistant

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.)

Note: 80 modifier: PAs, APNs and CRNFAs billing with their own National Provider Identifier (NPI) AND acting as an Assistant Surgeon, must use modifier 80 appended to the surgical code.

For additional information on modifiers for professional claims, visit the

Blue Cross and Blue Shield of Texas provider website at bcbstx.com/provider in the “General Reimbursement” section under “All Product News.”

New clotting factor management initiative

Patients with bleeding disorders such as hemophilia need immediate access to clotting factor and related products to manage bleeding episodes. Therefore, it is important that physicians who prescribe clotting factors prescribe amounts appropriate to the patient’s clinical situation.

Blue Cross and Blue Shield of Texas (BCBSTX) recommends the [Medical and Scientific Advisory Council Recommendation Concerning Prophylaxis](#) as a helpful resource in managing these patients. In addition, BCBSTX has implemented a review of prescription data to identify high utilization of clotting factors and related products. If high utilization is identified, a form requesting key clinical information and medical rationale may be sent to the prescribing physician. Completed forms are reviewed by a medical director, who will contact the prescribing physician with any questions or concerns. For additional information, visit bcbstx.com/provider/clotting_factor.htm.

Clear Claim Connection™ available to BCBSTX physicians and other professional providers

Clear Claim Connection (C3)*, a web-based code auditing reference tool, is now available to all contracted Blue Cross and Blue Shield of Texas (BCBSTX) physicians and other professional providers. You may access this tool through the secure provider portal at bcbstx.com.

C3 mirrors the ClaimCheck®** auditing rules that BCBSTX has adopted as part of its claim adjudication process. It provides easy access to ClaimCheck payment policies and rules in addition to clinical rationales, clarifications and source information for ClaimCheck edits. Certain claims, such as Medicare Primary and BlueCard, are exempt from ClaimCheck auditing.

The BCBSTX ClaimCheck database is updated periodically and upgraded to a new version annually, which may result in certain edit combinations being modified. Appropriate notice of such modifications will be provided on our website and through this *Blue Review* newsletter.

As of April 19, 2010, BCBSTX-contracted physicians and other professional providers are able to access the C3 web link via Availity®***, in addition to RealMed. Registration with RealMed or Availity is required prior to the first time you access C3. Instructions for registering with RealMed or Availity are located with the link to the respective portal. Once your registration process is completed, you will have access to C3.

To use C3, log on to the BCBSTX website at bcbstx.com and click on the “Providers” tab. You will find Clear Claim Connection in the “General Reimbursement Information” section under “Bundling Information.”

ClaimCheck audit results obtained on the BCBSTX website are specific to BCBSTX. Another carrier who offers C3 may have different edits, which will produce different results. This information is confidential and proprietary, and it is not to be shared.

If you need more information, please contact your local Professional Provider Network (PPN) office or Provider Customer Service at 800-451-0287.

* *Clear Claim Connection™* is a trademark of McKesson Information Solutions Inc.

** *ClaimCheck™* is a registered trademark of McKesson Information Solutions Inc.

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IN EVERY ISSUE

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 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 office. Please note the physician 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 Durable Medical Equipment (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 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 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.

Quest Diagnostics, Inc., is new, exclusive HMO and preferred statewide PPO/POS clinical reference lab provider

Effective June 1, 2010, Quest Diagnostics, Inc. became the **exclusive** outpatient clinical reference laboratory provider for HMO Blue[®] Texas members* and the **preferred statewide** outpatient clinical reference laboratory provider for Blue Cross and Blue Shield of Texas (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 220 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 setup an account, contact your Quest Diagnostics' Physician Representative or call **866-MY-QUEST** (866-697-8378).

For physicians 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 office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician'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.

Effective June 1, 2010, Laboratory Corporation of America (LabCorp) is no longer a contracted provider for HMO Blue Texas.

**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.*

BlueChoice® Solutions Large Employer Groups List

For your reference, the following is an alphabetical list of large employer groups currently enrolled in BlueChoice Solutions. Note that the employer groups listed below include insured and self-funded health plans. These employer groups may have chosen the BlueChoice Solutions network as an optional network for their employees. In addition, BlueChoice Solutions is offered to individual members.

BlueChoice® Solutions Large Employer Group List As of June 2010	
A.H. Beck Foundation Co., Inc. Air Force Villages, Inc. Centaurus Property Management, L.L.C. City of Sanger DCTA First Co. Naegeli Transportation, Inc. Overland Mortgage Corporation	Reef Industries, Inc. Research Analysis & Maintenance, Inc. Southwest Ford, Inc. SXSW, Inc. The Care Group of Texas The City of Glenn Heights The CMI Group, Inc. United Graphics

Fee schedule updates

Reimbursement changes and updates for BlueChoice® and HMO Blue® Texas (Independent Provider Network only) practitioners will be posted under "Reimbursement Changes/Updates" in the Professional Reimbursement Schedules section on the Blue Cross and Blue Shield of Texas 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 provider website. Also, the Drug/Injectable Fee Schedule will be updated on the following dates: 9/1/2010, 12/1/2010, 3/1/2011 and 6/1/2011.

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 pre-authorization process, should be submitted 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 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 and other professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician and 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.

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 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 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 our provider website portal on the first or the fifteenth 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 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 1st 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 the BCBSTX website at 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, 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.

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 provided more than one week from the date of the request.

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 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

Blue Cross and Blue Shield of Texas 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 supplemental charges, 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 Blue Cross and Blue Shield of Texas 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.

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 U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer's package insert.

The Blue Cross and Blue Shield of Texas (BCBSTX) Clinical Pharmacy Department is currently working on updating the QVT list for 2010. Visit bcbstx.com for an updated and detailed list under the Pharmacy section.

Preferred drug list

Throughout the year, the Blue Cross and Blue Shield of Texas (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 2010 drug updates, visit the BCBSTX provider website under the “Pharmacy” section, or follow this link: bcbstx.com/provider/quantity_time.htm

Are utilization management decisions financially influenced?

Blue Cross and Blue Shield of Texas (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.

