



**BlueCross BlueShield
of Texas**

Blue REVIEW

FOURTH QUARTER 2003

A PROVIDER PUBLICATION

All Product News

Information applicable to all lines of business for Blue Cross and Blue Shield of Texas and HMO Blue Texas.

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HMO Blue® Texas

Southwest Texas HMO, Inc.

Southwest Texas HMO, Inc. offers HMO plans and does business as HMO Blue Texas.

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TAXONOMY CODE REQUIREMENTS FOR ELECTRONIC CLAIMS

Although BCBSTX does not require the submission of taxonomy codes (this code list has replaced the specialty code list) some out-of-state plans may require the taxonomy code. To prevent claims processing delays and erroneous payments on out-of-state claims, please enter the provider's taxonomy code in the designated field. If you are unsure where to enter this in your software, please contact your software vendor. A complete list of the taxonomy codes is available at www.wpc-edi.com.

INSTITUTIONAL PROVIDERS CAN NOW FILE LATE CHARGES AND CORRECTED CLAIMS ELECTRONICALLY

Effective immediately, institutional providers currently submitting late charges, corrected claims, or a total replacement to a prior claim on paper for Blue Cross and Blue Shield of Texas (BCBSTX) may now file these claims electronically. These claims are identified by the three digits on the UB92 claim form "Type of Bill" ending in a "5" for late charges, "6" for corrected claims and "7" for replacement claims (i.e. 115, 135, 116, 136, 117,137).

Additional information related to this recent change includes the following:

- The charges on a late charge, correction or replacement claim will be added to the original claim. Any additional payment due will be made as an adjustment to the original. The late charge, corrected claim or replacement claim itself will then be zero paid with the message that the original claim has been adjusted to reflect the additional charges.
- If an outpatient late charge, corrected claim or replacement claim is filed and there is no original claim on history, that claim will be processed as if it were the original claim.
- If an inpatient corrected claim or replacement claim is filed and there

is no original claim on history, that claim will be processed as if it were the original claim.

- If an inpatient late charge claim is filed and there is no original claim on history, that claim will be denied with a message stating that we could not find the original claim. The late charges should be added to the original claim and submitted electronically.

To ensure you can submit late charges, corrected claims and replacement claims electronically, please review your system edits with your vendor, billing service or clearinghouse. It may be necessary for your vendor to accommodate the filing of these claims.

Blue Cross and Blue Shield of Texas and THIN encourage you to take advantage of this change to increase the number of claims you file electronically. This change will reduce administrative costs, save time as well as increase the accuracy of the claims to ensure faster reimbursement as compared to paper claims.

For more information regarding late charges, corrected claims and replacement claims, please call our THIN EDI Helpline at 972-766-5480.

DISCLOSURE NOTICE FOR MICROSCOPIC EXAMINATION OF THE HAIR

Effective on or after February 27, 2004, Blue Cross and Blue Shield of Texas will delete the Medical Policy for Microscopic Examination of the Hair, as this service is considered an allowable benefit. With the deletion of this policy our claims processing system will now bundle the Evaluation and Management visit codes (99201-99435) to Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality (96902). For HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group, you must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general policies and procedures.

MODIFIER 76 – REPEAT PROCEDURE BY THE SAME PHYSICIAN

New logic has been added to our processing system for modifier 76. Procedures that were previously denied as duplicates, should no longer deny for this reason unless they are true duplicates. Please refer to your modifier manual for proper usage of each modifier, or your CPT coding manual may contain a section in reference to modifiers. You may also contact the American Medical Association (AMA) for additional information.

PROCEDURE 90472

Some providers, due to their billing software limitations, have experienced procedure 90472 being denied as a duplicate, when their software splits the claim due to line limitations. If you are one of these providers, you can avoid this by billing multiple units of service on one line for this procedure code.

ELECTRONIC CLAIMS CAN PAY OFF FOR YOU

Hospitals, physicians and other providers that submitted 85 percent, or above, of their BCBSTX and HMO Blue Texas claims electronically for the last 90 days can receive their payments in Electronic Funds Transfers (EFT). Electronic claims submission speeds the claims process and EFT will further expedite payment.

What is Electronic Funds Transfer?

EFT is a form of direct deposit that allows the transfer of BCBSTX and HMO Blue Texas payments directly to a provider's bank account. EFT can speed the reimbursement process by three to five days. Reimbursements by EFT are made once a week.

Electronic Advantages

- Eliminates the risk of your paper checks being lost or stolen in the mail or a delay in delivery
- Saves you time and hassle of going to the bank to deposit checks
- Speeds funds to your bank account, where it can start earning interest immediately
- Claims can be submitted electronically 24-hours a day, seven days a week.
- Daily EFT available in 2004 (BCBSTX)

Providers will still receive a paper copy of their BCBSTX Provider Claim Summary; the only difference is that the check number will begin with an E, indicating electronic payment. Electronic Remittance Advice is also available for Texas providers, so you can automatically post payments to your patient's accounts.

Electronic Funds Transfer has now been added for HMO Blue Texas. Providers will still receive a paper copy of their HMO Blue Texas Explanation of Payment (EOP) and Remittance; the only difference will be a description added to the top right hand side of these forms stating "Processing Completed through EFT".

Electronic claims and electronic funds transfer is the fastest way an insurance company can pay a claim.

To determine if you qualify for EFT, please call the THIN EDI Helpline at 972-766-5480.

For more information on how you can submit your claims electronically visit our Web site at www.thinedi.com or contact your Provider Automation Representative.

TEMPORARY ID CARD NOW AVAILABLE ONLINE

Members are now able to print a temporary ID card online through Blue Access for Members at www.bcbstx.com. The online ID includes eligibility information, as well as the phone number to call to obtain additional benefit information. The online ID will include an expiration date for 10 days after the member prints it since it is a temporary form of identification for members to use while they await a replacement card.

NOTICE OF MEDICAL POLICY ACTIVITY

The following new or revised Medical Policies have recently been approved and will be effective on or after February 27, 2004. These policies can be viewed at www.bcbstx.com/provider. On the Web site, click on "Providers", then click on "Disclosure Notice" and this will take you to the General Reimbursement Information page (the password is "manual"). After reading the Policies Disclaimer, click on "Continue". There are two ways to access all policies. You can click on "Medical Policies" at the top of the screen or you can use the drop down box "Select a Policy." The policies listed below can be found in the "Future Changes" section of the Medical Policy site.

Policy #	Policy Name	Policy #	Policy Name
DME101.001	Hospital Beds and Related Equipment	SUR701.018	Cryosurgical Ablation for Breast Lesions
DME101.010	Wheelchairs and Accessories	SUR705.011	Distraction Devices, External Fixation Devices, Bone Lengthening Devices
DME101.021	Automatic External Defibrillator for Home Use		
PSY301.013	Electroconvulsive Therapy	SUR707.020	Minimally Invasive Coronary Artery Bypass Graft Surgery
RAD602.016	Spinal Ultrasound		
RAD603.001	Magnetic Resonance Angiography (MRA)	SUR709.025	Extracorporeal Shock Wave Lithotripsy (ESWL) for Gallstones
RRU1200.003	Minimally Invasive Total Hip Arthroplasty		
RX503.001	Off-Label Use of FDA Approved Drugs		

The following new or revised Medical Policies are being implemented immediately (or have been implemented) as the changes made do not impact current claims adjudication processes. This notification is being made so providers are aware of any changes to Medical Policy.

Policy #	Policy Name	Policy #	Policy Name
DME101.005	Blood Glucose Monitoring	SUR701.013	Laser Assisted Tonsillectomy
DME101.020	Home Apnea Monitor	SUR703.003	Brain Tissue Transplantation, Neurotransplantation for Treatment of Parkinson's Disease (Fetal Allograft or Autotransplantation)
MED201.005	Esophageal pH Monitoring		
MED202.038	Extracorporeal Membrane Oxygenation (ECMO)	SUR707.003	Automatic Implantable Cardioverter Defibrillator (AICD)
MED202.047	Transcranial Doppler (TCD) Ultrasound		
MED203.002	Antineoplaston Cancer Therapy	SUR710.008	Periurethral Bulking Agents for the Treatment of Urinary Incontinence
MED203.010	Tumor Vaccines		
PSY301.000	Mental Health Services	SUR717.004	Cryosurgical Ablation of the Prostate (CSAP)
RAD601.014	Thermography		

HIPAA NON-COMPLIANT PROVIDER CLAIMS AFTER OCTOBER 16

To achieve successful implementation of the new HIPAA transaction and code sets regulation, BCBSTX will continue to accept existing claim formats, in addition to HIPAA compliant transactions, under its contingency plan. During this time, BCBSTX will continue to transition their providers to HIPAA compliant transactions. **Continue to file your claims electronically. Do not file paper claims.**

PROFESSIONAL CLAIMS PROCESSING ENHANCEMENTS UPDATE

To help make filing claims easier, the following is a list of enhancements made to processing of professional claims and associated payment-auditing logic. Below are highlights of enhancements with their effective date that have been made since our last notice in the First Quarter 2003 Blue Review newsletter. This action is not retroactive to claims processed prior to the effective date listed.

- **Arthroscopy, shoulder, surgical: distal claviclectomy including distal articular surface (29824)** will be allowed with Repair of ruptured musculotendinous cuff open; chronic (23412). PPO/POS effective date 2/21/03, HMO effective date 3/7/03.
- **Therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular (90782)** will be allowed with all vaccine codes (90477, 90585-90634, 90645-90660, 90675-90676, 90690-90700, 90718, 90720-90723, 90740-90747). PPO/POS effective date 2/21/03, HMO effective date 3/7/03.
- **Ultrasound, pregnant uterus, real time with image documentation, limited, one or more fetuses (76815)** and **Ultrasound, pregnant uterus, real time with image documentation, follow-up, trans abdominal approach, per fetus (76816)** will be allowed with Ultrasonic guidance for chorionic villus sampling, imaging (76945). PPO/POS effective date 3/21/03, HMO effective date 4/4/03.
- **Doppler echocardiography color flow velocity mapping (93325)** will be allowed with Non-invasive physiologic studies of extracranial arteries, complete bilateral study (93875). PPO/POS effective date 3/21/03, HMO effective date 4/4/03.
- **Laryngoscopy direct, with or without tracheoscopy: diagnostic, except newborn (31525)** will be allowed with Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimens by brushing or washing. PPO/POS effective date 3/21/03, HMO effective date 4/4/03.
- **Injection, anesthetic agent to somatic nerves (64400-64450)** will be allowed with anesthesia services (00100-01953). PPO/POS effective date 3/21/03, HMO effective date 4/4/03.
- **Arthroscopy, knee, surgical; abrasion arthroplasty or multiple drilling or microfracture (29879)** will be allowed with Meniscectomy (medial and lateral, including any meniscal shaving) (29880) and Meniscectomy (medial or lateral, including any meniscal shaving) (29881). PPO/POS effective date 6/27/03, HMO pending.
- **Partial hymenectomy or revision of hymenal ring (56700)** will be allowed with Laparoscopy, surgical; with aspiration of cavity or cyst (49322). PPO/POS effective date 6/27/03, HMO pending.
- **Removal of vitreous, anterior approach; subtotal removal with mechanical vitrectomy (67010)** will be allowed with Removal of lens material; phacofragmentation technique, with aspiration (66850) and Extracapsular cataract removal with insertion of intraocular lens prosthesis, manual or mechanical technique (66984). PPO/POS effective date 6/27/03, HMO pending.
- **Cholecystectomy (47600)** will be allowed with Hepatectomy, resection of liver; total right lobectomy (47130). PPO/POS effective date 6/27/03, HMO pending.
- **Removal of mammary implant material (19330)** will be denied with Periprosthetic capsulectomy, breast (19371). PPO/POS effective date 6/27/03, HMO pending.
- **Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries with cardiopulmonary bypass (33919)** will be allowed with Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery (33920). PPO/POS effective date 6/27/03, HMO pending.
- **Physical therapy evaluation and Occupational therapy evaluation (97001, 97003)** will be allowed with Osteopathic Manipulative treatment modalities or Chiropractic Manipulative treatment modalities (98926-98929, 98940-98943). PPO/POS effective date 6/27/03, HMO pending.
- **Inpatient Consultations and Follow up Inpatient Consultations (99251-99255, 99261-99263)** will no longer bundle to surgical procedures. PPO/POS effective date 6/27/03, HMO pending.
- **Blood count; blood smear, microscopic examination with manual differential WBC count (85007)** and **Blood smear, microscopic examination with manual differential WBC count (85008)** will be allowed with CBC, automated and automated differential WBC count (85025). PPO/POS effective date 8/16/03, HMO pending.

- **Blood count; blood smear, microscopic examination with manual differential WBC count (85007)** will be allowed with CBC, automated (85027). PPO/POS effective date 8/16/03, HMO pending.
- **Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation (94014) and Recording (94015) and Physician review and interpretation only (94016)** will be allowed with Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation (94010). PPO/POS effective date 8/16/03, HMO pending.
- **Removal of cerclage suture under anesthesia (59871)** will be allowed with Routine obstetric care including antepartum care, cesarean delivery, and postpartum care (59510). PPO/POS effective date 8/16/03, HMO pending.
- **Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service (52005)** will be allowed with Cystourethroscopy, with biopsy (52204). PPO/POS effective date 8/16/03, HMO pending.
- **Therapeutic or Diagnostic Infusions (90780 and 90781)** will be allowed with Chemotherapy Administration, infusion technique < 1 hour, 1-8 hours, >8 hours (96410-96414). PPO/POS effective date 9/17/03, HMO pending.
- **Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time (94350)** will be allowed with Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method (94240). PPO/POS effective date 9/17/03, HMO pending.
- **Hysteroscopy, surgical; with removal of leiomyomata (58561)** will be allowed with Hysteroscopy, surgical; with endometrial ablation (eg. endometrial resection, electrosurgical ablation, thermoablation) (58563). PPO/POS effective date 9/17/03, HMO pending.
- **Introduction of needle or intracatheter; retrograde extremity artery (36140)** will be allowed with Transcatheter placement of an intravascular stent (non-coronary vessel) percutaneous; open (37205-37208). PPO/POS effective date 9/17/03, HMO pending.
- **Transmyocardial laser revascularization, by thoracotomy, performed at the time of other open cardiac procedures (33141)** will be allowed with all Coronary Artery Bypass Grafts (33510-33536). PPO/POS effective date 9/17/03, HMO pending.
- **Initial (new patient) visit when starred (*) surgical procedure constitutes major service at that visit (99025)** will be allowed with starred (*) procedures (too numerous to list here). PPO/POS effective date 9/17/03, HMO pending.



LABCORP PREFERRED OUTPATIENT CLINICAL REFERENCE LAB PROVIDER

Effective September 1, 2003, Laboratory Corporation of America (LabCorp) was named the statewide **preferred** outpatient clinical reference lab provider for the BlueChoice PPO/POS products. If you have any specific questions regarding your LabCorp account or need to set-up an account with LabCorp, please contact LabCorp's Client Services Department:

Dallas/Ft. Worth/El Paso/West Texas

800-788-9892, extension 6202
972-566-7500, extension 6202

Houston/San Antonio/Austin/South Texas

800-800-2387, extension 3999
713-856-8288, extension 3999

NO MORE EXCEPTIONS TO BLUECARD CLAIMS FILING PROCESS

Effective September 30, 2003, there are no longer exceptions to BlueCard claim filing for inpatient, outpatient and professional claims. All BlueCard (out-of-state) member claims should be filed to Blue Cross and Blue Shield of Texas.

Here are some key points to remember when filing claims:

- Look for the three-character alpha prefix that precedes the member's identification number on the identification card.
- Call BlueCard Eligibility 1-800-676-BLUE (2503) to check the patient's membership and coverage.
- Submit the claim electronically to BCBSTX, and always include the patient's complete identification number which includes the three character alpha prefix.

Medicare Supplemental Claims Filing

For Medicare Supplemental claims, always file with Medicare first. Include the complete Health

Insurance Claim Number (HICN), the patient's complete Blue Cross and Blue Shield identification number, including the three letter alpha prefix, and the Blue Cross and Blue Shield Plan name as it appears on the patient's identification card. This will ensure cross-over claims are forwarded appropriately.

When you receive the Remittance Advice (RA) or Explanation of Medicare Benefits (EOMB) from Medicare, typically a remark code will be printed on it stating that the claim information was forwarded to the patient's supplemental insurer. If the RA or EOMB does not indicate the claim crossed over, file the claim as you do today to BCBSTX.

It is no longer necessary for you to mail your out-of-state Medicare Supplemental claims to the member's home plan. File out-of-state Medicare Supplemental claims electronically to BCBSTX when the claim did not crossover from Medicare.

NEW PROMPT PAY LEGISLATION ADOPTED

Blue Cross and Blue Shield of Texas (BCBSTX) and HMO Blue Texas were impacted by the passage of the new Prompt Pay Legislation. Processes to support the new law were implemented by BCBSTX and HMO Blue Texas on September 2, 2003. The following provides a summary of the changes relating to the passage of this legislation and related legislation.

Verification

Providers of service have the right to request verification that a particular service will be paid by the insurance carrier. The Texas Department of Insurance (TDI) defines verification as "a guarantee by an HMO or preferred provider carrier that the HMO or preferred provider carrier will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the patient for whom the services are proposed."

To initiate a request for verification, please contact the appropriate Provider Customer Service Department and select the option for verification.

- **BlueChoice (PPO/POS) - 1-800-451-0287**
- **HMO Blue Texas - 1-877-299-2377**

Please be prepared to provide all the TDI required data elements at the time of your request. The required elements are as follows:

- Patient name
- Patient ID number, if included on an identification card issued by the HMO or preferred provider carrier
- Patient date of birth
- Name of enrollee or member/subscriber, if included on an identification card issued by the HMO or preferred provider carrier
- Patient relationship to enrollee or member/subscriber
- Presumptive diagnosis, if known, otherwise presenting symptoms

- Description of proposed procedure(s) or procedure code(s)
- Place of service code where services will be provided and if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided
- Proposed date of service
- Group number
- If known to the provider, name and contact information of any other carrier
- Name of the provider providing the proposed services
- Provider's federal tax ID number

In addition to the TDI required data elements, please be prepared to provide a referral or preauthorization number for those services which require a preauthorization. Also, to expedite the receipt of your written response, please provide your office fax number.

The verification process includes researching eligibility, benefits and preauthorizations. Blue Cross and Blue Shield of Texas or HMO Blue Texas will respond to the provider's request with one of the following letters within the required TDI established timeframes:

- Request for additional information
- Verification notice
- Declination notice

Verification is not applicable for all enrollees or providers. Routine eligibility and benefit information may be obtained for any enrollee or member/subscriber when verification is not applicable.

A Declination is simply a decision that a verification cannot be issued in advance, not a determination that a claim will not be paid. Therefore, if a declination is given, providers may not bill the member/subscriber at the time of service except for the applicable copayments, deductible and/or coinsurance amounts.

Requests for verification of HMO services will be processed by HMO Blue Texas only if the claim processing will be performed by HMO Blue Texas. If your request is for a service covered under a capitated independent physician association (IPA), medical group, or other delegated entity responsible for claim payment, please make your request for verification directly to the appropriate IPA or entity.

Timely Filing – HMO Blue Texas claims must be filed no later than the 95th day after the services are rendered. BlueChoice (PPO & POS) claims not submitted within 365 days of the date of service will not be considered for payment and provider may not seek payment from the subscriber.

Duplicate Filing – The regulation also prohibits providers from filing duplicate claims sooner than 31 days for electronic claims and 46 days for paper claims after the original claim was filed.

ID Card Requirements – Carriers will be required to include a unique symbol on ID cards which serves as an indicator to inform providers that the member's health benefit plan is subject to the Prompt Pay Legislation. TDI is in the process of determining the requirements of the symbol. Future newsletters will provide an update regarding the unique ID symbol.

Excluded Accounts – Certain groups, plans, claim types and providers are excluded from the Prompt Pay Legislation. Please refer to the TDI Web site at www.tdi.state.tx.us for additional information.

Additional Information – Please refer to the online provider manuals for more information about filing claims, preauthorization and verification for your HMO Blue Texas members and BlueChoice subscribers. The provider manuals are available at www.bcbstx.com/providermanuals.

TRS-ACTIVECARE ENROLLMENT INCREASES

Two of the largest school districts in Texas have joined TRS-ActiveCare, the health benefits program for active public education employees. Effective January 1, 2004, nearly 25,000 employees and dependents from Dallas Independent School District (DISD) and Fort Worth Independent School District (FWISD) will begin participating in the ActiveCare 1, 2 and 3 PPO plans administered by Blue Cross and Blue Shield of Texas. More than 1,000 school districts and over 200,000 members currently participate in TRS-ActiveCare statewide.

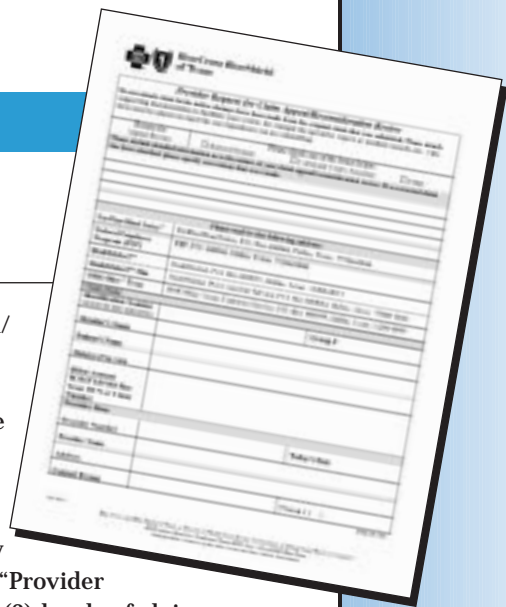
FIFTEEN NEW GROUPS MOVE TO UNIQUE ID IDENTIFIER

With a number of states now prohibiting the use of Social Security Numbers (SSN) for identification purposes, there is growing interest among employers to use a different unique number sequence to identify their group health plan members. The following Texas groups have begun or will begin using non-SSN IDs in the near future.

Effective Date of Change	Group Name	Group Number	Product
9/01/03	University of Texas University of Texas	71778 71779	PPO HMO
9/01/03	Texas A&M	39993	PPO
1/01/04	Alcatel	55699	HMO/PPO
1/01/04	Belo	3824	HMO
1/01/04	Compucom Systems	60691	PPO
1/01/04	Continental Airlines	81688	PPO
1/01/04	Dresser	69215	PPO/Trad/EPO
1/01/04	Engineered Air Balance Co.	53134	PPO
1/01/04	Express Jet	22944	EPPO/PPO
1/01/04	Guardian Industries	62821	PPO
1/01/04	Halliburton	54632	PPO/Trad
1/01/04	HEB	53345	PPO
1/01/04	Kellogg Brown & Root	21524	PPO
1/01/04	Oldcastle	81966, 81967,81968, 81969, 81970,82005, 82006	PPO/Trad
1/01/04	Pilgrim's Pride	05901 old, 84311 BlueSTAR	PPO/Rx/Dental
1/01/04	Service Experts	81472	PPO/EPO/Dental
1/01/04	TDS	81400	PPO

At this time, these groups are not changing the structure of their ID numbers. They will continue to use 9-digit, numeric IDs. However, it is important for you and your staff to note that these group membership numbers are not your patients' Social Security Numbers.

Additional groups will begin using new health plan identification numbers in the near future. It is always a good practice to verify member ID numbers on a regular basis. Watch for further updates in the **BCBSTX Blue Review** via mail and on the Web site at www.bcbstx.com/provider.



CLAIM APPEAL/RECONSIDERATION PROCESS

Blue Cross and Blue Shield of Texas (BCBSTX) is revising the current claim appeal/reconsideration form and is implementing a new claim appeal process for ParPlan/Traditional, BlueChoice and HMO Blue Texas. The following process will be effective on April 1, 2004. Claim appeal/reconsideration review requests must be submitted in writing on the "Provider Request for Claim Appeal/Reconsideration Review" form. **This form may also be found on the BCBSTX Web site at www.bcbstx.com/provider (downloadable forms section).** Although the revised claim appeal process does not become effective until April 1, 2004, you may begin utilizing this new form immediately. Please replace any copies of the former "Provider Request for Reconsideration Review" form with this new document. There are two (2) levels of claim appeals available to you.

For the following circumstances, the 1st appeal must be requested within the corresponding timeframes:

DISPUTE TYPE	Timeframe For Request
AUDITED PAYMENT	30 days of the receipt of written notice of request for refund due to an audited payment
OVERPAYMENT	45 days of the receipt of written notice of request for refund due to overpayment
CLAIM DISPUTE	180 days of the check paid date of a claim in dispute

BCBSTX will complete the 1st appeal within 45 days of the receipt of your request for a 1st appeal. You will receive written notification of the appeal determination. If the appeal determination is not satisfactory to you, you may request a 2nd appeal. The 2nd appeal must be requested within 15 days of your receipt of the 1st appeal determination.

BCBSTX will complete the 2nd appeal within 30 days of the receipt of your request for a 2nd appeal. You will receive written notification of the appeal determination. The appeal process for a specific claim will be considered complete following your receipt of the 2nd appeal determination. If you have any questions concerning the process for claim appeal, please contact your Provider Network Representative.

PERFORMING PROVIDER NUMBER

When submitting CMS-1500's either electronically or by mail, please help us process your claims promptly and correctly by submitting your Performing Provider Number in Box 24K or the EDI transaction equivalent. Your Performing Provider Number is a six character number that identifies the provider who performed the services that are being submitted for processing. It also helps determine if the charges will be processed as in-network or out-of-network and if a referral is needed for the services. Although Field 24K is

reserved for local use and is not required by the Texas Department of Insurance for a clean claim, BCBSTX is requesting you enter the Performing Provider Number as this will assist in having the claims processed appropriately. If the Performing Provider Number is not on the claim, the claim will be delayed while we attempt to identify your Performing Provider Number. If we are unable to identify the correct Performing Provider Number, it may be necessary for us to return the claim to you for this additional information.

CHIROPRACTIC COVERAGE UPDATE

BCBSTX announced in the Second Quarter *Blue Review* that certain Evaluation and Management (E&M) services would not be recognized for Chiropractors, based on Chiropractic Scope of Practice. After reviewing feedback from that announcement, including a statement on chiropractic scope of practice from the Texas Board of Chiropractic Examiners, **BCBSTX has decided it will not deny E&M services submitted by chiropractors based on scope of practice.** Member contract benefits, coding methodologies and medical policy remain in effect for all procedure codes billed.

CLAIMS PAYMENT AVOID DELAYS WITH PROPER SUBMISSIONS

HMO Blue Texas is committed to providing prompt payment of claims and complying with the requirements of Texas prompt pay laws and regulations (Texas Insurance Code Article 20A.18B and 28 Texas Administrative Code 21.2801 - 21.2820). Delays in claims payment can be avoided by submitting claims to the appropriate address.

If a member's primary care physician is affiliated with a capitated independent practice association (IPA) or medical group, claims for certain types of services must be submitted to the IPA or medical group rather than to the normal address used for HMO Blue Texas claims. If a paper claim should have been sent to an IPA or medical group, but was incorrectly submitted to HMO Blue Texas, the claim will be rejected and you will receive

notice to re-file it with the appropriate IPA or medical group. As of February 2003, an electronically submitted claim that should have been sent to an IPA or medical group, but was incorrectly submitted to HMO Blue Texas via THIN, will be forwarded to the appropriate IPA or medical group on your behalf. You will be notified via the rEDI-link Blue response file that the claim was forwarded and the name of the contact person. This notification will not be on the initial THIN response that you receive at the time of transmission, but will appear on the payer response generated by the HMO application the day after transmission.

To determine the appropriate IPA or medical group for claims submission, refer to the member's HMO Blue Texas ID card to obtain the

Physician Organization Code (POrg)	Capitated IPA/Medical Group Name	IPA/Medical Group Claims Filing Address	IPA/Medical Group Claims Inquiry and UM Phone Numbers & Email
HNIN or HNIT	Intercultural Physicians Network	Intercultural Physicians Network Attention: Claims P.O. Box 27479 Houston, TX 77227	713-986-1600 Claims 713-986-1600 UM
KELS	Kelsey-Seybold Clinic	Kelsey-Seybold Clinic Claims Administration P.O. Box 300368 Houston, TX 77230	713-442-5440 Claims 713-442-5339 UM
PFHC	Peopl 1st Healthcare Network, Inc.	Peopl 1st Healthcare Network, Inc. HMO Blue Texas-Commercial Claims P.O. Box 3687 Houston, TX 77253	claimsdiv@peopl1st.com Claims cc: drkyles@peopl1st.com 1-800-441-9188 UM
RNPO or RNPT	Renaissance Physician Organization	Renaissance Physician Organization P.O. Box 922001 Houston, TX 77292-2001	832-553-3333 Claims 832-553-3300 UM

Claims Payment – continued

physician organization (POrg) code. Then refer to the table on page 10 for the claims filing address, claims and Utilization Management (UM) phone numbers for the capitated IPAs and medical groups in your area. **It is important that you have a copy of the member’s most current ID card.**

If the POrg code that appears on the member’s ID card appears in the table on the previous page, claims for physician, other professional services and outpatient diagnostic testing services should be filed with the IPA or medical group. If the POrg code that appears on the member’s ID card does not appear in the table or if the claim is not for the services stated above, the claim should be filed with HMO Blue Texas or HealthSelect Plus (Group #38000N):

Claims for HMO Blue Texas EXCEPT HealthSelect Plus (Group #38000N):

HMO Blue Texas
 P.O. Box 660044 • Dallas, TX 75266-0044
 1-877-299-2377

Claims for HealthSelect Plus (Group #38000N for dates of service prior to 5/1/2003):

HealthSelect Plus (ERS)
 P.O. Box 833804 • Richardson, TX 75083-3804
 1-888-585-9393

If you have questions about which services should be filed with the capitated IPA or medical group and which services should be filed with HMO Blue Texas, call your local area provider network office.

Note: Behavioral health claims, regardless of the member’s PCP or physician POrg code, should be sent to Magellan Behavioral Health Providers of Texas, Inc. at:

Magellan Behavioral Health
 Attention: Claims
 P.O. Box 1659 • Maryland Heights, MO 63043
 1-800-729-2422

<p>HMO BLUE TEXAS STATEWIDE CLAIMS FILING ADDRESS</p> <p>P.O. Box 660044 Dallas, TX 75266-0044</p>	<p>HMO BLUE TEXAS CUSTOMER SERVICE</p> <p>1-877-299-2377</p>	<p>HEALTHSELECT PLUS — ERS CLAIMS FILING ADDRESS & CUSTOMER SERVICE NUMBER</p> <p>P.O. Box 833804 Richardson, TX 75083-3804 1-888-585-9393</p> <p><i>For dates of service prior to May 1, 2003</i></p>
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HMO BLUE TEXAS TO MERGE INTO PARENT COMPANY ON JANUARY 1ST

Pending regulatory approval, Southwest Texas HMO, Inc. d/b/a HMO Blue Texas, will merge into its parent company – Health Care Service Corporation, a Mutual Legal Reserve Company – on January 1, 2004. This merger will result in an HMO line of business offered by Health Care Service Corporation under the name of HMO Blue Texas.

After January 1, 2004, services you provide to HMO Blue Texas members will continue to be governed by your current HMO Blue Texas provider agreement. There will be no changes to day-to-day operations of the HMO, and your participation in other Blue Cross and Blue Shield

of Texas networks/products will continue to be governed by your current agreements with BCBSTX for those networks/products.

You may continue to use your existing HMO Blue Texas materials and contact information and your HMO Blue Texas patients can continue to use existing HMO Blue Texas ID cards.

Note: HMO Blue Texas ID cards issued after January 1, 2004 will carry the name Health Care Service Corporation.

If you have any questions, please call your local HMO Blue Texas Provider Network Representative.

HMO BLUE TEXAS CHANGE TO INDEPENDENT LABORATORY PROVIDER NETWORK

Quest Laboratories and CPL, Inc. are no longer participating outpatient clinical reference laboratory providers for HMO Blue Texas as of September 1, 2003.

HMO Blue Texas contracted providers are obligated to use participating facilities. Laboratory Corporation of America (“Lab Corp”) remains a participating outpatient clinical reference laboratory provider for HMO Blue Texas members. To find the closest LabCorp Patient Service Center, please access LabCorp’s phone system at 1-888-LABCORP, or their Web site at www.labcorp.com. Both of these systems will prompt you for your zip code and will provide those service centers nearest the zip code location. A complete list of participating providers can be found at www.bcbstx.com/provider (see Provider Finder) or you may contact your local Provider Network Management office.

NOTE: HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group regarding outpatient laboratory services.

HMO BLUE TEXAS PREAUTHORIZATION REQUIREMENTS

Starting January 1, 2004, the HMO Blue Texas preauthorization requirements will change specific to outpatient surgical procedures, cardiac rehabilitation, and sleep studies. In-Network/In-Plan Outpatient Surgical Procedures will no longer require preauthorization, except procedures listed on the HMO Outpatient Preauthorization Procedure list on page 15. Please note that if an unplanned procedure (included on the attached preauthorization list) is determined to be urgently necessary during the original outpatient procedure (not requiring preauthorization), the provider must

contact HMO Blue Texas within 48 hours after the procedure for a medical necessity determination. Also note that high tech outpatient diagnostic radiology procedures in the following Dallas/Ft. Worth counties require preauthorization: Collin, Dallas, Denton, Ellis, Grayson, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise. For preauthorization, call American Imaging Management (AIM) at 1-800-859-5299. **Please see complete Preauthorization/Notification/Referral Requirements chart on the following page.**

HMO BLUE TEXAS PREAUTHORIZATION/NOTIFICATION/REFERRAL REQUIREMENTS

Out-Of-Network/Out-Of-Plan Services always require medical management review. If no preauthorization/referral is obtained for the Out-Of-Network/Out-Of-Plan Services, no benefits (or no network benefits for members with a POS rider) are available and network claims will be denied. Emergency Services are an exception to this requirement. Physicians in a Limited Provider Network must refer care to providers contracted in the same network.

Preauthorization/Notification/Referral Requirements	Process In BlueLINK	Preauthorization	Referral
1. Facility Admissions — Hospital — Rehab — Skilled Nursing	> BlueLINK Notification For Selected Facility Admissions.	> Certain Facility Admissions Require Medical Management Review.	
2. 23 Hour Observation	> BlueLINK Notification.		
3. Obstetrical Care	> BlueLINK Maternity Notification.		
4. Hospice	> BlueLINK Notification.		
5. Pain Management		> Preauthorization Requires Medical Management Review.	
6. Cardiac Rehabilitation Preauthorization is not required for In-Network/In-Plan outpatient cardiac rehabilitation.		> Out-Of-Network/Out-Of-Plan Services always require medical management review. If no preauthorization is obtained for the Out-Of-Network/Out-Of-Plan Services, no benefits (or no network benefits for members with a POS rider) are available and network claims will be denied. Emergency Services are an exception to this requirement. Physicians in a Limited Provider Network must refer care to providers contracted in the same network.	
7. Outpatient Surgery* Reference HMO Outpatient Preauthorization Procedure list on page 15		> Preauthorization Requires Medical Management Review.	
8. In-Network/In-Plan Services	> BlueLINK Referral For ALL Primary Care Physician (PCP) Referrals to Specialists Outside Of The PCP's Call Group/Back Ups.		

*High tech outpatient diagnostic radiology procedures in the following Dallas/Ft. Worth counties require preauthorization: Collin, Dallas, Denton, Ellis, Grayson, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise. For preauthorization, call American Imaging Management (AIM) at 1-800-859-5299.

Preauthorization/Notification/Referral Requirements	Process In BlueLINK	Preauthorization	Referral
9. Out-Of-Network/Out-Of-Plan Services		<ul style="list-style-type: none"> > Out-Of-Network/Out-Of-Plan Services always require medical management review. If no preauthorization is obtained for the Out-Of-Network/Out-Of-Plan Services, no benefits (or no network benefits for members with a POS rider) are available and network claims will be denied. Emergency Services are an exception to this requirement. Physicians in a Limited Provider Network must refer care to providers contracted in the same network. 	<ul style="list-style-type: none"> > Out-Of-Network/Out-Of-Plan Services always require medical management review. If no referral is obtained for the Out-Of-Network/Out-Of-Plan Services, no benefits (or no network benefits for members with a POS rider) are available and network claims will be denied. Emergency Services are an exception to this requirement. Physicians in a Limited Provider Network must refer care to providers contracted in the same network.
10. Durable Medical Equipment (DME)		<ul style="list-style-type: none"> > Preauthorization Requires Medical Management Review Except For The Following Items, which do Not Require Preauthorization: <ul style="list-style-type: none"> • Nebulizers • Canes • Crutches • Walkers • Commode Chairs • Cervical Traction Units 	
11. Home Health Services		<ul style="list-style-type: none"> > Preauthorization Requires Medical Management Review. 	
12. Home Infusion Therapy		<ul style="list-style-type: none"> > Preauthorization Requires Medical Management Review. 	
13. Hyperbaric Treatment		<ul style="list-style-type: none"> > Preauthorization Requires Medical Management Review. 	
14. Drug/Alcohol Treatment		<ul style="list-style-type: none"> > Call Magellan for preauthorization. 	
15. Mental Health Services		<ul style="list-style-type: none"> > Call Magellan for preauthorization. 	
16. Physical Therapy Referral is not required for outpatient facility therapy.	<ul style="list-style-type: none"> > BlueLINK Referral. 		
17. Occupational Therapy Referral is not required for outpatient facility therapy.	<ul style="list-style-type: none"> > BlueLINK Referral. 		
18. Speech Therapy Referral is not required for outpatient facility therapy.	<ul style="list-style-type: none"> > BlueLINK Referral. 		
19. Sleep Studies Preauthorization is not required for In-Network/In-Plan outpatient sleep studies.		<ul style="list-style-type: none"> > Out-Of-Network/Out-Of-Plan Services always require medical management review. If no preauthorization is obtained for the Out-Of-Network/Out-Of-Plan Services, no benefits (or no network benefits for members with a POS rider) are available and network claims will be denied. Emergency Services are an exception to this requirement. Physicians in a Limited Provider Network must refer care to providers contracted in the same network 	
20. Dental Procedures		<ul style="list-style-type: none"> > Preauthorization Requires Medical Management Review. 	

HMO OUTPATIENT PREAUTHORIZATION PROCEDURE LIST

Procedure	Relevant Codes
Abdominoplasty	15831, 49560
Abdominoplasty/Diastasis Recti Repair	15831, 49560, 49565, 49568, 49570, 49585, 49590
Audiant Bone Conductor (Xomed)	69710, 69711
Blepharoplasty, Blepharoptosis Repair	15820-15823, 67900-67904, 67906, 67908, 67909, 67916, 67917, 67923, 67924
Breast Augmentation	19324, 19325
Breast Implant - Removal and/or Capsulectomy	19325, 19328, 19370, 19371
Breast Implant - Removal and/or Insertion	19325, 19328, 19330, 19396
Breast Procedures	19316-19499
Chemical Peels	15788, 15789, 15792, 15793, 17360
Chemonucleolysis	62292
Cochlear Device Implantation or Replacement	69714-69718
Collagen Implantation	11950-11954
Electrical Bone Growth Stimulation	20974, 20975
Endoscopic Injection Sclerotherapy for Esophageal Varices	43204
Excision Benign Lesions	11400-11446
Isolated Limb Perfusion (ILP) for Malignant Melanoma	36823
Keloid or Scar Revision Surgery	11400-11446
Mastectomy for Gynecomastia	19100, 19101, 19140
Mastectomy, simple, complete	19180
Mastopexy	19316
Morbid Obesity Surgery, including Gastroplasty	43842, 43843, 43846
Nasal Surgery	30130, 30140, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30520, 30620, 30630, 30999, 31020, 31030, 31032, 31040, 31050, 31051, 31070, 31090, 31200, 31201, 31205, 31225, 31230, 31231, 31233, 31235, 31237, 31238, 31239, 31240, 31254, 31255, 31256, 31267, 31276, 31287, 31288, 31290, 31291, 31292, 31293, 31294, 31299
Obstructive Sleep Apnea or Upper Airway Resistance Syndrome surgical treatment including orthognathic surgery	21085, 21120, 21121, 21122, 21123, 21125, 21127, 21142, 21143, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21210, 21215, 31600, 31601, 31603, 31605
Orthognathic Surgery, including Mandibular/Maxillary Resection for Prognathism or Micrognathism	21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21209, 21210, 21247, 21248, 21255
Otoplasty, Unilateral or Bilateral	69300
Pectus Excavatum, Pectus Carinatum	21740, 21742, 21743
Percutaneous Discectomy	62287, 62292
Radiofrequency Thermotherapy, Prostate	53852
Reconstructive Mammoplasty and Contralateral Breast Surgery	11920, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 19499
Reduction Mammoplasty	19318
Refractive Keratoplasty	65760, 65765, 65767, 65771
Rhinoplasty	30400-30420, 30430-30450, 30460-30462
Sclerotherapy for Varicose Veins & Telangiectases	36468, 36469, 36470, 36471
Subcutaneous Mastectomy	19182
Temporomandibular Joint (TMJ) Surgery	21240, 21242, 21243
Transurethral Microwave Thermotherapy (TUMT) of the Prostate	53850
Uvulopalatopharyngoplasty (UPPP), Palatopharyngoplasty (PPP), Uvulopharyngoplasty (UPP)	42145



CAHPS HMO MEMBER SURVEY RESULTS FOR 2003

HMO Blue Texas members recently rated their overall health plan experience by participating in the Consumer Assessment of Health Plans (CAHPS) survey. CAHPS is part of the National Committee for Quality Assurance (NCQA) accreditation process and is also required by state law. Most percentages stayed about the same as last year. HMO Blue Texas is encouraged by the relatively stable responses in light of industry-wide cost increases in health insurance premiums. Members continue to be satisfied with the relationship they

have with their primary health care provider and office staff. However, member satisfaction with specialists demonstrated a decrease in 2003; HMO Blue Texas is evaluating members perception in this area. HMO Blue Texas demonstrated the greatest improvement in customer service scores. Additionally, HMO Blue Texas is encouraged by the slight improvement in member satisfaction with claims processing. This demonstrates members are beginning to perceive the improvements which have been underway within HMO Blue Texas.

Following are the results of the HMO Blue Texas statewide 2002 CAHPS survey compared to the NCQA national averages:

Composite Category	HMO Blue Texas	NCQA National Average
Getting Needed Care ¹	65%	77%
Getting Care Quickly ²	71%	81%
How Well Doctors Communicate ²	88%	91%
Courteous & Helpful Office Staff ²	90%	93%
Customer Service ¹	65%	67%
Claims Processing ²	77%	85%
Rating of Health Plan ³	54%	61%

1 Percentage of members surveyed who answered "Not a Problem"

2 Percentage of members surveyed who answered "Usually or Always"

3 Percentage of members who rated the health plan 8, 9 or 10 on a scale from 1 to 10 with 10 being the highest

Blue Review

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