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Blue Review

Electronic Submission Expedites Secondary Institutional Claim Payment

In an effort to pay claims quickly, Blue Cross and Blue Shield of Texas (BCBSTX) would like to announce that **ALL** BCBSTX secondary to commercial carrier institutional claims can be submitted electronically. **Electronic secondary claims do not require the submission of the primary payer's explanation of benefits.** They only require the submission of a few additional data elements as indicated in the box to the left.

If you are unsure of primary versus secondary status for a claim or if you have questions regarding claim payment or need other claim information, please contact BCBSTX provider customer service at **(800) 451-0287**. For Federal Employee Program (FEP) claims, call **(800) 442-4607** or the toll-free number located on the back of each member's BCBSTX identification card.

To help avoid delays with coordination of benefits on secondary claims, consider these questions before submitting claims electronically:

- Were all of the required electronic data elements supplied on the claim?
- Have you verified with your software vendor that your software accommodates the required electronic data elements for secondary claims?
- Does your or your vendor's software have certain preset defaults preventing you from submitting a secondary claim?

If you have any questions regarding electronic claims submission, please contact our EDI Helpline at **(972) 766-5480** or **(877) EDI-THIN**.

Fee Schedule Updates

New or updated reimbursement information for BlueChoice® and HMO Blue® Texas (Independent Provider Network only) practitioners will be posted under "Pending Changes" in the Professional Reimbursement Schedules section on the BCBSTX Web site at www.bcbstx.com/provider on the first day of each month, every month. Those changes requiring disclosure 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 this Web site. The password is "manual".

EDI Requirements for Submitting BCBSTX Electronic Secondary Institutional Claims When Another Commercial Carrier is Primary (ANSI 837I Format – Version 4010A1)

Primary Payer Name

Loop 2330B – Other payer name, NM103
Enter the name of the primary insurance carrier

Primary Payer Amount Paid

Loop 2320 – Prior payment amount, AMT02 with C4 qualifier
Enter the amount paid by the primary insurance carrier

Primary Payer Group Number

Loop 2320 – Reference Identification, SBR03
Enter the member's primary insurance group number

Other Carrier's Member Identification

Loop 2330A – Identification Code, NM109
Enter the member's primary insurance ID number

Other Carrier's Member Name

Loop 2330A - Other member name, NM103 and NM104
Enter the name of the primary insurance carrier's member name

Please note: The claim submission requirements for BCBSTX secondary to Medicare are different and have been provided in the BlueChoice Facility Manual on our Web site at www.bcbstx.com.



Professional Claims Processing Enhancements Update

BCBSTX will be regularly communicating enhancements made to processing of professional claims and associated payment-auditing logic within this quarterly *Blue Review* newsletter. Below are highlights of enhancements with their effective dates that have been made since our last notice. This action is not retroactive to claims processed prior to the effective date listed.

DISALLOWED PROCEDURE CODE	ALLOWED PROCEDURE CODE	BUNDLING LOGIC	PPO/POS DATE TO PRODUCTION	HMO DATE TO PRODUCTION
11719, 11720, 11721	S0390	Remove edit	09/14/05	09/14/05
S0390	11719, 11720, 11721	Add edit	09/14/05	09/14/05
28308	28750	Remove edit	09/14/05	09/14/05
36200	35492	Remove edit	09/14/05	09/14/05
47562	49600	Remove edit	09/14/05	09/14/05
48510	Assistant Surgeon	Remove edit	09/14/05	09/14/05
58550	58558	Remove edit	09/14/05	09/14/05
58558	58550	Add edit	09/14/05	09/14/05
58661, 58662	58940	Remove edit	09/14/05	09/14/05
58940	58661, 58662	Add edit	09/14/05	09/14/05
58925	59510, 59514, 59515, 59525	Remove edit	09/14/05	09/14/05
59160	59414	Remove edit	09/14/05	09/14/05
61584	61592	Remove edit	09/14/05	09/14/05
67840	67800	Remove edit	09/14/05	09/14/05
67800	67840	Add edit	09/14/05	09/14/05
76003	70551	Remove edit	09/14/05	09/14/05
76005	64418, 70551	Remove edit	09/14/05	09/14/05
76082	76092	Remove edit	09/14/05	09/14/05
77332	77600	Remove edit	09/14/05	09/14/05
77417	77427, 77431, 77432, 77470	Remove edit	09/14/05	09/14/05
93350	93318	Remove edit	09/14/05	09/14/05
28124	28285	Reversal see below	10/17/05	10/17/05
28285	28124	Add edit	10/17/05	10/17/05
31000	31254, 31255	Remove edit	10/17/05	10/17/05
32000	32405	Remove edit	10/17/05	10/17/05
33225	33223	Remove edit	10/17/05	10/17/05
33822	33750	Remove edit	10/17/05	10/17/05
44139	44120	Remove edit	10/17/05	10/17/05
47561	44970	Remove edit	10/17/05	10/17/05
64721	25116, 25130, 25135, 25136, 25145, 25151, 25170, 25210, 25215	Remove edit	10/17/05	10/17/05
76003	47000	Remove edit	10/17/05	10/17/05
76083	76090	Remove edit	10/17/05	10/17/05

The five-character codes included in this article are obtained from the **Physician's Current Procedural Terminology (CPT®)**, copyright 2005 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five-character identifying codes and modifiers for reporting medical services and procedures performed by physicians. CPT is a registered trademark of the AMA.

THIN Online Internet Inquiry Now Includes Benefit and Out-of-Area Member Information

Texas Health Information Network (THIN) is pleased to announce that effective Jan. 3, 2006, providers who utilize THIN Online Internet Inquiry will be able to determine membership eligibility, benefits and claim status not only for BCBSTX members but also for out-of-area Blue Cross and Blue Shield members. For example, if you render services to a Blue Cross and Blue Shield of Florida member, you can log on to THIN Online and check the Florida member's membership eligibility and benefits and claim status after the claim has been filed with BCBSTX. For your convenience, you can also use the inquiry tool to verify information on some commercial payers.

Join the growing number of providers who take advantage of our online solutions. To enroll in THIN Online Internet Inquiry, please visit our Web site at www.thinedi.com or call our EDI Helpline at (972) 766-5480 or our toll-free number (877) 334-8446.

Use Correct Revenue Codes for Supplies, Services Billed with Surgical and Endoscopic Claims

As a general reminder and to avoid claim payment delays or rejections, facilities billing for surgical and endoscopic procedures should only bill the procedures under the following Revenue Codes:

- 036X (Operating Room Service)
- 049X (Ambulatory Surgical Care)
- 075X (Gastrointestinal Services)

Laboratory, radiology, supplies and other services provided in conjunction with an outpatient surgical or gastrointestinal service should be billed under the most appropriate Revenue Code representing the actual service provided. For example, an MRI or MRA performed in conjunction with an outpatient surgery should be billed under Revenue Code 061X (Magnetic Resonance Technology) and not under Revenue Codes 036X, 049X or 075X.

Limit Supplementary "E" Codes to Secondary Diagnosis Codes on Facility Claims

The Supplementary "E" Codes, E800-E999, are used to classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. These codes should be used in addition to a primary ICD-9 code and submitted on the UB-92 claim form Field 77 or its electronic equivalent only. As a reminder, "E" codes should not be utilized as the primary diagnosis code nor should they be used when filing the CMS-1500 claim form or its electronic equivalent.

THIN to Accept Only Compliant Electronic Claim Formats as of December 2005

Now that the HIPAA contingency period has expired, more payers have implemented stricter editing processes to ensure compliance. THIN has attempted to meet their requirements, but it is becoming more challenging due to receiving non-compliant claim formats. To ensure that our payers and trading partners receive HIPAA-compliant transactions, we must take the following action.

Effective Dec. 31, 2005, THIN will no longer accept the non-compliant electronic claim formats for professional and institutional claim submissions listed below:

Professional Claim Formats	Institutional Claim Formats
NSF versions 1.04, 2.01, 3.01	UB92 versions 5.0, 6.0 and T60
ANSI versions 3030.2B, 3051.3B, 3051.3B.01	ANSI versions 3051.3A, 3051.3A.01

THIN **will continue** to receive HIPAA-Compliant Formats including the **ANSI 4010A1** and the **T0301 Expanded Professional Format**.

THIN submitters have been receiving a warning message for a few months now, alerting them that they are submitting a non-compliant format and **must migrate to one of the current HIPAA-compliant formats that include either the ANSI 4010A1 Professional, Institutional, or Dental Format or the Expanded Professional T0301 Formats**.

You will notice that the THIN T60 version is included in the list of non-compliant electronic claim formats. Although THIN implemented this version as a flat file alternative for our trading partners in 2000, it will no longer be supported. This version was not widely supported or utilized and will not be updated to support the National Provider Identifier (NPI) fields as there are not sufficient records/fields available.

We urge you to contact your software vendor immediately and begin the migration process. If your vendor does not currently or intend to support the HIPAA-compliant formats, you may view the THIN Vendor Partner list on the THIN Web site for a list of potential vendors or contact your Provider Automation Representative to assist you.



2006 Updates on the Specialty Drug Program

The updated Specialty Drug list will be posted at the end of December on the BCBSTX Web site at www.bcbstx.com under the Pharmacy section. This list will be effective in March 2006.

Save Time and Get Faster Payments by Sending Claims Electronically

THIN has dedicated and experienced representatives available to assist you with information about electronic claims and other electronic solutions for your office. Please visit the THIN Web site at www.thinedi.com or contact your THIN Representative listed below for assistance.

THIN Clearinghouse Contacts

Representative/Territory

Deborah Chandler — (972) 766-5580
Austin, Temple, Waco, Bryan, College Station, Abilene,
Midland, Odessa, San Angelo

Tiffany Buchanan — (972) 766-6313
Dallas/Fort Worth Metroplex

Donna Edmonds — (972) 766-0883
San Antonio, Corpus Christi, Harlingen/McAllen, Victoria

Helen Jarrett — (972) 766-7203
Houston, Beaumont, Conroe, Galveston

Allison Duckworth — (972) 766-6730
Tyler, Longview, Texarkana, Paris

Melissa Harris — (972) 766-5725
Amarillo, Lubbock, Midland/Odessa, Wichita Falls

Brad Jeske — (972) 766-5725
National Accounts & Facility Representative

Daniel Garcia — (xxx) xxx-xxxx
El Paso, New Mexico

Vendor and Payer Representatives

Representative

Ryan Porter, THIN Vendor Representative
(972) 766-5585

Donna Lomonaco, THIN Vendor Representative
(972) 766-6316

Lori Phillips, THIN Payer Representative
(972) 766-6337

As always, the THIN EDI Helpline staff is available to assist you from 8 a.m. to 6 p.m. CT, Monday through Friday. You may call us toll-free at **(877) 334-8446**, or at **(972) 766-5480 (select options 2-2-1)**.



2006 Preferred Drug List Coming Soon

Throughout the year, the BCBSTX Pharmacy team continually reviews the preferred drug list. Tier placement decisions for each drug on the list follow a rigorous process with several committees reviewing efficacy, safety and cost of each drug.

The updated 2006 Preferred Drug List will be posted at the end of December on the BCBSTX Web site at www.bcbstx.com under Pharmacy. Generic drugs are noted in lowercase, boldface font. Preferred brand drugs are noted in uppercase. Please remember that brand name drugs not included on the list are available at the highest copayment.



Important Notice for BCBSTX ERA and EPS Receivers

In a continuing effort to provide our customers with EDI solutions and more efficient methods to manage their practices in a paperless environment, BCBSTX is pleased to announce the implementation of Electronic Payment Summary (EPS) for providers receiving Electronic Remittance Advice (ERA).

- EPS is an electronic print image of the paper Provider Claim Summary (PCS) in an easy-to-read text format, with no special programming required.
- EPS will replace and provide the same information as the paper PCS that you currently receive.
- The EPS file will be placed in your electronic mailbox along with your ERA files. EPS will eliminate waiting for the paper Provider Claim Summary in order to allocate payments. The first three letters of the file name will be **EPS**.
- You will continue to receive HMO Blue[®] Texas payments on the paper PCS.

Under the HIPAA rules, only files in the compliant format are eligible for EPS. CMS has not yet set a date that old formats will no longer be supported. We encourage users to convert to the HIPAA compliant ANSI ASC X212N v4010A1 835 format as soon as possible. BCBSTX will discontinue supporting the old formats on the date that CMS sets.

Medical Policy Disclosure Statement

New or revised medical policies will be posted on the BCBSTX Web site 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 www.bcbstx.com/provider and click on Medical Policies. After reading the policies disclaimer, click on "I Agree" to advance to the Medical Policy page. The policies can be accessed by clicking on the View Pending Policies tab.

Draft Medical Policy Review

In an effort to streamline the medical document review process we will begin posting draft medical policies on the BCBSTX Web site. After logging on to the Web site you can review the documents and provide your feedback online. The documents will be made available for your review on the first and the fifteenth of each month with a review period of approximately two weeks.

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

The electronic payment summary files are available via EDI-link under the following file name, with a description of the format, the payer number (G84980 for BCBSTX) and version code:

- 835sssss.835 ANSI 835 ERA
- EPSsssss.EPS BCBS Electronic Payment Summary (PCS Text File*)

*Helpful Tips Regarding the EPS:

- Line feed and carriage returns are present in this text file, but page breaks are not present.
- Files can be saved to a Note Pad or Microsoft[®] Word document.
- Adjust the font and use landscape setting with five inches for top margin, two inches for bottom margin and one inch for the right and left margins. These are the most common settings.

Important Reminder: BCBSTX ERA and EPS receivers should contact their billing services, clearinghouses, vendors or their IT system staff regarding this process to ensure you have the capability to download these files from your electronic mailbox. Information concerning ERA/EPS was previously sent out in THIN Hot Topics during May and July.

Thank you for your continued support of our electronic process enhancements. If you have any questions or need additional information, please contact the THIN EDI Helpline at (877) 334-8446, your THIN Marketing Representative or visit the THIN Web site at www.thinedi.com.

Follow These Billing Procedures for Radiation Treatment Management

CPT Code 77427 includes five treatments of Radiation Treatment Management. Therefore, please bill one unit for five treatments. Report code 77427 if there are three or four fractions beyond a multiple of five at the end of a course of treatment. When there are only one or two fractions beyond a multiple of five remaining at the end of a course of treatment, they are not reported separately. Following are examples of how the code should be billed.

Example No. 1:

Radiation delivery performed daily for two weeks (Monday through Friday, beginning on Monday Sept. 12 through Friday Sept. 23).

Date	Procedure Code	Quantity Billed
09-12-2005	77427	1
09-19-2005	77427	1

Example No. 2:

Radiation delivery performed each weekday beginning on Wednesday, Sept. 14 through Friday, Sept. 30. Please note that the reporting of Sept. 28 is allowed because there are still three days remaining after the other services are reported.

Date	Procedure Code	Quantity Billed
09-14-2005	77427	1
09-21-2005	77427	1
09-28-2005	77427	1

Example No. 3:

Radiation delivery performed daily (Monday through Friday, beginning on Wednesday, Sept. 14 through Wednesday, Sept. 28). When there are only one or two fractions beyond a multiple of five remaining at the end of a course of treatment, they are not reported separately. Please note you may only report code 77427 twice because there was only one day remaining after the other services were reported.

Date	Procedure Code	Quantity Billed
09-14-2005	77427	1
09-21-2005	77427	1

New QVT Limits on Select Prescription Drugs

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

Currently, drug classes with limits include nasal inhalers, asthma inhalers, migraine therapies and anti-ulcer medications. Beginning Jan. 1, 2006, the QVT drug classes have been expanded to include Bisphosphonates and asthma/COPD nebulizers. For existing classes, new drug additions and revised limits will be implemented as well.

The updated QVT list will be posted at the end of December on the BCBSTX Web site at www.bcbstx.com under the Pharmacy section.

Understanding the Federal Employee Program and OBRA Part A

The Federal Employee Program (FEP) is unique in many ways. The federal government writes the policy that is administered and federal laws apply to the program's contracts. While many of these federal laws are not written specifically in the provider contract, they must be complied with.

One such law is the Omnibus Reconciliation Act of 1990 (OBRA '90), which initially included only the Part A component of OBRA. The Act was amended in 1993 adding OBRA '93 Part B. OBRA affects patients who are 65 or over who do not have Medicare coverage and are on the plan as a policyholder, annuitant, former spouse, or as a covered family member of an annuitant or former spouse. In addition, it limits plan benefits to those to which the patient would have been entitled if they had Medicare coverage. The provider's contracting status with Medicare and with the plan determines the maximum amount for which the patient can be billed.

How Part A and Part B Work

OBRA '90 Part A only applies to inpatient services. The OBRA '90 pricing allowance is calculated based upon Medicare DRG pricing. If the patient has no Medicare and is not employed by an entity that confers with an FEP benefit plan, plan benefits will apply, and the claim will be paid according to the Medicare allowance for the stay. If the patient has Part B coverage, claims for ancillary services will still need to be submitted to Medicare for payment. The Explanation of Medicare Benefits (EOMB) will also need to be included with the claim. The plan will consider the payment that Medicare made on the claim.

For OBRA '93 Part B, the allowed amount will apply if there is an equivalent Medicare allowable for your service. If there is no Medicare equivalent, the plan allowance will apply. Some services, such as laboratory, ambulance, and durable medical equipment, are not subject to OBRA '93 pricing. Please keep in mind that if a patient is over 65 and actively working, OBRA '90 and OBRA '93 do not apply. You may consult the plan for a further explanation of how both the Part A and Part B claims are processed.



How to Order Synagis for 2005-2006 RSV Season

Medimmune, the manufacturer for Synagis, has created a limited distribution network for the prescription drug used to prevent respiratory syncytial virus (RSV). The national vendors for the 2005–2006 RSV season are as follows:

Vendor	Phone No.	Fax No.
Accredo, Health Inc.	(877) 482-5927	(877) 369-3447
CuraScript Pharmacy, Inc.	(888) 773-7376	N/A
PharmaCare	(888) 900-3232	N/A

BCBSTX selected Accredo as the preferred vendor for Synagis in the upcoming RSV season. Accredo will coordinate the delivery of each dose of Synagis with the physician's office. Ordering Synagis through Accredo allows the physician's office to avoid "buying and billing" for the medication.

Please follow these steps to order Synagis from Accredo:

STEP 1 – Health Plan Authorization Process

- Complete the BCBSTX Synagis Request Form in its entirety. The form is posted at www.bcbstx.com/provider/pdf/synagis_request_form.pdf.
- Fax the Synagis Request Form to Allan J. Chernov, M.D. (Medical Director, Health Care Quality & Policy) at (972) 766-5559.

STEP 2 – Ordering Process

- Fax the completed Synagis Request Form, along with written authorization from BCBSTX,* to Accredo at (877) 369-3447.

**Please note that if the request form is incomplete or does not have the BCBSTX written authorization attached, the order will not be processed and the form will be returned to the physician for completion.*

Claims Processing System Upgraded in December

As you were notified by our Sept. 14 mailing, changes will be made to the claims processing system that affect our bundling logic. We will be upgrading to McKesson ClaimCheck Version 35 effective on or after Dec. 14, 2005 for PPO/POS lines of business. Due to our licensing agreement with McKesson, mass lists or spreadsheets of bundling combinations cannot be distributed. Please note that HMO Blue® Texas will not be updated to McKesson ClaimCheck Version 35 until after the first quarter of 2006.

For further information about payment policies, Medical Policy, and bundling methodologies, or to request specific code to code bundling, please access our Web site at www.bcbstx.com/provider.

Hospital Patient Satisfaction Survey

To assess member satisfaction with network hospitals, BCBSTX conducted a pilot Hospital Satisfaction survey during the second quarter of 2005. A random sample of members who had an inpatient stay at one of 16 network hospitals across the state received the survey. 3,567 surveys were mailed with 1,000 returned for an overall response rate of 28 percent. The survey asked members to rate the hospitals on aspects of their stay related to communication with health care providers, care and treatment, as well as education and coordination of care. Members were generally satisfied regarding care and service; however, opportunities for improvement were identified related to education and coordination of care. Aggregate results of the pilot hospitals are presented below.

Overall Satisfaction Composite Score	Overall Percentage
Overall, how would you rate the quality of care you received in the hospital during your stay? (Excellent or Very Good)	82%
Would you return to this hospital for care in the future? (Yes or Probably Yes)	94%
How likely would you be to recommend this hospital to a friend or relative? (Definitely or Probably Recommend)	93%
Mean Overall Satisfaction	90%
Education and Coordination of Care Composite	
Rate your involvement with decision making regarding care. (Excellent or Very Good)	78%
Rate the education you were given about your medical condition. (Excellent or Very Good)	77%
For members receiving medication, rate the education you received about the medication(s). (Excellent or Very Good)	68%
For members who received diagnostic tests, rate the explanation about what would happen during the tests. (Excellent or Very Good)	77%
For members who had a surgical procedure, rate the education received about the purpose and risk of surgery. (Excellent or Very Good)	87%
If you received written discharge instructions, rate your understanding of the instructions (Excellent or Very Good)	85%
Before you left the hospital, were you given information about new medications? (Yes)	80%
Before you left the hospital, were you given instructions for a follow-up visit with your physician? (Yes)	89%
Mean Education and Coordination of Care	79%

Hospital specific results are being provided to key contacts at the pilot hospitals. A statewide Hospital Satisfaction survey is planned for 2006.



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 exception). To find the closest LabCorp Patient Service Center, please call LabCorp's automated phone system toll-free at (888) LABCORP (888-522-2677) or visit their Web site at www.labcorp.com. Both of the systems will prompt you for your zip code and will provide those service centers nearest the zip code location.

You may also find a complete list of participating providers by using the Provider Finder® search tool at www.bcbstx.com/provider or by contacting your local Provider Network Management office. 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 may access the county listing and the revised Reimbursable Lab Services list that will be effective Feb. 1, 2006 at www.bcbstx.com/provider under the General Reimbursement section. The password for the General Reimbursement section is "manual".

NOTE: Members whose PCP is associated with a capitated IPA/Medical Group must receive services from the IPA/Medical Group designated lab.

Implementation Delayed for Two New Pharmacy Management Programs

Implementation for the two new clinical pharmacy programs scheduled to go into effect Jan. 1, 2006 for HMO Blue Texas will be delayed. The new implementation date is slated for mid-June 2006.

Future notification and relevant program information regarding Growth Hormone Prior Authorization and TNF-Blocker Step Therapy will appear in an upcoming issue of *Blue Review*.

We apologize for any inconvenience to you or our members.

Advantages of Using AIM's Provider Portal to Obtain a Preauthorization/RQI

American Imaging Management's Provider Portal makes it easy for your office staff to enter an order for a high-tech diagnostic imaging exam via the Web. The Web-based Provider Portal gives you 24/7/365 access to HMO Blue® Texas preauthorization, claims, and eligibility information. Best of all, not only can you enter an exam, but you can receive an approval online in real time (as long as additional clinical information is not needed).

To obtain an HMO preauthorization or a PPO RQI number, just log into 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 be given a preauthorization or RQI number. If criteria are not met or additional information is needed, the case will automatically be transferred for further clinical evaluation, and an AIM nurse will follow up with your office.



Other great features:

- Convenient access, no waiting, available 24/7
- You can locate radiology providers in the patient's area that are contracted with BCBSTX
- Reduces phone time by allowing information to be retrieved online
- Imaging providers can verify that a RQI/Preauthorization number has been issued through the RQI/preauthorization feature
- CPT Groupers & Clinical Guidelines available online

If you have not already, explore AIM's Provider Portal to see for yourself how easy, efficient, and reliable it is to order an exam via the Web!

NOTE: Preauthorization is not required for outpatient, non-emergency diagnostic imaging services for HMO Blue Texas members, performed by providers located outside of the following counties: Collin, Dallas, Denton, Ellis, Grayson, Johnson, Kaufman, Parker, Rockwall, Tarrant and Wise.



Crossover Process Saves Time and Money for Medicare Part A & B Electronic Claims

The BCBSTX Defensive Strategy Medicare Part A & B Team implemented an electronic submission process that may impact as many as two million claims currently submitted on paper each year.

Most patients who are eligible for Medicare Part A & B have their supplemental claims automatically generated via the crossover process. When Medicare releases its payments, the claims then cross over to BCBSTX for processing of the supplemental benefits. This is the best way to obtain your secondary payment with the least amount of effort. By allowing the crossover process to work, we all save time and money.

However, when patients have not updated their BCBSTX membership information, the claims do not automatically cross over. BCBSTX is now offering an electronic alternative to obtain that supplemental payment when BCBSTX claims do not cross over.

Use the timeline below when Medicare is primary and BCBSTX is secondary to determine when crossover has not occurred or will occur. (This guideline assumes the primary Medicare claim was submitted in the HIPAA compliant 837 format.)

Start with the date you receive your Explanation of Medicare Benefits:

Day 1 - Receive payment and Explanation of Medicare Benefits (EOMB) from Medicare indicating the claim has been forwarded to BCBSTX for supplemental payment.

Days 4 - 19 - Receive the supplemental crossover payment from BCBSTX (crossover claims are highlighted with a message on the Provider Claim Summary).

Day 20 - If no payment or denial is indicated on the Provider Claim Summary, you may then file the supplemental portion electronically to BCBSTX using the guidelines on the Web site at www.bcbstx.com/provider.

Reminders:

- For non-HIPAA compliant claims and paper submissions, please add 14 days to this timeline.
- The crossover process requires the patient to provide BCBSTX with the HICN Number assigned by Medicare. When claims do not cross over for patients or do so inconsistently, please advise them to provide BCBSTX with their HICN number by contacting Customer Service at the toll-free number on the back of their BCBSTX member identification card.

Visit www.bcbstx.com/provider to learn more about the Medicare Part A & B Guidelines and EDI Requirements.

BlueChoice® PPO/POS Vision Hardware Fee Update

Effective March 1, 2006, BCBSTX will implement a change in the maximum allowable fee schedule used for vision hardware dispensed by physicians and optometrists for the BlueChoice PPO/POS network. The maximum allowable fee schedule will be updated to reflect a 25 percent discount from the provider's usual billed charge. Please note that benefits payable are subject to eligibility requirements, benefit plan limitations and guidelines established by BCBSTX.

If you have any additional questions regarding this change, please contact your local Professional Provider Network office.

Expect PPO Plan Changes, More Debit Cards for TXU Members in 2006

Starting in January 2006, there will be a significant increase in the number of TXU members (active employees and pre-age 65 retirees) who will be on a BCBSTX PPO plan with deductibles and coinsurance. The increase results from TXU's no longer offering a PPO plan with copays.

TXU members will also have a Health Reimbursement Account (HRA) managed by a third party in which TXU has placed funds to help TXU members meet their BCBSTX deductible and/or coinsurance expenses. In conjunction with the HRA, the TXU members will have a MasterCard debit card.

If you do not know the BCBSTX allowed amount and the member's co-share at the time services are rendered, please consider waiting to bill them until after you receive the Explanation of Benefits (EOB) back from BCBSTX. Otherwise, if the TXU member pays more than their required portion of the allowed amount up front, the physician's/professional provider's office will need to credit the debit card—or return the overpayment to the member—who will then need to reimburse the HRA. Therefore, waiting to receive the EOB from BCBSTX can greatly simplify the administration of the billing process for both the physician and the member.

If you have questions about EOBs for TXU members, please contact BCBSTX. For concerns regarding MasterCard, please call the number listed on the debit card.

New Disease Management and Wellness Programs for HealthSelectSM Members

Blue Care[®] Connection is a new disease management and wellness program available to HealthSelect members (group 038000), effective Sept. 1, 2005. The program simplifies the coordination of members' health care benefits, educates and empowers them to make informed choices, and supports wellness by aiding their understanding of preventive care guidelines, personal risk assessments, and preventive screenings. These services are part of their benefits and are provided to HealthSelect members at no additional cost. Key components of Blue Care[®] Connection include:

- **Wellness Programs** - targeted participant mailings regarding key preventive screenings and disease specific immunizations
- **24/7 NurseLine** - caring, experienced nurses available 24 hours, seven days a week—even on holidays
- **Mayo Clinic Online** - online resources including Diseases A-Z, Health Risk Assessment, and Ask a Specialist*
- **Care Management** – operates through the pre-authorization process
- **Case Management** - provides continuity of care for members requiring more complex treatment
- **Disease Management** - programs designed for members with specific conditions such as asthma, diabetes, congestive heart failure, or coronary artery disease
- **Special Beginnings[®]** - integrates high-risk pregnancy identification and the case management program

For more information on the Blue Care[®] Connection program, go to <http://www.bcbstx.com/hs/bluecareconnection.htm> on the HealthSelect Web site.

*The relationship between Blue Cross and Blue Shield of Texas and Mayo Clinic is solely that of independent contractors.

BlueChoice Solutions Fall 2005 Evaluation Results Completed

We recently completed the 2005 Fall evaluations for the BlueChoice Solutions physician and professional provider network. Participating BlueChoice physicians and professional providers received a notification letter regarding their participation status in the BlueChoice Solutions network. BCBSTX Provider Finder® on www.bcbstx.com will be updated in January 2006 to reflect changes to the BlueChoice Solutions network.

If you cannot locate your eligibility notification letter or if you are interested in obtaining a copy of your Fall 2005 Provider Summary, please contact your local Professional Provider Network office.

BlueChoice Solutions Employer Groups

For your reference, the following is an alphabetical list of large employer groups currently enrolled in BlueChoice Solutions. Please note that the employer groups listed below include both insured and self-funded health plans. These employer groups may have chosen the BlueChoice Solutions network as an optional network for their employees. For example, BCBSTX, HEB and TXU offer BlueChoice Solutions as an optional network for their employees.

BlueChoice Solutions Large Employer Groups

Alabama-Coushatta Tribe of Texas	Dolly Vinsant Memorial Hospital
American Steel Building Co., Inc.	Eagle Construction and Environmental Services
Ameri-Tech Kidney Center, P.A.	First National Bank of Huntsville, Texas
Ari-Tex Electric, Inc.	HEB Grocery Company
Austin Traffic Signal Construction Co.	House Calls Home Based Healthcare
BA Research International	Mammoet U.S.A., Inc.
Bert Ogden Olds, Nissan & BMW, Inc.	Mid-Coast Electric Supply, Inc.
Blue Cross and Blue Shield of Texas	Parent / Child Inc.
Border Steel	Plant Automation Services, Inc.
Brazos Valley Council of Governments	R & R Marine Fabrication & Drydock
Bridgeport Tank Trucks, Inc.	Red Dot Corporation
Brock Enterprises Inc.	Southern Services, Inc.
Challenger Process Systems Co.	Specialized Maintenance Services
City of Harlingen	St. Joseph Academy
City of Pharr	Syracuse's Italian Sausage Co.
City of South Houston	Toromount Industries
Consolidated Benefit Systems, Inc.	TXU
Crowley Independent School District	Ypone Operations, LLC
Del Papa Distributing Company	Zyvex Corporation
DIAB LP DBA DIAB, Inc.	

A sample of the BlueChoice Solutions ID card is provided here. Each subscriber identification card includes the BlueChoice Solutions logo for easy recognition. The network number is also specific to BlueChoice Solutions – **PSNOA**. The standard subscriber number developed for BlueChoice Solutions begins with the alpha prefix of ZGO. However, there are exceptions to the **ZGO** prefix for certain BlueChoice Solutions employer groups.



Please note: In Texas, BlueChoice Solutions subscribers must use BlueChoice Solutions providers for in-network benefits.

For additional information about BlueChoice Solutions, please visit the BCBSTX Web site at www.bcbstx.com/provider and click on “Learn More – BlueChoice Solutions”.

Predetermination Request Resources Now Available Online

BCBSTX just made it easier to request a predetermination. We are now offering a Predetermination Request Reference Guide that provides the supporting documentation needed for each service, and a Request for Predetermination Form to route your request more efficiently. You can access the guide and the form on the BCBSTX Provider Web site at www.bcbstx.com/provider under the Reference Guide and Downloadable Forms sections, respectively.

Use of the guide should enable your office to identify the required supporting documentation for the most commonly requested services. And the Request for Predetermination Form will ensure your request is routed to the appropriate area for immediate processing.

In addition, we have introduced a new toll-free fax number (800) 579-7935 dedicated to receiving predetermination requests, which will expedite routing and processing of the requests and help avoid the extra time involved when mailing them.

Note: Predetermination requests are not applicable to HMO Blue Texas or Federal Employee Program members.



Locate Claims Easily with These Automated Phone System Tips:

- Use the performing provider number rather than the clinic number. The performing provider number generally starts with an “8” and contains six alpha/numeric characters.
- When entering the performing provider number, substitute all alpha characters with the number “1”. For example: “8R8531” would be entered “818531”.
- When the performing provider number is less than six characters, always zero-fill in front of the number to ensure six characters are entered. For example: “BB35” would be entered “001135”.
- Always enter the **first** date of service of the claim.
- Enter the member’s correct ID number based on the date of service. For example, services provided prior to the conversion to a Unique ID number (UID) should be entered using the member’s Social Security number (SSN). For services provided after the conversion to a UID, you should enter the member’s new UID. For a limited time, claims processed under a new UID may be located by the automated system if the member’s SSN is on file with BCBSTX.



Request BlueCard Preauthorization Requirements to Avoid Delays, Denials

As a PPO/POS or Traditional contracted provider, you can avoid claims processing delays or possible denials when you remember to:

- Request preauthorization requirements when requesting benefits and eligibility. As a reminder, preauthorization requirements may vary based on the member's benefits.
- Notify the appropriate Plan prior to rendering services for services requiring preauthorization, or as soon as possible for emergent care:
 - For members enrolled in an out-of-state PPO or Traditional policy, you should contact the Plan in which the member is enrolled (i.e., Blue Cross and Blue Shield of Florida or Blue Cross and Blue Shield of Arkansas).
 - For members enrolled in a POS policy (Primary Care Physician assigned), you should contact the Plan in which the PCP participates.

To assist in contacting the appropriate Plan, the preauthorization phone number is provided on the back of each member's identification card.

- Contact the Plan that issued the preauthorization with updated or clinical information as necessary if there is a change in the patient's status from the original preauthorization.

The preauthorization must cover the **entire date span** and **all services** submitted on the claim in order to avoid requests for additional information and possible delays or denials.



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The information provided in *Blue Review* does not constitute a summary of benefits, and all benefit information should be confirmed or determined by referring to the appropriate benefit booklet. 42600.1205



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BlueChoice is a PPO and POS product provided or administered by Blue Cross and Blue Shield of Texas with networks for contracting PPO and POS providers

A Provider Publication