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- **Texas Provider Access and Servicing Strategy (PASS)**
- **Daily Electronic Funds Transfer**
- **Quality Improvement Program (QIP)**
- **Patient Appointment Access**

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## Electronic Remittance Advice (ERA) Codes are Necessary

For providers receiving a detailed electronic voucher of claims processed, referred to as an Electronic Remittance Advice (ERA), Blue Cross and Blue Shield of Texas must use the HIPAA mandated code sets. The Remittance Remark Codes are used to convey messages critical to understanding the adjudication of a health insurance claim.

These codes are maintained by The Centers for Medicare and Medicaid Services (CMS), but must be used by all healthcare payers for HIPAA compliant transactions. Please be advised that Blue Cross and Blue Shield of Texas provides the codes as published; however, some software vendors may alter these codes somewhat i.e., adding additional characters in front of the published codes. For a listing of the EDI standard Remittance Remark or Claim Adjustment Reason Codes utilized by HCSC, please visit [www.wpc-edi.com/codes](http://www.wpc-edi.com/codes).

For further assistance, please contact your software vendor directly or our Provider Customer Service at 1-800-451-0287 for an explanation of the adjudication of your claims.

# blue

## Blue Review

## New Provider Enrollment Process Streamlined

THIN has made it easier than ever to set up a new provider to do electronic billing through an existing THIN Submitter. Previously, all new providers and existing providers who changed their provider numbers had to present a signed EDI Information form along with a signed EDI Agreement before submitting claims electronically. Under HIPAA, only the entity that is actually transmitting the claims directly to THIN (Trading Partner) is required to submit an agreement which includes the privacy and security provisions, the Submitter Trading Partner Agreement. Therefore, if you are a provider who will be submitting your claims electronically through a third party, billing service or clearinghouse, you only need to submit the new Provider Enrollment Form to THIN to get enrolled. The new Provider Enrollment Form is located on the THIN Web site, [www.thinedi.com](http://www.thinedi.com). This form can be faxed to the THIN Enrollment Area at 972-766-5102 or e-mailed to [enrollment@thinedi.com](mailto:enrollment@thinedi.com). Your e-mail address must be included to receive an enrollment confirmation. The confirmation will be returned within five business days.

New providers that will be submitting claims directly to THIN from their offices qualify as Trading Partners and will need to complete the Submitter Enrollment Form and Trading Partner Agreement located on the THIN Web site, [www.thinedi.com](http://www.thinedi.com). There are detailed submitter instructions included in the Submitter Enrollment Packet.

For additional questions on enrollment, please contact the EDI Helpline at 972-766-5480 (8 am - 6 pm CST) or e-mail [enrollment@thinedi.com](mailto:enrollment@thinedi.com).

## 2004 Wellness Guidelines Now Available

The 2004 Adult Wellness Guidelines and Childhood and Adolescent Wellness Guidelines were recently completed. The Suggested Prenatal Care Guidelines are unchanged from 2003. Please see the Blue Cross and Blue Shield of Texas Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) (Wellness Guidelines) or contact the Quality Improvement Programs Department at 1-800-863-9798 for a copy.



## Texas Provider Access and Servicing Strategy

In 2003, Blue Cross and Blue Shield of Texas established a team to partner with Provider Customer Service, Network Management and the Office of Physician Advocacy (OPA) to foster BCBSTX satisfaction from our nearly 40,000 contracting physicians, hospitals, and ancillary providers statewide. This team is called the Provider Access and Servicing Strategy (PASS) Department.

PASS is comprised of a number of provider specialty positions which are dedicated to providing unsurpassed service to our providers through enhanced provider education, communication and more focused provider servicing.

The PASS departmental strategy entails servicing our providers through:

- **Enhanced Education** by conducting on-site workshops and focus-topic seminars at locations convenient to providers, as well as hot-topic training for BCBSTX internal provider servicing departments.
- **Increased Communications** to providers via the provider newsletter, *Blue Review*, and additional offerings on the provider Web site that include enhanced reference guides, contact lists, frequently asked questions (FAQs), and electronic forms with submission capabilities.
- **Technical Coordination** through facilitation of technological solutions and enhancements that promote a higher service level to our providers. Enhancements have recently been made to the automated voice response unit by adding new information and expanding functionality, while making the system more user friendly.
- **Provider Services Central Support** with resources dedicated to resolving complex inquiries and coordinating process improvements.
- **Root Cause Analysis and Elimination** through tracking, profiling, and trending provider claim and inquiry activities.

PASS staff is motivated and raring to go! With the outlined strategies and initiatives underway, PASS is determined to raise the bar on BCBSTX satisfaction in the provider community.

## Correction

The following, incorrect, statement was part of the Blue Cross and Blue Shield of Texas Documentation Guidelines in the Second Quarter 2002 Blue Review:

Providers will not have to duplicate required documentation provided at time of pre-determination or pre-certification (when required). If pre-determination or pre-certification is approved, any requirement for operative report is waived.

**The CORRECT statement is as follows. We apologize for any inconvenience this may have caused:**

Providers will not have to duplicate required documentation provided at time of pre-determination or pre-authorization (when required). However, an operative report is not considered duplicate documentation and must be submitted, if required for a specific procedure, even if pre-determination or pre-authorization is approved.

## Medical Policy Disclosure Statement

New or revised Medical Policies, when approved, will be posted in the “Pending Policies” section of the Medical Policy site on the Blue Cross and Blue Shield of Texas Web site on the first day of each month, every month. Those policies requiring disclosure will become effective 90 days from the posting date. The specific effective date will be noted for each policy that is posted.

To review policies, view the Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider), click on General Reimbursement Information — Medical Policies. After reading the policies disclaimer, click on I Agree to move to the Medical Policy page. As noted, disclosure notices can be found within the Pending Policies section (see box on left of screen).

## Your Satisfaction is Our Top Priority

More than 900,000 BlueCard® Program members are currently residing in Texas. Blue Cross and Blue Shield of Texas (BCBSTX) continues to experience growth in out-of-area membership. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

To help determine whether the BlueCard Program is meeting your needs and expectations, BCBSTX routinely participates in an annual BlueCard Provider Satisfaction Survey. This year’s survey will be administered from May through July. The Response Center, an independent research company, will conduct telephone interviews on behalf of BCBSTX using a randomly selected sample of providers who have serviced BlueCard members within the past year.

The Response Center will ask to speak with the person who is most knowledgeable about filing Blue Cross and Blue Shield claims and/or the billing department. Please share this information with the appropriate staff in your office. If you receive a call we strongly encourage you to participate. Your feedback is important to us.

We continually seek ways to improve our service to you. If you have questions about the BlueCard Program or have suggestions for improvement, please contact your Professional Provider Network representative. Your comments are always welcome.

## Numbers Required for Filing Electronically

In order to file claims electronically, all facilities must have a BCBSTX Provider Number (including out-of-network facilities). This will assure proper routing of the electronic claims from THIN to the correct BCBSTX claim processing system.

To receive a BCBSTX facility provider number, please contact Facility Provider Services at 972-996-8199 or write to:

**Facility Provider Services**  
2400 Lakeside Blvd., 1st floor  
Richardson, TX 75082

For more information on how to file your claims electronically, please call the THIN EDI Helpline at 972-766-5480 or visit the THIN Web site at [www.thinedi.com](http://www.thinedi.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 date that have been made since our last notice. This action is not retroactive to claims processed prior to the effective date listed.

- Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty) will be allowed with Arthroscopy, knee, surgical with meniscectomy (medial and lateral, including any meniscal shaving), or Arthroscopy, knee, surgical; with meniscus repair (medial and lateral). **PPO/POS effective date 2/18/04; HMO effective date pending.**
- Introduction/Injection of Anesthetic Agent (nerve block), Diagnostic or Therapeutic; will be allowed with Anesthesia Qualifying Circumstances. **PPO/POS effective date 2/18/04; HMO effective date pending.**
- Evaluation and Management codes will bundle 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. **PPO/POS effective date 2/18/04; HMO effective date pending.**
- Arthroscopy, knee, surgical; synovectomy, major, two or more compartments; will be allowed with Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture. **PPO/POS effective date 2/18/04; HMO effective date pending.**
- Thoracoscopy, surgical will be allowed with removal of intrapleural foreign body or fibrin deposit. **PPO/POS effective date 3/18/04; HMO effective date pending.**
- Inpatient pediatric critical care, Inpatient neonatal critical care, Intensive low birth weight services will be allowed with Prolonged extracorporeal circulation for cardiopulmonary insufficiency, initial 24 hours and each additional 24 hours. **PPO/POS effective date 3/18/04; HMO effective date pending.**
- Removal of mammary implant material will be allowed with Periprosthetic capsulectomy, breast. **PPO/POS effective date 3/18/04; HMO effective date pending.**
- Electrocardiogram, routine ECG with I2 leads, non-invasive ear or pulse oximetry, electroencephalogram extended monitoring will bundle to Electroconvulsive therapy single seizure and multiple seizures. **PPO/POS effective date 3/18/04; HMO effective date pending.**
- Osteotomy of spine, posterior or posterolateral approach, one vertebral segment, thoracic and each additional vertebral segment will be allowed with Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments. **PPO/POS effective date 3/18/04; HMO effective date pending.**
- Assistant surgeon will be allowed for procedure code 33694. **PPO/POS effective date 4/17/04; HMO effective date pending.**
- Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes); and intermediate joint or bursa (temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); will be allowed with injection(s); single tendon origin/insertion. **PPO/POS effective date 4/14/04; HMO effective date pending.**



## Notice to Providers of Sanderson Farms Employees

Effective January 1, 2004 Sanderson Farms employees in Texas will utilize the Blue Cross and Blue Shield of Texas Traditional PAR Network. Claims for dates of service January 1, 2004 and forward should be filed with the Blue Cross and Blue Shield of Texas plan.

It is important that claims for services provided prior to January 1, 2004 continue to be filed directly to Blue Cross & Blue Shield of Mississippi at Post Office Box 1043, Jackson, Mississippi 39215-1043. This will help to ensure that claims are properly processed.

If you have any questions, please feel free to contact our Provider Services department at 1-800-257-5825.

## HEB Partners Access Savings with Debit Card

On January 1, 2004, HEB's Partners (employees) began using a debit card to access pre-tax dollars in their Flexible Savings Account (FSA). This debit card acts like a credit card and can be used anywhere that displays the MasterCard logo. (The CREDIT option must be selected on the card reader). This product is administered for HEB by Ceridian. These funds can be used to pay for prescription and medical co-pays, co-insurance and deductibles.

If you are providing treatment to a HEB Partner and your office accepts MasterCard, please make sure you take any co-insurance amount off the contracted rate and not billed charges.

## New HIPAA Edits for Electronic Claims

HIPAA has made many of us change the way we do business. To further ensure your electronic claims meet all of the HIPAA transaction and code set requirements, THIN has begun implementing ongoing new edits this year. We encourage you to monitor your THIN response reports closely for the activation of new edits. We will activate them initially as a warning message for a minimum of two weeks. As long as the message type is "W" for Warning, your claims will be forwarded to the Payer. To avoid rejections on future claims when the edit is changed to an "R" for Reject, you should make the necessary changes to correct the error as soon as possible.

As new edits are implemented, they will be posted as new THIN Hot Topics on the THIN Web site at [www.thinedi.com](http://www.thinedi.com). We appreciate your cooperation as we move to a HIPAA compliant environment. If you have any questions, please contact the EDI Helpline at 972-766-5480 (8 am - 6 pm CST).

## Consumer Choice Plans

BCBSTX offers PPO and HMO Small Group Employer Consumer Choice plans as mandated by the Texas Insurance Code. **The Consumer Choice Options are:**

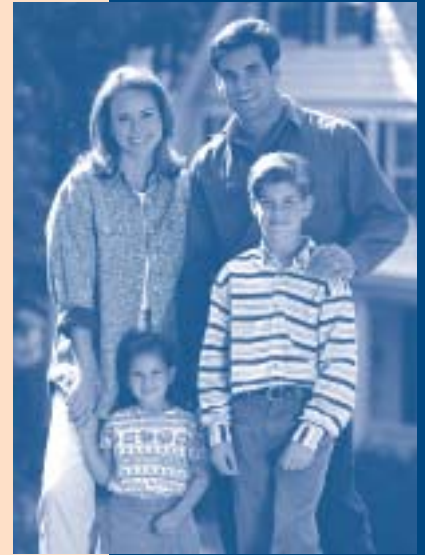
### Consumer Choice PPO Plan — Plan L100

Participants may access the BlueChoice network, one of the largest provider networks in the state. Members should seek care from BlueChoice network providers to receive the highest level of benefits. Or, they may choose to seek care from a non-network provider and receive a reduced level of benefits.

The **Consumer Choice PPO Plan** has a \$1000 individual/\$3000 family combined deductible, no office visit copayment, 80%/60% coinsurance, \$150 ER copayment, \$3000 individual/\$9000 family coinsurance stop-loss, \$1,000,000 lifetime maximum per participant and a \$20/\$35/\$50 prescription drug program.

The **Consumer Choice PPO Plan** does not include, in whole or in part, coverage for the following health care services as mandated by state law:

- Treatment of chemical dependency
- Prescription contraceptive drugs and devices and related drugs (Oral Contraceptives not excluded)
- In-Vitro Fertilization
- Serious Mental Illness (non-public entities only)
- Speech and Hearing
- Home Health Care



### Consumer Choice HMO Plan — Plan 99

Members must access the HMO Blue Texas network of providers for services to be covered. If members receive care from a network provider other than their PCP and are not referred to that network provider by their PCP, or if they receive services from a non-network provider, those services are not covered.

The **Consumer Choice HMO Plan** has a \$25 physician office visit copayment, \$500 copayment per day/\$2500 per admission maximum inpatient hospital care, \$150 copayment per visit for ER, \$5,000 individual/\$10,000 family out-of-pocket and no lifetime maximum. There is an optional, \$20/\$35/\$50, prescription drug rider available.

The **Consumer Choice HMO Plan** does not include, in whole or in part, coverage for the following health care services:

- Treatment of chemical dependency
- Prescription contraceptive drugs and devices and related drugs (Oral Contraceptives not excluded)
- In-Vitro Fertilization
- Serious Mental Illness (non-public entities only)
- Speech and Hearing Plan

## Are Your Facility Claims Denying as Duplicates?

These denials may be due to the Type of Bill (TOB) submitted on the UB-92. Facility claims are identified by the 3-digit TOB, ending in 5 for late charges, 6 for corrected claims, and 7 for replacement claims.

For electronic claims, the TOB is located in Record 40, Field 04, Positions 25-27. For UB-92 paper claim submissions, the TOB is located in form locator Field 4.

### BlueChoice® PPO/POS Claims

#### Late Charges (TOB XX5)

The original claim will be reviewed and adjusted as a result of the information found on the late charge claim. If a matching claim is not found, then the late charge claim for outpatient services is processed as an original, while that for inpatient services will be denied due to no original claim found.

#### Corrected Charge Claims (TOB XX6) or Replacement Claims (TOB XX7)

If a matching claim is found, whether inpatient or outpatient, the original claim will be reviewed and adjusted. If a matching claim is not found, then the corrected/replacement claim is processed as an original claim.

### HMO Blue® Texas Claims

#### Late Charge/Corrected/Replacement Claims (TOBs XX5, XX6, XX7)

If a matching claim is found and additional payment is owed to the provider, then the original claim is reversed (adjusted to zero-pay) and the late charge or corrected claim is processed with the new information and the previous claim data. If a lesser payment is owed to the provider, then the late charge or corrected claim is denied and the original claim will be reprocessed with the new information. If a matching claim is not found, then the late charge or corrected claim is processed as an original claim.

Using the correct bill type will result in accurate processing and will eliminate unnecessary denials.

For additional information regarding late charges and corrected claims, please visit our Web site at [www.bcbstx.com/provider/late\\_charges\\_corrected\\_claims.htm](http://www.bcbstx.com/provider/late_charges_corrected_claims.htm).

## Daily Electronic Fund Transfers Offered

Last year, BCBSTX began offering weekly Electronic Funds Transfer (EFT) to providers who filed 85 percent of their claims electronically. To improve the service and broaden the number of providers who qualify, BCBSTX now offers Daily EFT to providers who file 25 percent of their claims electronically. EFT for HMO Blue Texas will continue on a weekly basis.

As a submitter of electronic claims, you can still choose to receive paper checks, receive weekly EFT payments or begin receiving daily EFT payments. The BCBSTX EFT program is designed to reward providers who appreciate the cost and time savings achieved by submitting claims electronically.

For more information regarding EFT or to begin filing your THIN claims electronically in order to qualify, please call the THIN EDI Helpline at 972-766-5480 or visit the THIN Web site at [www.thinedi.com](http://www.thinedi.com).

## New Address for Verification Requests

In accordance with Texas Prompt Pay Legislation, Blue Cross and Blue Shield of Texas (BCBSTX) accepts telephone and written requests for verification for BlueChoice PPO and HMO Blue® Texas. In order to expedite processing of written requests for verification, a new dedicated P.O. Box address has been established. However, to receive the quickest response, providers are encouraged to initiate a telephone request to avoid additional mail delivery time.

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

**BlueChoice (PPO) — 1-800-451-0287**

**HMO Blue Texas — 1-877-299-2377**

Upon completion of processing, requests by telephone for verification will receive a fax notice followed by a written notice via U.S. Mail.

For those providers who prefer to submit a written request, please complete the Provider Request for Verification Form available in the Downloadable Forms section on our provider Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) and submit to the following address:\*

**BCBSTX or HMO Blue Texas  
Request for Verification  
P.O. Box 833908  
Richardson, TX 75083**

Upon completion of processing, written requests for verification will receive a written notice via U.S. Mail.

If a provider participates in a limited provider network and claims are paid by the limited provider network, the verification process will be completed by the limited provider network.

\*Written requests for verification will only be accepted at this P.O. Box address. In addition, this P.O. Box may not be used for claims filing or any other written correspondence.

## 2004 Behavioral Health Clinical Practice Guidelines

BCBSTX and HMO Blue Texas, working with the Behavioral Health vendor, Magellan Behavioral Health, Inc., have adopted the following American Psychiatric Association clinical practice guidelines:

- Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Revision) (April, 2000)
- Practice Guideline for the Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids (1996)
- Practice Guideline for the Treatment of Patients with Schizophrenia (1997)

Copies of these guidelines may be viewed through the BCBSTX Web site at [www.bcbstx.com](http://www.bcbstx.com) or at [http://www.psych.org/psych\\_pract/treatg/pg/prac\\_guide.cfm](http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm).

Printed copies may be ordered through the American Psychiatric Publishing, Inc. (APPI) at [www.appi.org](http://www.appi.org), by calling (800) 368-5777, or by U.S. mail at:

**American Psychiatric Publishing, Inc.  
1000 Wilson Blvd., Suite 1825  
Arlington, VA 22209-3901**

## Update on BlueCard Unique ID

Several states including Texas have passed Identity Theft laws to protect the confidentiality of Social Security Numbers (SSN) for their members. To comply, the Blue Cross and Blue Shield Association has mandated that, by 2006, all members be provided with unique (non-Social Security Number) identification numbers (UID).

Although the alpha prefix you are accustomed to seeing will not change, each member's identifier will change. Most plans are continuing to use a 9-digit numeric identifier. However, some have implemented other variations to help keep their members' SSNs confidential. Listed below are some examples of 9-digit UID configurations other than all numeric that you may see:

• Begins with 1 alpha followed by 8 numeric	A # # # # # # # #
• Begins with 2 alphas followed by 7 numeric	A A # # # # # # #
• Begins with 3 numeric, 4th position is alpha, followed by 5 numeric	# # # A # # # # #
• All numeric with 4th and 5th positions being zeroes	# # # 0 0 # # # #
• Begins with 7 numeric followed by 2 alphas	# # # # # # # A A
• Begins with 5 X's followed by 4 numeric	X X X X X # # # #

In addition, some states have opted to use from 6-14 alpha-numeric digit configurations instead of the conventional 9-digit configuration. More information regarding unique IDs including BlueCard may be found on our provider Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider).

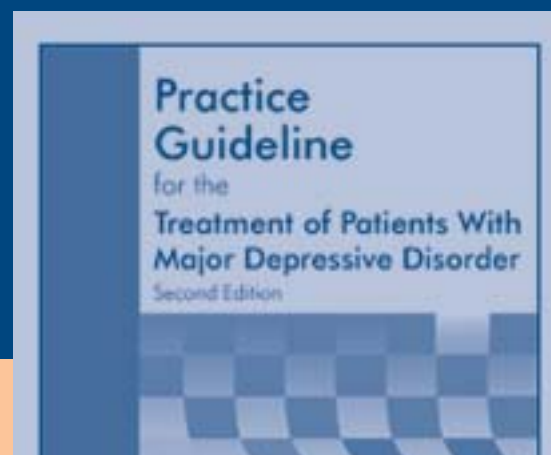
These variations should be transparent to you when submitting claim information to BCBSTX. Please remember to obtain a copy of the member's current ID card and use the new ID number exactly how it appears on the member's ID card for claim submissions. To avoid eligibility ('no membership found') denials, you must include the alpha-prefix to ensure the claim is transmitted to the correct Home plan. Although we have recently added BlueCard claim status to our automated voice response unit (VRU), claims for those members with an alpha-numeric identifier are not currently accessible through our VRU. Please be advised we are working towards an integrated voice response system that will offer this functionality.

In addition to the APA, the Practice Guideline for the Treatment of Patients with Schizophrenia was adopted to be used with the Texas Implementation of Medications Algorithms (TIMA) Guidelines for Treating Schizophrenia, Physician Procedural Manual (last edited November, 2001). Copies are available through the Texas Department of Mental Health and Mental Retardation at [www.mhmr.state.tx.us/CentralOffice/MedicalDirector/tima.html](http://www.mhmr.state.tx.us/CentralOffice/MedicalDirector/tima.html).

The Clinical Practice Guideline for Assessing and Managing the Suicidal Patient (2002), developed by Magellan Behavioral Health, Inc. has also been adopted by BCBSTX and

HMO Blue Texas and is available on the BCBSTX Web site at [www.bcbstx.com](http://www.bcbstx.com).

If you would like a hard copy of the clinical practice guidelines, you may contact the BCBSTX Quality Improvement Programs Department at 1-800-863-9798.



## Patient Appointment Access 2003 Year End Results

Blue Cross and Blue Shield of Texas and HMO Blue Texas have developed patient appointment access standards and performance goals which are measured through the Physician Office Review Program and member satisfaction surveys. The following table includes the access indicator, established standard and performance goals, as well as the 2003 year end results.

Access Indicator	Standard	2003 Average	Performance Goal (% of Physicians who Meet Standard)	2003 Outcome
Urgent Care	Within 24 hours	7.6 hours	90%	99.6%
Routine Symptomatic Care	Within 5 days	2.0 days	90%	98.0%
Preventive Care/ Annual Physical Exam	Within 30 days	9.5 days	90%	98.1%
Initial New Patient Visit	Within 30 days	7.1 days	90%	98.2%
In-Office Wait Time	30 minutes or less	19.8 minutes	90%	96.0%
<b>After Hours Care</b>				
Urgent Care	Method for directing patients to emergency care after hours	NA	90%	98.1%
Alternative Care	Method for directing patients to alternative care for non-emergent symptoms after hours	NA	90%	97.7%

For 2003, the majority of network physicians are meeting the established standard and performance goals.

## Hospital Comparison Tool Available to Providers on the BCBSTX Provider Web Site

Blue Cross and Blue Shield of Texas provided members access to a Hospital Comparison Tool online in the Fall of 2003. This tool allows members to compare and evaluate hospitals' outcomes by specific diagnoses and procedures. The Hospital Comparison Tool is based on outcome data that hospitals are required to report to state and federal government agencies as well as BCBSTX hospital cost data. This data compares hospital performance factors such as mortality, length-of-stay, complications and how frequently the hospital performs specific procedures. To provide a meaningful comparisons, the data are adjusted for severity of illness.

This tool is now available to BCBSTX contracted providers ([www.bcbstx.com/provider](http://www.bcbstx.com/provider)). Providing this information to both members and providers will support and encourage discussions on selection of the hospital to meet the member's need.

## Notice of Medical Policy Activity

The following new or revised Medical Policies have recently been approved and will be effective on or after September 17, 2004. These policies can be viewed at [www.bcbstx.com](http://www.bcbstx.com). On the Web site, click on “Providers,” then click on “Medical Policies.” After reading the Medical Policies Disclaimer, click on “I Agree.” The policies listed below can be found in the “Pending Policies” section of the Medical Policy site.

POLICY #	POLICY NAME	BRIEF DESCRIPTION OF CHANGE (if any)
DMEI01.045	Skin Contact Monochromatic Infrared Energy (MIRE) Devices	New Policy. Investigational.
DMEI04.009	Speech Generating Devices (SGD)	New policy with conditional coverage criteria
MED201.011	Alternative Modes of Nutrition in the Outpatient and Home Setting	Change in coverage position statement.
SUR712.006	Neuromuscular Electrical Stimulation for Scoliosis	Change in coverage position from conditional coverage to not medically necessary
SUR714.003	Implantable Bone Conduction Hearing Aids	Revised/updated policy with conditional coverage criteria.
RRUI200.011	Physician Standby	Change in coverage position statement.

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

POLICY #	POLICY NAME	BRIEF DESCRIPTION OF CHANGE (if any)
MED202.003	Ambulatory Cardiac Event Monitors (AEMs or CEMs)	Policy updated. Change in coverage to allow for some indications.
MED205.008	Electroencephalograms	Policy updated.
MED207.088	Functional Intracellular Analysis	Policy updated. Policy name change.
MED207.092	Cancer Screening of the Cervix	Policy updated.
RAD601.041	Percutaneous Vertebroplasty and Kyphoplasty	Change in the coverage position statement. Procedure is allowed in some indications.
RAD603.009	Magnetic Resonance Imaging of the Breast	Change in the coverage position statement. Procedure is allowed for some indications.
SUR702.003	Intravenous Analgesia or Monitored Anesthesia Care (MAC)	No change in coverage position statement. Updated references.
SUR703.021	Autologous Chondrocyte Transplantation (ACT)	Policy updated. Change in coverage to allow for some indications.
SUR716.003	Surgery for Morbid Obesity	Policy updated. Change in coverage position.
THE801.007	Hyperthermia	No change in coverage position statement. Updated references.
THE801.021	Infusion and Injectable Therapy in the Home	No change in coverage position statement. Updated references.
RRUI200.012	Telephone Advice Guidelines	No change in coverage position statement. Updated references.

## HMO Announces Hearing Aid Fee Schedule Change

Effective July 1, 2004, Blue Cross and Blue Shield of Texas will implement a change in the maximum allowable fee schedule used for hearing aids dispensed by physicians and audiologists for the HMO Blue Texas network. The maximum allowable fee schedule will be updated to reflect a forty 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.

## Non-Emergency Outpatient Diagnostic Imaging Services for HMO Blue Texas

Effective September 1, 2003, American Imaging Management, Inc.(AIM), is responsible for managing outpatient, non-emergency diagnostic imaging services for HMO Blue Texas Members in the following counties: Collin, Dallas, Denton, Ellis, Grayson, Johnson, Kaufman, Parker, Rockwall, Tarrant and Wise.

For procedures that are performed on or after September 1, 2003, and in order to qualify for reimbursement, all HMO Blue Texas providers are required to obtain a preauthorization from AIM before scheduling or performing outpatient diagnostic CT, MRI/MRA, PET and Nuclear Cardiology studies. Imaging services performed in conjunction with emergency room services are excluded from this preauthorization requirement. Imaging services performed in conjunction with inpatient hospitalization, outpatient surgery (hospital and freestanding surgery centers) or 23-hour observation still require an HMO Blue Texas preauthorization for the approved level of care; however, a separate preauthorization from AIM is not required.

If you have questions concerning the Specialty Radiology Network and the preauthorization requirements, please contact your HMO Blue Network Representative or you may contact AIM at 1-800-859-5299 or access AIM's Web site at [www.americanimaging.net](http://www.americanimaging.net).



## HMO Blue Texas Changes to Independent Laboratory Provider Network

Quest Laboratories and CPL, Inc. are no longer participating outpatient clinical reference laboratory providers for HMO Blue Texas effective September 1, 2003. HMO Blue Texas contracted providers are obligated to use participating facilities. Laboratory Corporation of America (“Lab Corp”) remains the exclusive 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](http://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](http://www.bcbstx.com/provider) (see Provider Finder®) or you may contact your local Provider Network Management office. For physicians located in the following counties, only the lab services/tests indicated on the Stat Lab Services list will be reimbursed on a fee-for-service basis if performed in the physician’s office for HMO Blue Texas members. **Note:** All other lab services/tests performed in the physician’s office will not be reimbursed. The revised STAT Lab Services list will be effective July 1, 2004 and can be accessed at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) (see General Reimbursement section). The password for the General Reimbursement section is “manual.”

Austin	Chambers	Fannin	Harris	Kaufman	Montgomery	San Jacinto	Washington
Atascosa	Collin	Fort Bend	Hood	Lavaca	Nueces	Somervell	Wharton
Bell	Colorado	Galveston	Houston	Leon	Orange	Tarrant	Wilson
Bexar	Comal	Gonzales	Hunt	Madison	Parker	Trinity	Wise
Brazoria	Cooke	Grayson	Jackson	Matagorda	Polk	Victoria	
Brazos	Dallas	Grimes	Jefferson	McLennan	Robertson	Walker	
Calhoun	Denton	Guadalupe	Jim Wells	Medina	Rockwall	Waller	
	Ellis	Hardin	Johnson	Montague			

**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.

## Quality Improvement Program Available to All HMO Members

HMO Blue Texas has a Quality Improvement Program to better serve you and our members. The program focuses on chronic illnesses, preventive health, behavioral health, and health service delivery.

Member care and service are evaluated on a regular basis to determine whether members are receiving appropriate care and service and are satisfied with the health plan. Quality Improvement initiatives include satisfaction surveys, disease management programs, and wellness programs. As part of the program, birthday cards and targeted mailings are distributed and outbound calls are conducted to encourage preventive services such as immunizations, breast and cervical cancer screenings.

Information regarding the Quality Improvement Program is available in the HMO Blue Texas Provider Manual. This manual is available online at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) under Provider Library. The password is “manual.” To receive a written summary of the Quality Improvement Program, which includes outcomes, please call the Quality Improvement Programs Department 1-800-863-9798.

## New Disease Management Programs Announced

HMO Blue Texas offers wellness and disease management programs for:

- Expectant mothers (Special Beginnings®)
- Members with asthma, diabetes, congestive heart failure, AIDS/HIV, Hepatitis C, Postpartum Depression, ESRD, transplants and neonatal intensive care. The programs provide educational materials and support that may help your members better understand and manage their condition. Members will receive individualized educational information based on their specific health needs. The disease management programs supplement your direction.

A new program was implemented on January 1, 2004, called the HMO Blue Texas Coronary Artery Disease (CAD) Management Program and is being conducted in collaboration with our vendor, QMed, Inc. The program is designed to promote coronary wellness, decrease the risk for myocardial infarction, and reduce readmissions for heart failure. This program also serves to improve clinical outcomes and enhance the relationship between you and your patient. The program is designed to:

- Identify patients who may be at risk for coronary artery disease
- Help patients with cardiovascular disease and heart failure to take an active role in their own daily monitoring and self-care
- Support physicians in managing quality and costs for these patients
- Improve quality of care as reflected by process measures and clinical outcomes
- Enhance coordination of patient care by linking the physician and the health plan

The enrollment process is initiated when a QMed account representative contacts you or your office staff and provides a listing of potential member candidates as well as information about the program. Based upon your feedback, your patient will be mailed informational materials about program enrollment and also receive a telephone call.

As an HMO Blue Texas member, your patient may be eligible to participate in an applicable program at no cost. Enrollment is voluntary. We advise members to contact your office or HMO Blue Texas if they are interested in enrolling in one of these programs. The toll free telephone number for HMO Blue Texas is 1-800-462-3275.

## HMO Recoupment Draws from PPO Accounts

Effective April 19, 2004, Blue Cross and Blue Shield of Texas (BCBSTX) began utilizing one recoupment platform for both the PPO and HMO products. To avoid the offset of claims payments when an overpayment request is received, please be sure to promptly refund the overpayment or contact us at the number listed below. When you choose to refund the overpayment directly, please be sure to use the remittance form and postage paid envelope **which are included with the refund request letter**. It is essential for you to provide us with the patient's BCBS group and member number in order for us to identify the overpayment.

When the money is recouped from your account, you will receive a Provider Claim Summary (PCS) showing the recouped line with the HMO member/overpayment information.

An HMO claim adjustment will generate an Explanation of Payments (EOP) within an EOP message stating **“previously you were notified that an overpayment was identified; this transaction reflects a recoupment. Please see PCS for recoupment amounts. If you have questions regarding this transaction, please call 1-866-825-6012.”** This transaction will be for informational purposes only. You will need to reference your PCS for the recoupment information.

If you were in a recoupment status before April 19, 2004, there is a possibility you may still receive an Explanation of Recoupments (ERP) because of the refund(s) that were requested prior to implementation of the new process. Your office has been previously notified of this new process in the form of a check stuffer. Please reference the BCBSTX Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) for additional information and sample copies of the PCS/EOP with recoupment transactions. See the General Reimbursement section, password is “manual.”

## We've Been Listening . . . Update!

Thank you for your suggestions regarding our BlueChoice automated voice response unit (VRU). A dedicated team has been created to track and trend issues for the provider options in our VRU in order to make this a more valuable self-service option for your office.

As a result of your feedback and this team's efforts, several enhancements to the VRU (excluding FEP, HealthSelect, and Texas Health Insurance Risk Pool) have been implemented to-date.

- **Added ability** to obtain BlueCard (out-of-state) claim status information.
- **Availability to enter a member's** social security number in lieu of the new unique identification (UID) member number for benefit determination inquiries. Although we prefer you to enter the member's UID, our system will cross-reference from the social security number to the appropriate UID member number to obtain the requested information.
- **Offering more detailed information** within the benefit categories including copays, out-of-pockets, lifetime maximums, laboratory and x-rays.
- **Added a new feature** which gives an automated confirmation number (with a repeat option) for claim status, eligibility/benefits, and out-of-pocket accum inquiries. This confirmation number quoted by the VRU is the same as that which would be quoted by a Customer Service Representative. The number and the information provided during the call is permanently recorded in our customer service tracking system for reference.
- **Created an additional option** to obtain individual deductible and out-of-pocket information separate from benefit inquiry.
- **Eliminated the quoting** of our referral disclaimer message for inquiries involving PPO policies.
- **Created an option** to obtain our claims and correspondence mailing address only.
- **When requesting** claim status, additional time has been allocated for entry of the six-digit provider number.

We are continually looking for ways to improve the service provided to you by our VRU. Currently, we are working to make available more benefit options such as preventative and outpatient diagnostics, and to permit multiple benefit inquiries for the same member during one call.

We welcome any suggestions you may have to help us make our provider VRU a valuable resource to service your office. Please forward your suggestions to [PASS\\_Team@bcbstx.com](mailto:PASS_Team@bcbstx.com).



## BlueChoice Solutions

By now, you have received your eligibility letter for the BlueChoice® Solutions network. The new network has been developed to meet the demands faced by employer groups to provide affordable health care options to their employees. For additional information about BlueChoice Solutions, please visit the Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider), click on "There's a New Network — Learn More About BlueChoice Solutions".



## LabCorp is Preferred Outpatient Clinical Reference Lab Provider

Effective September 1, 2003, Laboratory Corporation of America (LabCorp) is 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

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### A Provider Publication