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Anesthesia Payment and Billing Information

Blue Cross and Blue Shield of Texas (BCBSTX) has updated the "Anesthesia Payment & Billing Information" section on the Web site. The updated information can be found at <http://www.bcbstx.com/provider> under the section titled "General Reimbursement Information ...and more..." (password: manual). Payment calculation information was added to clarify each component of an anesthesia procedure billed using the time and points methodology.

We appreciate your continued support of and participation in HMO Blue[®] Texas and BCBSTX. If you have any questions, please contact your Professional Provider Network Representative.

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Blue Review

Working Together to Halt Health Care Fraud

Combating health care fraud is a high priority for BCBSTX and your help is needed now more than ever. Law enforcement estimates that between \$51 billion and \$170 billion of the \$1.7 trillion* spent nationwide on health care in 2003 was attributed to health care fraud. Trying to control costs while absorbing the substantial losses due to health care fraud has been a daunting task for government and private insurance plans. As a result, health care costs in the United States continue to rise at an alarming rate and the percentage of Americans who are underinsured or uninsured is growing. What can be done to control health care fraud? Here are some ways that we can work together to help.

What BCBSTX is Doing

BCBSTX created a Special Investigations Department (SID) to identify and investigate health care fraud and the results have been tremendous. BCBSTX believes that the best deterrent to health care fraud is the civil and criminal prosecution of those who participate in the fraud. Law enforcement continues to accept SID's cases for criminal prosecution under state and federal statutes that bring severe fines and lengthy prison terms. SID has developed creative ways to detect health care fraud, including a pharmacy fraud program that has already identified hundreds of members and providers who obtained or prescribed controlled substances for illicit purposes. The SID's staff is comprised of intelligence analysts, insurance experts and former federal law enforcement agents who work together to identify and investigate health care fraud.

What You Can Do

Despite the SID's success, BCBSTX cannot solve the problem of health care fraud on its own. The provider community must be an active, willing and responsible participant in the effort to reduce costs and identify health care fraud. Working together, we can provide quality services or products to our customers while doing our best to ensure their safety. Recent cases, like the California Rent-A-Patient scheme, have shown that patients are often put at a substantial risk of harm when health care fraud is involved. Those in the provider community who do not participate in fraudulent activities must be willing to report those who do. To enable you and your staff to do this, BCBSTX has established a toll-free Fraud Hotline (877-272-9741) that operates 24 hours a day, seven days a week. All calls are confidential and you can report your suspicions of fraud on an anonymous basis, if necessary. For more information about health care fraud, go to www.bcbstx.com/sid.

* 2005 National Health Care Anti-Fraud Association



Professional Claims Processing Enhancements Update

Below are highlights of claims processing enhancements with their effective date since our notice last quarter. 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 |
|---------------------------|------------------------|--------------------------------|----------------------------|------------------------|
| 38572 | 55866 | Removed | 05/23/05 | 05/23/05 |
| 64445 | 27096 | Removed | 05/23/05 | 05/23/05 |
| 75625 | 75716 | Removed | 05/23/05 | 05/23/05 |
| 76000 | 00090T – 00098T | Added | 05/23/05 | 05/23/05 |
| 76005 | 62362, 62365 | Removed | 05/23/05 | 05/23/05 |
| 76872 | 76942 | Removed | 05/23/05 | 05/23/05 |
| 96410 | 96414 | Removed | 05/23/05 | 05/23/05 |
| 96412 | 96414 | Removed | 05/23/05 | 05/23/05 |
| 96414 | 96412 | Removed | 05/23/05 | 05/23/05 |
| 22851, 49010 | 0090T – 0098T | Added | 05/23/05 | 05/23/05 |
| 35606 | 35691 | Removed | 06/29/05 | 06/29/05 |
| 76003 | 64405, 69650 | Removed | 06/29/05 | 06/29/05 |
| 90780 | 36416 | Removed | 06/29/05 | 06/29/05 |
| S9325-S9803 | 99601, 99602 | Removed | 06/29/05 | 06/29/05 |
| 21040 | 21025 | Removed | 08/08/05 | 08/08/05 |
| 21465 | 21462 | Removed | 08/08/05 | 08/08/05 |
| 23405 | Assistant Surgeon | Removed Assistant Surgeon Edit | 08/08/05 | 08/08/05 |
| 27130 | Assistant Surgeon | Removed Assistant Surgeon Edit | 08/08/05 | 08/08/05 |
| 27332 | 29879 | Removed | 08/08/05 | 08/08/05 |
| 29826 | Assistant Surgeon | Removed Assistant Surgeon Edit | 08/08/05 | 08/08/05 |
| 33244 | 33224 | Removed | 08/08/05 | 08/08/05 |
| 33617 | 33870 | Removed | 08/08/05 | 08/08/05 |
| 44970 | 59426 | Removed | 08/08/05 | 08/08/05 |
| 45505 | 45540 | Removed | 08/08/05 | 08/08/05 |
| 46946 | 46700 | Removed | 08/08/05 | 08/08/05 |
| 50395 | 50551 | Removed | 08/08/05 | 08/08/05 |
| 51040 | 51900 | Removed | 08/08/05 | 08/08/05 |
| 57268 | 57250 | Removed | 08/08/05 | 08/08/05 |
| 57500 | 58670 | Removed | 08/08/05 | 08/08/05 |
| 57511 | 58563 | Removed | 08/08/05 | 08/08/05 |
| 58120 | 59426 | Removed | 08/08/05 | 08/08/05 |
| 61700 | 61698 | Removed | 08/08/05 | 08/08/05 |
| 62005 | 61312 | Removed | 08/08/05 | 08/08/05 |
| 67255 | 66180 | Removed | 08/08/05 | 08/08/05 |
| 67917 | 67912 | Removed | 08/08/05 | 08/08/05 |
| 76005 | 62350 | Removed | 08/08/05 | 08/08/05 |
| 76856, 76857 | 93975, 93976 | Removed | 08/08/05 | 08/08/05 |
| 94725 | 94720 | Removed | 08/08/05 | 08/08/05 |
| 94720 | 94725 | Added | 08/08/05 | 08/08/05 |
| 94640 | 94060 | Removed | 08/08/05 | 08/08/05 |
| L3650 | L3660 | Removed | 08/08/05 | 08/08/05 |
| Q0091 | 88142 – 88167 | Removed | 08/08/05 | 08/08/05 |
| S0820 | 92002 – 92014 | Removed | 08/08/05 | 08/08/05 |

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.



New Info Online for NPI and Legacy Identifiers

The Workgroup for Electronic Data Interchange (WEDI) has published a document that provides education and awareness on the dual use of National Provider ID (NPI) and Legacy identifiers in HIPAA X12 standard transactions. To review the document, log on to the WEDI Web site at:

http://www.wedi.org/cmsUploads/pdfUpload/WhitePaper/pub/WEDISNIPNPIDualIdentifiers_FINAL.pdf

THIN/HCSC encourages you to read and learn more about NPI. You can obtain helpful information about NPI from the Center for Medicare and Medicaid Services by calling the HIPAA Hotline toll-free at 1-866-282-0659 or e-mailing AskHIPAA@cms.hhs.gov.

Reminder to Use In-network Facilities and Providers

BCBSTX understands that you have sole responsibility for and authority over your professional practice when it comes to the care of your patients. However, please remember that your participating provider agreement requires that you utilize participating in-network facilities and providers. Use of non-participating facilities and providers could result in the termination of your participation in the BCBSTX PPO/POS network. If you have any questions regarding in-network facilities or providers in your area, you may visit our Web site at www.bcbstx.com or contact your local Professional Provider Network Representative.

Log On and Learn about BlueCard®

General information about the BlueCard program is now available by logging on to the BCBSTX Provider Web site. Set your browser to the Provider Library section at www.bcbstx.com/provider to access helpful information about the program.

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.

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 Blue Cross and Blue Shield of Texas 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".





Benefit Reminder for Orthotic and Prosthetic Services

Not all group contacts cover orthotics and prosthetics. To receive the correct benefit quote, please be sure to request orthotic or prosthetic benefits when providing those services.

In general, DME, orthotic and prosthetic services are clearly defined in the current HCPCS code ranges listed below:

| Service | HCPCS Code Range |
|---------------------------|------------------|
| Durable Medical Equipment | E0100 – E9999 |
| Orthotics | L0000 – L4999 |
| Prosthetics | L5000 – L9999 |

It's also important to remember that certain services may be assigned a temporary "K", "S", or "V" code. In addition, certain services may have a corresponding CPT code (e.g., 92393 – supply of ocular prosthesis). Refer to your current *HCPCS/CPT Manual* for the most up-to-date information on these services.

Claims are processed subject to the terms and provisions of the patient's policy. Receiving accurate benefit quotes is subject to ensuring the correct benefit is requested.

Include Billing Provider Number to Expedite Claims

BCBSTX and HMO Blue® Texas are committed to providing prompt payment of claims. To help us process your claims accurately, please be sure to include the physician's or provider's billing provider number. The billing provider number is a clean claim element under Texas prompt pay laws and regulations.

Effective Nov. 15, 2005, we will return paper claims that do not have the billing provider number listed correctly in the appropriate block on the claim form. To avoid delays, please list your billing provider number in block 33 on the CMS 1500 claim form or in form locator 51 on the UB 92 claim form.



Crossover Process Saves Time and Money Medicare Part B: Submit Supplemental Claims Electronically

The BCBSTX Defensive Strategy Medicare Part B Team recently 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 B will have their supplemental claims automatically generated via the crossover process. When Medicare releases its payment for Part B claims, these claims will then cross over to BCBSTX/Health Care Service Corporation 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, in some cases when patients have not updated their BCBSTX membership information, the claims will not automatically cross over. BCBSTX is now offering an electronic alternative to obtain that supplemental payment when Blue Shield (professional) claims do not cross over.

Use the timeline below 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.) Procedures for Medicare Part A crossovers will follow in a future newsletter.

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

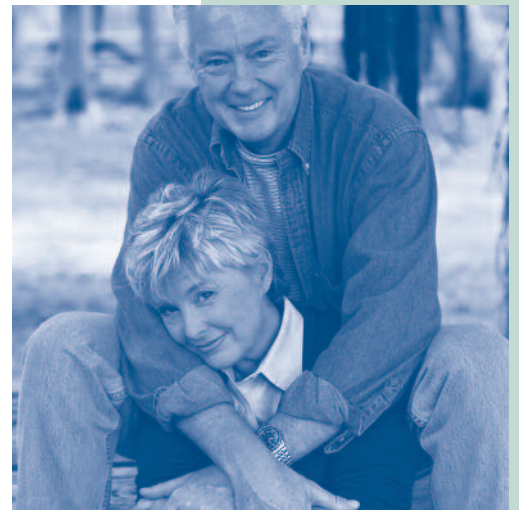
Day 1 - Receive payment and Explanation of Medicare Benefits (EOMB) from Medicare indicating the claim has been forwarded to BCBSTX for supplemental payment.

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

Day 20 - If no payment or denial indicated on the PCS is received, file the supplemental portion electronically to BCBSTX using the guidelines on the Web site at www.bcbstx.com/provider.

Notes:

- 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. Where claims do not cross over for patients or do so inconsistently, please advise them to provide BCBSTX with their HICN# by contacting Customer Service at the toll-free number on the back of their BCBSTX identification card.



Web Info: Go to www.bcbstx.com/provider for the Medicare Part B Guidelines and EDI Requirements.

Two New Pharmacy Management Programs On the Way

Effective Jan. 1, 2006, the HMO Blue Texas Pharmacy Department will launch two new clinical programs that will complement existing medical policy. BCBSTX remains very selective when choosing appropriate pharmacy management programs and the new programs, Growth Hormone Prior Authorization and TNF-Blocker Step Therapy, will be the first standard programs incorporated into our fully-insured business.

After Oct. 1, 2005, you can access clinical authorization criteria and relevant program information by logging on to our Web site at www.bcbstx.com and selecting "Providers" and "Pharmacy." You can also get additional information about either program by calling Prime Therapeutics at 1-800-821-7423. In addition, physician specialties focusing on growth hormone deficiencies or chronic inflammatory disease can refer to BCBSTX Medical Policies RX501.040 (Growth Hormone) and RX501.051 (TNF Alpha Inhibitors for Treatment of RA and other Chronic Inflammatory Diseases).

Growth Hormone Prior Authorization Program

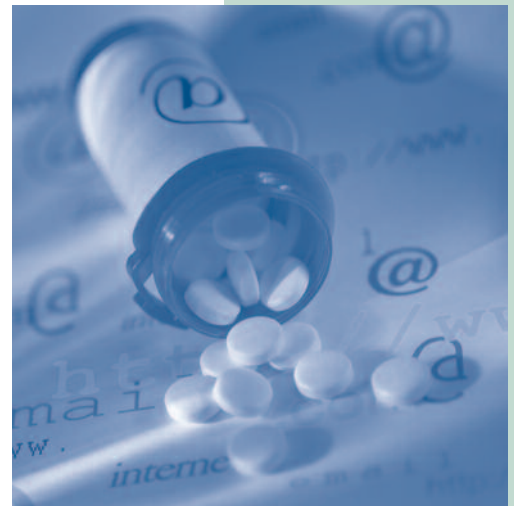
The program will require review and approval according to established clinical criteria of all new and current prescriptions for growth hormones (e.g. Genotropin, Humatrope, Norditropin, Nutropin/AQ, Saizen, Serostim). Patients currently receiving a prescription for growth hormone will be notified in October by mail and advised to contact their physician. **Physicians may begin proactive submission of authorization forms beginning Dec. 1, 2005.**

TNF-Blocker Step Therapy Program

This program was designed to encourage appropriate use of first-line therapy before authorizing new prescriptions for TNF-Blockers (e.g. Enbrel, Humira, Kineret). Patients currently treated with a TNF-blocker will be approved or "grandfathered" for continued therapy. HMO Blue Texas members with prescription claims history already on file will be **automatically approved** at the pharmacy if they are eligible for grandfathering or have previously tried first-line therapy. New or current HMO Blue Texas members who have no record of receiving first-line therapy will need their physician to submit the necessary authorization form for consideration.

HMO Blue Texas welcomes your comments and suggestions for improving our clinical programs. Please direct your feedback to:

HMO Blue Texas
Clinical Pharmacy Programs
Pharmacy Department
P.O. Box 660201
Dallas, TX 75266-0201



HMO Blue Texas Claims Filing and 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. You can help us avoid delays in claims payment 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. Paper claims that should have been sent to an IPA or medical group, but were incorrectly submitted to HMO Blue Texas, will be rejected and you will receive notice to re-file it with the appropriate IPA or medical group. Claims submitted electronically to HMO Blue Texas via THIN that should be sent to an IPA or medical group will be forwarded to the appropriate IPA or medical group on your behalf. We will notify you via the rEDI-link Blue response file that the claim was forwarded and provide you with 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, please refer to the member's HMO Blue Texas identification card to obtain the physician organization (POrg) code. You may refer to the table below for the claims filing address, and the claims and Utilization Management (UM) phone numbers for the capitated IPAs and medical groups in your area. **Please note it is important that you have a copy of the member's most current identification card.**

| Physician Organization Code (POrg) | Capitated IPA/Medical Group Name | IPA/Medical Group Claims Filing Address | IPA/Medical Group Claims Inquiry/UM Phone Numbers |
|------------------------------------|-------------------------------------|---|--|
| KELS | Kelsey-Seybold Clinic | Kelsey-Seybold Clinic Claims Administration P.O. Box 300368 Houston, TX 77230 | Claims: 713-442-5440 UM: 713-442-5339 |
| PFHC | People 1st Healthcare Network, Inc. | Global Healthcare Alliance People 1st Claims 2 Greenway Plaza, Suite 300 Houston, TX 77046 | Claims: 713-759-0154 UM (HMO Blue Texas): 1-800-441-9188 |
| RNPO | Renaissance Physician Organization | Renaissance Physician Organization P.O. Box 922001 Houston, TX 77292-2001 | Claims: 832-553-3333 UM: 832-553-3300 |

continued on next page

If the POrg code that appears on the member's identification card appears in the table on page 8, you should file claims for physician, other professional services and outpatient diagnostic testing services with the IPA or medical group. If the POrg code that appears on the member's identification card does not appear in the table or if the claim is not for the services stated above, you will need to file the claim with HMO Blue Texas and send it to:

**HMO Blue Texas
P.O. Box 660044
Dallas, TX 75266-0044**

1-877-299-2377 for claims questions

For questions about which services should be filed with the capitated IPA or medical group and which services should be filed with HMO Blue Texas, please call your professional provider network office.

Behavioral Health HMO Claims Filing

Behavioral health claims filed by behavioral health providers should be mailed to:

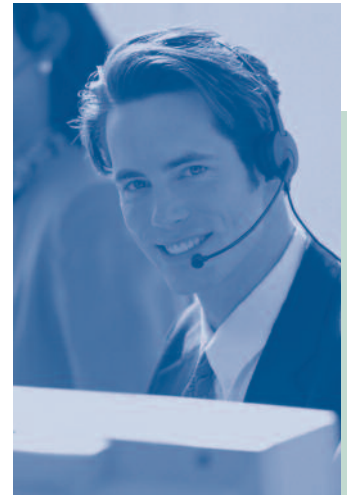
**Magellan Health Services
Attention: Claims
P.O. Box 1659
Maryland Heights, MO 63043**

1-800-729-2422 for claims questions

Behavioral health claims filed by the member's PCP or physician (other than a behavioral health provider) should be mailed to:

**HMO Blue Texas
P.O. Box 660044
Dallas, TX 75266-0044**

1-877-299-2377 for claims questions



Bundling Logic Disclosure Statement

BCBSTX will be upgrading to McKesson ClaimCheck Version 35 effective on or after Dec. 14, 2005 for PPO/POS and Par Plan/Traditional lines of business. HMO Blue Texas will not be updated to McKesson ClaimCheck Version 35 until after the first quarter of 2006. The claim processing system for the HMO product will be consolidated in 2006 to the same system used for PPO/POS and Par Plan/Traditional lines of business.

This system consolidation will allow for improved efficiency in processing claims and responding to inquiries. In addition, it will allow us to provide one consolidated Provider Claim Summary (PCS) for all lines of business. 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.

TRS-ActiveCare plan changes in effect on September 1

The Teacher Retirement System of Texas (TRS) has announced minor changes to the three TRS-ActiveCare PPO plans administered by Blue Cross and Blue Shield of Texas effective September 1, 2005:

Following are the upcoming changes to the plans:

| ActiveCare 1 | ActiveCare 2 | ActiveCare 3 |
|--|--|---|
| <ul style="list-style-type: none"> No copay for preventive care services up to the first \$500 per plan year; remaining charges subject to deductible and coinsurance | <ul style="list-style-type: none"> Patient pays \$25 primary/\$35 specialist copay for all preventive care services billed with an office visit by a network doctor (<i>\$500 limitation removed</i>) \$50 deductible per participant per plan year for prescription drugs | <ul style="list-style-type: none"> Plan pays 80 percent; patient pays 20 percent network coinsurance Plan pays 60 percent; patient pays 40 percent non-network coinsurance Patient pays 20 percent network/40 percent non-network plus \$100 per day inpatient hospital copay (\$500 maximum copay per admission; \$1,500 maximum copay per person per plan year) Patient pays 20 percent network/40 percent non-network plus \$100 copay per visit for outpatient surgery in a hospital/facility Patient pays 20 percent after \$100 emergency room copay (<i>copay waived if admitted</i>) \$50 deductible per participant per plan year for prescription drugs |

See the *TRS-ActiveCare Quick Reference Guide* inserted into the middle of this publication. This guide provides details on TRS-ActiveCare coverage and sample ID cards. All plans include prescription drug benefits (administered by Medco Health Solutions, Inc. “Medco”) and behavioral health benefits (provided by INROADS Behavioral Health Services of Texas, L.P., a Magellan Behavioral Health Company).

As one of the largest public health care programs in the state, participation in TRS-ActiveCare continues to grow. Currently, there are more than 1,046 districts/entities with nearly a quarter of a million covered employees and family members. More information on TRS-ActiveCare, including information on new participating districts, will be featured in future editions of *Blue Review*.

BlueChoice® Radiology Quality Initiative Introduced Statewide

Blue Cross and Blue Shield of Texas (BCBSTX) recently contracted with American Imaging Management, Inc. (AIM) to implement a new Radiology Quality Initiative (RQI) for outpatient diagnostic imaging services. The initiative for BlueChoice PPO/POS and BlueChoice Solutions members is statewide.

BlueChoice PPO/POS and BlueChoice Solutions members who meet **all three** of the following qualifications **must have** an RQI number prior to scheduling outpatient, diagnostic high technology imaging services (CTs, MRI/MRAs, PETs or nuclear cardiology studies):

- Members who reside in Texas
- Members whose benefits are written or administered by BCBSTX
- Members who carry a BlueChoice PPO/POS or BlueChoice Solutions member identification card

An RQI number is **not** required in the following circumstances:

- Members who reside **outside** of the state of Texas
- Members whose benefits are written or administered by a Blue Cross plan **other than** BCBSTX (Please refer to the back of the member's identification card to find the member's Blue Cross plan.)
- Members whose **primary** insurance is Medicare

Effective for dates of service on or after Oct. 1, 2004, compliance with the RQI will be required for certain outpatient diagnostic imaging services performed in a physician's office, the outpatient department of a hospital or a freestanding imaging center. These services include the following:

- CT
- MRI
- MRA
- Nuclear cardiology studies
- PET scans

Physicians must contact AIM to obtain an RQI number prior to ordering any of the above studies. Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospital and freestanding surgery centers) or 23-hour observation will be excluded from this requirement.



The Results Are in For Fall BlueChoice® Solutions Evaluations

We recently completed the 2005 Fall evaluations for the BlueChoice Solutions physician and professional provider network. In October, physicians and professional providers will receive a notification letter regarding their participation status in the BlueChoice Solutions network. If you are interested in obtaining a copy of your Fall 2005 Provider Summary, please contact your local professional provider network office.

Par Plan Participation Open to All Physicians and Professional Providers

Now is a great time for physicians and professional providers to submit applications for participation in the Par Plan program. BCBSTX Network Management is currently processing applications for the program, which offers convenient, cost-effective medical services to members of BCBSTX health plans. We developed the program in response to employers' concerns about health care costs by making those costs more predictable and providing more convenient payment options for their employees. Par Plan offers many advantages for providers and members, as well as for employers providing coverage through BCBSTX. As a Par Plan provider:

- You agree to file claims on behalf of the member
- BCBSTX reimburses you for claims you file for covered benefits
- You accept BCBSTX allowable amounts and don't balance bill the member
- Your reimbursement for professional services is fee-for-service

If you have additional questions or are interested in participating in the Par Plan program, please contact your Professional Network Representative or local area Network Management office. You can find a listing of the professional provider network offices under "Contact Us" at www.bcbstx.com/provider.



Blue Review Published quarterly for BlueChoice®, Par Plan and HMO Blue® Texas contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome.

Please mail to: Corporate Communications, **Blue Review** Editor, Blue Cross and Blue Shield of Texas, P.O. Box 655730, Dallas, Texas 75265-5730.

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HealthSelectSM administered by Blue Cross and Blue Shield of Texas

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.

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BlueCross BlueShield of Texas

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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