



## Issue 3, 2009

### Special coverage for H1N1 vaccine

With the impending delivery of the new vaccine for the A H1N1 flu virus, Blue Cross and Blue Shield of Texas (BCBSTX) wants to make our network physicians aware of our policy concerning coverage of charges for administering the vaccine to BCBSTX members.

Some members' health plan medical benefits may not cover vaccination charges. BCBSTX has implemented a policy to cover the administration of the vaccine for members of our fully insured health plans without regard to whether their current plan covers vaccinations. We will cover this service without applying the benefit payment to their deductible or coinsurance.

We will also work proactively with all of the employers we work with who have self-funded employer health benefit plans, recommending that they adjust their benefit coverage to also cover administration of the vaccine.

In order to benefit from this special coverage, a member must receive the vaccination from a BCBSTX network provider. When using a provider that is not in the BCBSTX network, normal benefits coverage will apply.

Coverage will be available for those five priority populations that the Centers for Disease Control and Prevention (CDC) recommends receive the vaccine first:

- Pregnant women.
- People who live with or care for children younger than 6 months of age.
- Health care and emergency medical services personnel.
- Persons between the ages of 6 months through 24 years.
- People age 25 through 64 who have chronic health disorders or compromised immune systems.

Please use the following codes for the H1N1 vaccine:

- **90663** — Influenza virus vaccine, pandemic formulation, H1N1
- **90470** — H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

Because the vaccine is being supplied by the federal government at no charge, BCBSTX will allow \$.01 for CPT code 90663. A claim for the vaccine (90663) is required in order to process the claim for administration (90470).

### **BCBSTX offers replacement coverage to UniCare members**

#### **UniCare set to exit Texas commercial health insurance market; Blue Cross Blue Shield of Texas (BCBSTX) offering guaranteed coverage to all members affected**

UniCare announced Oct. 27 that it will no longer be providing group or individual health insurance policies in Texas beginning in 2010. As part of their exit plan from the commercial market, UniCare has collaborated with Blue Cross and Blue Shield of Texas (BCBSTX) to ensure UniCare customers are provided the best opportunity to continue health insurance on a guaranteed basis.

Under the agreement with UniCare, BCBSTX has closely mapped our products to UniCare's products so that we are able to offer policyholders similar benefits in most cases. We are also offering guaranteed acceptance with no lapse in coverage. The guarantee means no members lose their coverage due to pre-existing conditions.

The deadline for current UniCare clients to accept the BCBSTX offer is Dec. 1, 2009. The new BCBSTX coverage begins Jan. 1, 2010. Members will be sent new BCBSTX ID cards by Jan. 1.

If UniCare policyholders don't accept our offer, they can keep their UniCare policy to the end of their contract in accordance with its terms.

Although UniCare will no longer offer commercial health insurance in Texas, they will continue to carry Medicare, Medicaid, senior products, MHealth (Memorial Hermann Health Plan) and the Group Insurance Commission (GIC) of Massachusetts. They will also continue to carry standalone specialty products (dental, vision, life/AD&D).

### **More than health care, Seasons of Life program is health caring**

As surely as each season closes, someday the active practice of every physician comes to an end. Whether planned (as in retirement) or suddenly (with a life-threatening illness or unexpected death), Blue Cross and Blue Shield of Texas (BCBSTX) stands ready to help.

Seasons of Life for Physicians is a special pilot program offered through the Office of Physician Advocacy at BCBSTX, designed to assist physicians' office staffs and family representatives. Upon notification, BCBSTX will assign a highly trained customer service advocate to review outstanding claims and service issues. Once the initial review is complete, the advocate will advise the physician's staff and/or family representative that dedicated support is just a phone call away, until all BCBSTX claims and issues are resolved.

BCBSTX customer service advocates who are a part of the program receive additional training from a licensed clinical social worker who specializes in grief counseling. Staff and/or the family representative can call their advocate directly with any questions or concerns, typically without waiting on hold or re-explaining claims or issues each time they call.

Once all BCBSTX claims and issues are resolved, the physician's staff and/or family representative will receive a notification. As a courtesy to the physician and their families, the Office of Physician Advocacy will automatically notify the Texas Medical

Association, the Texas Osteopathic Medical Association and the local county medical society when that the physician is no longer practicing.

Seasons of Life for Physicians is another way BCBSTX is living out its commitment to promoting the well-being and peace of mind of Texas physicians, their staffs and families.

For more information about the Seasons of Life for Physicians program, or to request help, please call the BCBSTX Office of Physician Advocacy project coordinator at 972-766-8823 Monday through Friday from 8 a.m. to 4:30 p.m. Voicemail is available after hours, on weekends and holidays.

### **Paperless transactions are gaining popularity**

While promoting the benefits of environmentally friendly business practices, Blue Cross and Blue Shield of Texas (BCBSTX) has been encouraging providers to enroll in our Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS) programs. Since January 2009, we have seen a 204 percent increase in enrollments compared to total enrollments for 2008.

### **Join in the movement – go electronic**

Your colleagues are enjoying quicker access to their funds, lower security risks and easier retrieval of archived data. Do you want to take advantage of the same opportunities? Find out how by visiting the Electronic Commerce section of our website at [bcbstx.com/provider](http://bcbstx.com/provider), where you can access the enrollment forms and view answers to frequently asked questions about EFT, ERA and EPS.

### **Say goodbye to your paper provider claim summary**

One of the benefits of enrolling in the Electronic Remittance Advice (ERA) is that you automatically receive the Electronic Payment Summary (EPS). The EPS contains the same information as your paper provider claim summary (PCS). The advantage of going paperless is that you receive your payment information sooner, and it is also easier to archive.

- New ERA/EPS enrollees will continue to receive their paper PCS for 30 days after they start receiving their ERA and EPS files. This 30-day transition period is designed to help providers make a gradual switch from paper to electronic files. **When the transition period ends, the PCS will be discontinued and providers will receive only the ERA/EPS going forward.**
- If you enrolled in ERA/EPS directly or through your clearinghouse/billing agent more than a month ago, you may have continued to receive both the ERA/EPS and the PCS in your office for longer than 30 days. **Please be advised that your PCS will now be discontinued. Going forward, you will receive only the ERA/EPS.**

If you are not yet enrolled in ERA/EPS, or if you are interested in signing up for Electronic Funds Transfer (EFT), please visit the Electronic Commerce section of our Web site at [bcbstx.com/provider](http://bcbstx.com/provider) for access to the ERA enrollment form and EFT agreement. You will also find answers to frequently asked questions about EFT, ERA and EPS on our website. If you need additional assistance, please contact our Electronic Commerce Center at 800-746-4614.

### **Medicare Advantage mandatory provider FWA training**

Blue Cross and Blue Shield of Texas (BCBSTX) and Blue Medicare PPO are committed to complying with Centers for Medicare and Medicaid Services (CMS) requirements. To that end, we are committed to ensuring that our contracted providers remain in compliance.

On Dec. 5, 2007, CMS published "Revisions to the Medicare Advantage and Part D Prescription Drug Contract Determinations, Appeals, and Intermediate Sanctions Processes; Final Rule," which includes a requirement that Medicare Advantage plan sponsors provide all contracting providers (i.e., physician practices, facilities, DME providers, etc.) participating in a Medicare Advantage (Part C) network with fraud waste and abuse (FWA) training annually.

CMS specifies that participation in this training is mandatory for anyone in the provider's practice who may interact with a Medicare Part C beneficiary. BCBSTX will leave the decision as to who in the physician's practice will complete the training to the discretion of the physician or compliance officer. This rule became effective on Jan. 1, 2009. The training for 2009 must be completed by Dec. 31, 2009 in order for providers to remain active in the Blue Medicare PPO network in 2010.

This requirement grew out of an ongoing concern about the rising cost of health care combined with the overwhelming number of FWA cases involving the Medicare program and its beneficiaries. BCBSTX/Blue Medicare PPO strongly supports this requirement because we believe that it is the right thing to do.

To meet this requirement, BCBSTX/Blue Medicare PPO will make its FWA training program for providers online. No special software is required; however, you will need an active Internet connection. To access the training, go to the Medicare Advantage Mandatory Provider FWA Training website at [nmchili.org/2004/Conference04/ConfPlan.htm](http://nmchili.org/2004/Conference04/ConfPlan.htm). You will find an attestation at the end of the course. The training will take approximately 45-60 minutes to complete. Please be sure to turn on the sound on your computer, as the training is narrated.

If you have already completed the FWA training provided by another Medicare Advantage plan sponsor, you can use that training to satisfy this requirement. Just go to the Medicare Advantage Mandatory Provider FWA Training Web site. Scroll down and click on the Providers who have already taken another Plan's Part C and Part D training link; this will take you directly to the attestation page. You must identify the source of the training on this attestation.

Providers who do not have Internet access can request the hardcopy training/attestation by calling 713-354-7685 for providers in the Houston area or 915-496-6600 (select option 2) for providers in the El Paso area. These providers will be required to fax their attestations to Blue Medicare PPO to receive credit for meeting the training requirement. The fax number is on the attestation form.

We recognize that because CMS requires that each Medicare Advantage plan sponsor make FWA training available to its participating providers, you could be inundated with training requirement requests depending on the number of Part C networks in which you are participating. In order to reduce the training burden, BCBSTX/Blue Medicare

PPO does not require that you complete our FWA training course specifically. We will accept the following in lieu of our FWA course:

- Completion of a FWA training course offered by any other Medicare Advantage plan sponsor with whom you are contracted.
- Completion of a FWA training course on the Medicare Learning Network (MLN).
- Completion of a FWA training course offered by a hospital where you have admitting privileges.
- Completion of an in-house-developed FWA training course as long as it includes the following:
  - Information about the various laws and regulations related to FWA.
  - How to detect, prevent and correct FWA.
  - How and where to report potential FWA violations.
- Completion of a vendor-developed FWA training course as long as it includes the following:
  - Information about the various laws and regulations related to FWA.
  - How to detect, prevent and correct FWA.
  - How and where to report potential FWA violations.

Training must be completed between Jan. 1, 2009 and Dec. 31, 2009.

Upon completion of the training, BCBSTX/Blue Medicare PPO requires that the contracting physician or compliance officer complete our online certification attesting that all employees identified as requiring FWA training have completed it.

In addition, and in compliance with CMS regulations, the practice or entity will be required to maintain training logs and information regarding who completed the training, the date on which the training was completed, and information regarding the training program completed by each employee. These records must be maintained for a period of 10 years, which is the Medicare record retention period. These training records must also be made available to BCBSTX/Blue Medicare PPO as requested for audit purposes.

Thank you for your cooperation in complying with this important CMS requirement. If you have any questions, please contact your local professional provider network department at [bcbstx.com/provider/contact\\_us.htm](http://bcbstx.com/provider/contact_us.htm).

### **Coordination of benefits**

Members occasionally have two or more benefit policies. When they do, insurance carriers take this into consideration; this is known as coordination of benefits.

This article is meant to assist physicians, other professional providers and facilities in understanding the coordination of benefits clause from the contracting perspective.

Per Blue Cross and Blue Shield of Texas (BCBSTX) coordination of benefits contract language, physicians, other professional providers and facilities have agreed to accept the BCBSTX allowable amount (as defined by the contract) less any amount paid by the primary insurance carrier.

### **What does this mean for you?**

Once BCBSTX has processed the claim as the secondary carrier, the only patient share amount that may be collected from the member is the amount showing on the BCBSTX provider claim summary.

The primary carrier does not take into account the member's secondary coverage. This means that once the claim is processed as secondary by BCBSTX, any patient share amount shown as owed on the primary carrier's explanation of benefits is no longer collectible.

If you would like additional information and/or education regarding coordination of benefits and this article, please see our Provider website at [bcbstx.com/provider/index.htm](http://bcbstx.com/provider/index.htm) and click Request Training in Your Area.

If you have questions regarding a specific claim, please contact Provider Customer Service at 800-451-0287 to speak with a customer advocate.

### **BlueEdge product portfolio**

Blue Cross and Blue Shield of Texas (BCBSTX) offers our BlueEdge product portfolio for employers and subscribers looking for consumer-driven health plans. The BlueEdge product portfolio includes the Health Care Account (HCA) product, the Health Savings Account (HSA) product and the BlueEdge Direct HCA product.

### **BlueEdge Direct**

BlueEdge Direct HCA plans are available with the BlueChoice and BlueChoice Solutions networks. With BlueEdge Direct, the member is required to pay a portion of the cost before accessing the HCA funds given by the employer.

This differs from BlueEdge HCA, which is funded by the employer plan first; the member is responsible for the remaining balance. With both products, BCBSTX accesses the HCA funds, when available, to coordinate claims processing on your behalf.

In the case of PPO-eligible expenses, submit your claims to BCBSTX. The member will be responsible for paying you for non-eligible expenses.

To ensure accurate and quick processing of BlueEdge and BlueEdge Direct member claims:

1. Ask the member to show their BlueEdge ID card. This card will list "BlueEdge" or "BlueEdge Direct" in the lower right corner of the ID card.
2. Call the toll-free provider customer service number to verify benefits and eligibility.
3. Submit all claims to BCBSTX.
4. With BlueEdge and BlueEdge Direct, you do not need to collect copayments or deductible amounts from the member at the time of service. You will be reimbursed from the member's account.
5. BCBSTX will notify you of any remaining patient responsibility through the provider claim summary (PCS).
6. After receiving the PCS, you can bill the member directly for any deductible and coinsurance amount owed.

Both BlueEdge HCA and BlueEdge Direct HCA provide preventive care covered at 100 percent even before the deductible is met. There are no deductibles or office visit copayments for the following preventive/wellness services:

- Physicals
- Routine labs and X-rays
- Diagnostic tests
- Mammograms
- Well child care and immunizations

### **Life Time Fitness**

If your patients are looking for the advantages of fitness from a full-service health club, Blue Cross and Blue Shield of Texas (BCBSTX) encourages you to let them know about a new BlueExtras<sup>SM\*</sup> program benefit with Life Time Fitness.

As of July 1, 2009, Life Time Fitness introduced an exclusive offer to new members with coverage under a BCBSTX health care plan.

BCBSTX members who are new to Life Time Fitness:

- Will receive a free RiskPoint Health Screening at Life Time Fitness.\*\*
- Can join for a \$0 enrollment fee. An administrative fee applies to new memberships.

Applicants for this Life Time Fitness program will be asked to show their active BCBSTX ID card as proof of BCBSTX membership.

Through the BlueExtras program, members are eligible to save money on health care products and services that help support healthy lifestyles. There are no claims to file, no referrals and no pre-authorizations. Members can also use discounts for complementary alternative medicine services, weight management programs, and vision and hearing exams and products.

For more information on the BlueExtras discount program, members should visit [Blue Access<sup>®</sup> for Members](#) at [bcbstx.com](http://bcbstx.com). Members will find a link to the Life Time Fitness Web site to check locations.

*\* The relationship between BCBSTX and Lifetime Fitness is that of independent contractors.*

*\*\* The offer for a free RiskPoint Health Screening is for a limited time only. Life Time Fitness and BCBSTX may alternate the health screening with another value-added service, i.e., personal training, after 90 days. Check with Life Time Fitness for the current promotional offer.*

### **Blue Care Connection<sup>®</sup> program for tobacco cessation**

The American Heart Association reports that an estimated 23.5 percent of men and 18.1 percent of women are smokers. As a leading cause of lung cancer, chronic obstructive pulmonary disease and strokes, smoking is the most preventable cause of premature death in the United States. Smoking is also cited as a major contributing factor for coronary artery disease, hypertension, atherosclerosis and high cholesterol.

The Lifestyle Management staff within the Blue Care Connection program can assist members who have decided to stop smoking. Wellness coaches — who are licensed

professional counselors or licensed masters of social work — empower members with the knowledge, confidence and encouragement to stop smoking and successfully manage continued cessation.

Coaches help members set a quit date, identify the advantages of quitting, discuss alternate behaviors to help avoid relapse, and provide educational and online resources. If necessary, coaches also encourage members to consult with their physician for prescription medications specifically for smoking cessation.

To refer a member to the Blue Care Connection program for smoking cessation, have them call 866-412-8795 to speak to a wellness coach.

### **Weight loss and stop smoking wellness tools for individual members**

These targeted online tools, which are part of the Lifestyle Management program, are now available to members with health care benefit plans in individual markets who want to stop smoking or better manage their weight.

Focused on enabling members to take a more active role in improving their overall health and well-being, these two new online wellness tools give specific educational information on smoking cessation and weight management. The new Weight Loss and Stop Smoking icons appear in the For Your Health section of the member's Personal Health Manager home page. After the member clicks on the icon to see a description of the smoking cessation or weight management program, he or she can then click yes to enroll.

For members who want to quit smoking, the smoking cessation program incorporates not only basic stop smoking information, but also targeted guidance in response to self-reported assessments that are offered within the program. This program emphasizes understanding the barriers to quitting smoking, provides support and motivation, and addresses treatment options.

For members who want to better manage their weight, the weight management program provides information that will enable members to learn a whole new way to think about food, exercise and their health. This educational online self-management program focuses on understanding what being overweight means, why it matters and what they can do about it. The weight management program emphasizes healthy eating habits, being more active, setting goals, and provides targeted information in response to the member's self-reported assessments.

### **Taxonomy codes — definition and claims use**

Taxonomy codes are administrative codes for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique, 10-character alphanumeric code that enables providers to identify their specialty at the claim level. Taxonomy codes are assigned at both the individual provider and organizational provider level.

Taxonomy codes have three distinct levels: Level I is the provider type, Level II is classification, and Level III is the area of specialization. You can find a complete list of taxonomy codes within the Health Insurance Portability and Accountability Act

(HIPAA)-related code list section of the Washington Publishing Company (WPC) Web site at [wpc-edi.com/products/codelists/alertservice](http://wpc-edi.com/products/codelists/alertservice). If you do not have Internet access, contact the WPC at 425-562-2245 to find out how to purchase a printed code list.

Taxonomy codes are self-reported, both by registering with the National Plan and Provider Enumeration System (NPPES) and by electronic and paper claims submission.

Taxonomy codes registered with NPPES at the time of NPI application are reflected on the confirmation notice document received from NPPES with the provider's assigned NPI number. You can view currently registered taxonomy codes, including any subsequent changes, on the NPI Registry Web site at <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>.

A provider can have more than one taxonomy code. It is critical to register all applicable taxonomy codes with NPPES and to use the correct taxonomy code to represent the specific specialty when filing claims. This will help ensure more accurate and timely claims processing.

Blue Cross and Blue Shield of Texas (BCBSTX) does not currently require taxonomy codes, but does strongly recommend them. The BCBSTX system uses taxonomy codes to assist in determining the most appropriate payment; therefore, the absence of these codes can result in incorrect payments.

Taxonomy codes on electronic claim submissions with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level, and segment PRV03 and loop 2420A for the rendering level. For paper UB04 institutional claims, the taxonomy code should be placed in box 81 and submitted with the B3 qualifier.

For paper CMS-1500 professional claims, the taxonomy code should be identified with the qualifier ZZ in the shaded portion of Box 24i. Place the taxonomy code in the shaded portion of Box 24j for the rendering level and in Box 33b, preceded with the ZZ qualifier for the billing level.

### Claim appeal/reconsideration review process

To submit claim appeal/reconsideration review requests, you must complete the Physician and Provider Request for Claim Appeal/Reconsideration Review form on the Blue Cross and Blue Shield of Texas (BCBSTX) Web site at [bcbstx.com/provider](http://bcbstx.com/provider). Click on Claim Appeal/Reconsideration Review Process & Billing Dispute External Review Process (BDERP) in the Provider Library.

There are two levels of claim appeals/reconsideration reviews available. For the following circumstances, you must request the first claim appeal/reconsideration review within the corresponding timeframes outlined below:

Dispute type	Time frame for request
Audited payment	Within <b>30 days</b> following the receipt of written notice of request for refund due to an audited payment.

Overpayment	Within <b>45 days</b> following receipt of written notice of request for refund due to overpayment.
Claim dispute	Within <b>180 days</b> following the check date/date of the HMO Blue Texas explanation of payment (EOP) or the date of the BCBSTX provider claims summary (PCS) for the claim in dispute.

- BCBSTX/HMO Blue Texas will complete the first claim appeal/reconsideration review within **45 days** following the receipt of your request for a first claim appeal/reconsideration review. You will receive written notification of the claim appeal/reconsideration review determination.
- If the claim appeal/reconsideration review determination is not satisfactory to you, you can request a second claim appeal/reconsideration review. You must request the second claim appeal/reconsideration review within **15 days** following the receipt of the first claim appeal/reconsideration review determination.
- BCBSTX/HMO Blue Texas will complete the second claim appeal/reconsideration review within **30 days** following the receipt of your request for a second claim appeal/reconsideration review. You will receive written notification of the claim appeal/reconsideration review determination.
- The claim appeal/reconsideration review process for a specific claim will be considered complete following your receipt of the second claim appeal/reconsideration review determination.

If you have any questions concerning the process for a claim appeal/reconsideration review, please contact your local professional provider network representative.

#### **Medicare Part D pharmacy updates:**

##### **FDA takes action to ensure safe use of propoxyphene-containing products**

On July 7, 2009, the Food and Drug Administration (FDA) announced that it would allow the continued marketing and sale of propoxyphene-containing products on the U.S. market, but that it was taking several actions to reduce the risk of overdose and other adverse effects.

Propoxyphene has been available on the U.S. market since 1957 and is most commonly known as either Darvon or Darvocet-N-100, although generic equivalents have been available for many years. Many experts have long questioned its efficacy in treating mild to moderate pain, believing that its pain-relieving properties are no better than acetaminophen. Now, its safe use, especially in the elderly, has been called into question.

According to the FDA, about 21 million prescriptions containing propoxyphene were written in 2007. At the same time there were 503 propoxyphene-related deaths, 20 percent of which were classified as suicides. The National Health Service in Great Britain removed the drug in 2005, citing a trail of suicides and accidental overdoses;

European Union (EU) drug regulators have just recommended that EU countries follow suit.

In addition, the consumer watchdog group Public Citizen petitioned the FDA in February 2006 to remove all propoxyphene-containing products from the U.S. market. Earlier this year (Jan. 30, 2009), on a vote of 14-12, the FDA's own advisory committee recommended a phased market withdrawal of all propoxyphene products. The FDA does not have to follow the recommendations of its advisory committee, but generally does.

FDA proposed actions include the following:

- The agency is requiring manufacturers to strengthen the labeling of their products, including a boxed warning, emphasizing the potential for overdose when using these products. Manufacturers will also be required to provide a medication guide to patients stressing the importance of using these drugs as directed. All of these proposed changes are to be submitted to the FDA within 30 days.
- The FDA also ordered the manufacturer, Xanodyne Pharmaceuticals, to perform a new safety study to monitor the cardiovascular effects of higher-than-recommended doses. This could lead to future regulatory actions.
- The FDA is working with the Centers for Medicare and Medicaid Services (CMS) to study the safety and prescribing patterns of propoxyphene among the elderly. Specifically, the FDA will examine the rates of fatalities and hip fractures among elderly patients and compare these rates to those in elderly patients taking other analgesics.
- The FDA will also work with the Veterans Administration and possibly one or more of its epidemiology contractors (e.g. Kaiser-California, etc.) to study additional safety aspects of this medication therapy.

In regards to the FDA's decision to continue marketing propoxyphene-containing products, Dr. Janet Woodcock, director of FDA's Center for Drug Evaluation and Research, CDER, stated that "At this time, propoxyphene is an acceptable choice for the treatment of mild to moderate pain when taken as directed. When it comes to acetaminophen or opioids, the FDA is constantly balancing benefit versus risk." The FDA further defended its position by pointing out that there are not a lot of alternative drugs without similar adverse effects.

Lastly, propoxyphene is included on a number of lists of potentially inappropriate drugs for the elderly (BEERs, HEDIS, etc.). The general consensus is that although its use in all elderly patients may not be wrong, its relatively poor efficacy and increased risk of adverse effects should prompt providers to seek safer and more effective alternatives. As a consequence of these longstanding safety and efficacy concerns, Blue Cross Blue Shield of Texas plans to remove propoxyphene-containing products from its 2010 Medicare Part D formulary.

Medical providers should monitor their patients carefully for unusual signs and symptoms while taking propoxyphene-containing products and report all suspected adverse drug reactions to the FDA's MedWatch Program by phone at 800-FDA-1088; fax at 800-FDA-0178; mail at MedWatch, HF-2, FDA, 5600 Fishers Ln., Rockville, MD 20852-9787; or the MedWatch Web site at [fda.gov/medwatch](http://fda.gov/medwatch).

### **Additional reading**

U.S. Food and Drug Administration. FDA Takes Actions on Darvon, Other Pain Medications Containing Propoxyphene.

[fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm170769.htm](http://fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm170769.htm) (accessed July 7, 2009).

U.S. Food and Drug Administration. Propoxyphene Questions and Answers.

[fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm170268.htm](http://fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm170268.htm) (accessed July 7, 2009).

FDA orders overdose warnings for Darvocet. [ncpa.yellowbrix.com](http://ncpa.yellowbrix.com) (accessed on July 9, 2009).

Rebelo, K. FDA adds stronger warnings to propoxyphene. Medscape Medical News. [medscape.com/viewarticle/705441](http://medscape.com/viewarticle/705441) (accessed July 8, 2009).

### **Medicare-related claims for BlueCard members**

In our ongoing efforts to better serve you, Blue Cross and Blue Shield of Texas (BCBSTX) has information to help make filing your BlueCard Medicare-related claims easier. Medicare-related claims are those that are secondary or supplemental to Medicare and coverage is provided by a Blue Cross and Blue Shield plan.

If you are a provider who accepts Medicare assignments and renders care to members from other Blue plans, we recommend you contact BlueCard eligibility at 800-676-BLUE (2583) to check the patient's membership and coverage before providing services.

When Medicare is primary, submit claims to your Medicare intermediary and/or Medicare carrier first. It is essential that you enter the correct Blue plan name as the secondary carrier, which may be different from BCBSTX. The member ID must include the alpha prefix in the first three positions. The correct alpha prefix is critical for confirming membership and coverage and key to facilitating prompt payments.

After receipt of the explanation of payment or remittance notice from Medicare, check to see if the claim has been automatically forwarded (crossed over). If the remittance shows that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue plan and the claim is in process. Please allow ample time to receive payment and/or processing information from the appropriate Blue plan before initiating any inquiries. If the claim was not crossed over, submit the claim electronically to BCBSTX with Medicare's remittance notice data.

Please do not submit Medicare-related claims to BCBSTX before receiving a Medicare remittance notice from the Medicare intermediary and/or Medicare carrier. Duplicate claims submissions can delay claim processing and create administrative inefficiencies.

## Crossover process saves time and money for Medicare Part A & B electronic claims

The Blue Cross and Blue Shield of Texas (BCBSTX) Defensive Strategy Medicare Part A & B team implemented an electronic submission process that could 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 through 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 crossover. This guideline assumes the primary Medicare claim was submitted in the Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 format.

### **Start with the date you receive your explanation of Medicare benefits (EOMB).**

- **Day 1** — Receive payment and EOMB from Medicare indicating that 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 can then file the supplemental portion electronically to BCBSTX using the guidelines on the Web site at [bcbstx.com/provider](http://bcbstx.com/provider).

### **Reminders**

- For non-HIPAA compliant claims and paper submissions, please add 14 days to this timeline.
- The crossover process requires that patients 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 [bcbstx.com/provider](http://bcbstx.com/provider) to learn more about the Medicare Part A & B guidelines and EDI requirements.

## EDS collaborates with Express Scripts

The Electronic Data Systems (EDS) Health Advocate Program was implemented effective Jan. 1, 2008 with a focus on health advocacy. The program is an integrated medical care management model that combines elements of traditional health care management with a health coaching component to create a care management strategy sensitive to the needs of individual members.

In addition to the wellness and chronic care programs, EDS also forged a collaborative partnership with its pharmaceutical vendor, Express Scripts (ESI).

Blue Cross and Blue Shield of Texas (BCBSTX) receives real-time referrals from ESI bimonthly. The referral sources within the ESI report include data from the first fill of prescriptions, complicated disease processes and poly-pharmacy, as well as medication adherence and lab monitoring. During the first quarter of 2009, EDS received 365 such referrals, with a 38 percent unique member reach rate.

To ensure continuity in this collaborative effort, EDS custom team members and ESI personnel participate in monthly clinical teleconferences. One recent topic focused on educational opportunities such as disease process overviews, treatment guidelines and prescribed medications. Other topics of discussion have included atrial fibrillation, influenza and Alzheimer's. With the addition of the oncology diagnosis in early 2009, there has been a concerted effort to overview pharmacological cancer medication treatments.

In addition to the teleconferences, ESI frequently forwards educational information on medications via e-mail such as formulary changes, new medication indications, recalls and recent FDA approvals.

The EDS pharmacy initiative will continue on an ongoing basis with a detailed analysis of the report data. The EDS team will work with other BCBSTX internal programs as well as ESI to develop materials and outreach strategies to raise medication compliance awareness.

Should you have an EDS patient that needs assistance related to their medication compliance, please have them contact the BCBSTX EDS Health Advocate Program at 866-737-1337.

#### **Fee schedule updates effective in August**

As you have already been notified, the ParPlan, BlueChoice<sup>®</sup> and HMO Blue<sup>®</sup> Texas (Independent Provider Network only) maximum allowable fees for practitioners were updated to reflect 2009 relative values effective Aug. 15, 2009.

Geographic practice cost indices (GPCIs) will not be applied to the relative values, so relative values will not differ by Medicare locality. ParPlan, BlueChoice and HMO Blue Texas relative values will consider the site where the service is performed (facility or non-facility).

The drug/injectable fee schedule will be updated on the following dates: June 1, 2009; Sept. 1, 2009; Dec. 1, 2009; March 1, 2010; and June 1, 2010.

Blue Cross and Blue Shield of Texas provides general reimbursement information policies, request forms for allowable fees and fee schedule information at [bcbstx.com/provider](http://bcbstx.com/provider). To view this information, visit the General Reimbursement Information section on the Web site.

To request a sample of maximum allowable fees or if you have any other questions, contact your local Professional Provider Network office.

Reimbursement changes will be posted under Reimbursement Changes/Updates in the Professional Reimbursement Schedules section on the Web site. The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted.

## NOTICES AND ANNOUNCEMENTS

### Proper speech therapy billing

CPT<sup>®</sup> codes 92506, 92507 and 92508 are defined as “treatment of speech, language, voice, communication and/or auditory processing disorder; individual” in the CPT manual. Codes 92506, 92507 and 92508 are not considered time-based codes and should be reported only one time per session; in other words, the codes are reported without regard to the length of time spent with the patient performing the service.

Because the code descriptor does not indicate time as a component for determining the use of the codes, you need not report increments of time (e.g., each 15 minutes). Only one unit should be reported for code 92506, 92507 and 92508 per date of service. Blue Cross and Blue Shield of Texas (BCBSTX) adheres to CPT guidelines for the proper usage of these CPT codes.

**Note:** Unless there are extenuating circumstances documented in your office notes — for example, multiple visits on the same day — we will only allow one unit per date of service for these codes. Because of system limitations, our claims system previously could not identify multiple units on same day for these codes; however, these limitations have now been corrected and, as of Oct. 1, 2009, the claims system is able to adjudicate these codes to allow for only one unit per day.

Current Procedural Terminology (CPT<sup>®</sup>), copyright 2008 by the American Medical Association (AMA). CPT is a registered trademark of the AMA.

### American Imaging order requests now approved online

The ProviderPortal for American Imaging Management (AIM) has been enhanced such that all orders for advanced imaging services on HMO Blue<sup>®</sup> Texas (HBT) members will be approved online immediately if the order information meets clinical criteria. When the information provided at intake meets AIM’s clinical criteria and is consistent with HBT medical policy, you will be guided to select an imaging provider where the study will be performed, and an order ID number will be issued in real time. A physician or nurse review is only required if the criteria are not met or additional information is needed.

To submit an imaging order request today, go to AIM online at [americanimaging.net/goweb](http://americanimaging.net/goweb) or [americanimaging.net](http://americanimaging.net). AIM’s ProviderPortal application offers a full range of Web-based services, including real-time, 24/7/365 access to inquiries for advanced diagnostic imaging services. Key services available through *ProviderPortal* include the following:

- Obtain order request approvals on a real-time basis.
- Confirm order requests for members referred for service.
- Locate AIM HBT-contracted imaging providers.

If you are already registered for *ProviderPortal*, you do not need to re-register. To add HBT to your existing health plans, go to the Profile Manager section of *ProviderPortal*. Under Manage my Groups, select Add a Health Plan.

### **2009/2010 Synagis predetermination process**

#### **Step 1 — Blue Cross and Blue Shield of Texas (BCBSTX) health plan predetermination/authorization process**

- Complete the BCBSTX Synagis Request Form in its entirety. Two types of forms are posted at [www.bcbstx.com/provider/downloadable\\_forms.htm](http://www.bcbstx.com/provider/downloadable_forms.htm): an online form and an interactive version to complete and fax.
- Submit the online version of the Synagis request form or fax the hard-copy version to Allan J. Chernov, M.D., medical director, Health Care Quality & Policy, at 972-766-5559.
- If you submit the form online, BCBSTX will send notification of the review outcome by e-mail. If you submit the form by fax, notification will be sent by mail, unless you specifically request e-mail notification.

#### **Step 2 — Ordering process for Triessent**

- Fax the Synagis request form, along with written authorization from BCBSTX, to Triessent at 866-203-6010.
- If the request form is incomplete or does not have the BCBSTX written authorization attached, the order will not be processed and will be returned to the physician.
- If approved, the predetermination will cover a maximum of five monthly injections for that patient for the 2009-2010 respiratory syncytial virus (RSV) season, which began Oct. 15, 2009 and continues through March 15, 2010. No additional reviews will be needed.
- For out-of-state members, contact the member's home plan for eligibility and benefit information. The phone number will be on the back of the member's ID card.

### **Urgent care center services billed using CPT code S9088**

Effective March 1, 2009, Blue Cross Blue Shield of Texas (BCBSTX) considers CPT code S9088 a non-covered procedure; therefore no reimbursement will be allowed.

### **Billing errors on CMS 1500: submitting a corrected claim**

If you or someone in your office discovers that charges by a professional or ancillary provider's office were submitted incorrectly, then a corrected claim is warranted. The corrected claim must be on paper and submitted with the required form (Physician/Professional Provider & Facility/Ancillary Request for Claim Appeal/Reconsideration Review) on top. The form is located on the Blue Cross and Blue Shield of Texas provider Web site at [bcbstx.com/provider](http://bcbstx.com/provider), under Forms. The instructions for filling out the form are located directly beneath the link. This will ensure that the appropriate review/correction is made to the claim.

Please do not attempt to electronically submit corrections to claims submitted on a CMS 1500.

### **Draft medical policy review**

In an effort to streamline the medical policy review process, you can view draft medical policies on our provider portal and provide your feedback online. The documents will be made available for your review around the first and the 15th of each month with a review period of approximately three weeks.

To view draft policies, go to the General Reimbursement Information section of our provider portal at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) and click on Draft Medical Policies. After reading the disclaimer, click on I Agree to advance to the Draft Medical Policies page.

### **Reasons for returned paper claims**

Blue Cross and Blue Shield of Texas (BCBSTX) will return paper claims that are partially legible, on a colored background, or where the print is too light or too dark. It is also important to verify that the National Provider Identifier (NPI), current group policy number and alpha-prefix identification number are included in the appropriate fields. Paper claims without these three fields completed will be returned.

Using colored ink can also cause the writing on claims to be illegible when scanned. Please use blue or black ink when submitting claims or any other type of paper correspondence.

### **AIM RQI reminder**

Physicians and professional providers must contact American Imaging Management (AIM) first to obtain an RQI number when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's office, a professional provider's office, the outpatient department of a hospital or a freestanding imaging center:

- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study
- PET scan

To obtain a PPO RQI number, log in to AIM's provider portal at [americanimaging.net](http://americanimaging.net) and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an RQI number. If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office.

Once an RQI number is obtained, you need not submit additional medical records to BCBSTX for review of that procedure.

*Note: Facilities cannot obtain an RQI number from AIM on behalf of the ordering physician. Also, the RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program. AIM's provider portal uses the term "Order" rather than "Preauth" or "RQI."*

### **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

exceptions). To find the closest LabCorp Patient Service Center, call LabCorp's automated phone system toll free at 888-LABCORP, or visit their website at [labcorp.com](http://labcorp.com). Both systems will prompt you for your ZIP code and will provide those service centers nearest that ZIP code location.

You can find a complete list of participating providers by using the Provider Finder search tool at [bcbstx.com/provider](http://bcbstx.com/provider). 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 can access the county listing and the revised Reimbursable Lab Services list, which will become effective Nov. 1, 2009, at [bcbstx.com/provider](http://bcbstx.com/provider) under the General Reimbursement Information section.

*Note: Physicians who are contracted/affiliated with a capitated IPA/medical group and physicians who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.*

### **Pass-through billing**

BCBSTX does not permit pass-through billing. Pass-through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider.

The performing provider should bill for these services unless otherwise approved by BCBSTX.

BCBSTX does not consider the following scenarios to be pass-through billing:

1. The service of the performing provider is performed at the place of service of the ordering provider and is billed by the ordering provider.
2. The service is provided by an employee of a physician or other professional provider (e.g., physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering provider) and the service is billed by the ordering provider.

### **Reminder — Contracted providers must file claims**

As a reminder, providers must file claims for any covered services rendered to a patient enrolled in a Blue Cross and Blue Shield of Texas (BCBSTX) health plan. You may collect the full amounts of any deductible, coinsurance or copayment due, and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your provider contract with BCBSTX.

**BlueChoice® Solutions large employer groups list**

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

BlueChoice Solutions large employer group list as of August 2009	
Air Force Villages, Inc. Alamo Iron Works, Inc. Bert Ogden Olds, Nissan & BMW, Inc. Blue Cross and Blue Shield of Texas Career Point Institute Centaurus Property Management, L.L.C. City of Sanger Community Health Service Agency Community Hospice of Texas Crestview RV DCTA Epic Medstaff Services, Inc. First Co. Gabriel Holdings, LTD Good Fulton & Farrell Guido Management Services, Inc. Health Services Management of Texas, L.L.C. Hi-Tech Plastics John Burns Construction Co. of Texas John L. Wortham & Son, L.P. Lantern Drilling Company	M. Hanna Construction Co., Inc. Mass Group Marketing, Inc. MHMR Services of Texoma Mike Calvert Toyota Naegeli Transportation, Inc. Odyssey Aerospace Components, L.L.C. Reef Industries, Inc. Research Analysis & Maintenance, Inc. Six Day Dental & Orthodontics — North TX, P.A. Southwest Ford, Inc. SXSW, Inc. Taylor & Hill TEI & Associates, L.L.C. The Care Group of Texas The CMI Group, Inc. The Spencer Company United Graphics VLSIP Technologies, Inc. Wal-Mart Yantis Company

