Blue Review
A Provider Publication

Issue 4, 2010

Blue Care Connection® works with physicians through Physician Collaboration

Blue Care Connection (BCC) has launched a collaborative effort with network physicians to close gaps in care for Blue Cross and Blue Shield of Texas (BCBSTX) members suffering from chronic conditions.

Blue Care Connection regularly provides BCBSTX members with resources aimed at helping them lead healthier and more productive lives. In addition to providing online educational information and tools, BCC actively reaches out to members to encourage healthy lifestyle changes.

To better support its member-outreach initiatives, BCC launched the Physician Collaboration Program in April 2010 as a way of closing gaps in care to BCBSTX members suffering from any of six chronic conditions: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure and hypertension.

BCC contacts physicians' offices when BCBSTX identifies a gap in care for one of its members. In turn, the physicians' offices contact their patient, encouraging them to schedule an appointment for follow-up care. BCC will later follow up with the physician to determine whether the patient scheduled an appointment.

Want to know more about the physician outreach initiative? Read an article about the program on the Texas Medical Association's website here, or call Blue Care Connection at 866-412-8795.

BCBSTX physician network contracts allow physicians to share patient information when the situation involves health care clinical operations and to participate in quality initiatives with the plan. Enlisting the help of physicians is integral to the success of the BCC program to improve members' overall health.

Condition-specific gaps in care include the following:

Diabetes	**Chronic Obstructive Pulmonary Disease (COPD)**
No HbA1C in the past 12 months	No physician office visit in 6 months
No physician office visit in 6 months	Bronchodilator adherence
No LDL level in the past 12 months	**Coronary Artery Disease (CAD)**
No eye exam in the past 12 months	No physician office visit in 6 months
Asthma	No LDL level in the past 12 months
No physician office visit in 6 months	CAD Beta Blocker Usage
Not on controller medication	**Congestive Heart Failure (CHF)**
Hypertension (HTN)	No physician office visit in 6 months
Hypertension – HTN>140/90	CHF ACE/ARB Usage

New Online Resource Available for Maternity Program

Blue Cross and Blue Shield of Texas is pleased to announce an additional resource is now available for the Special Beginnings®' program. All expectant members who have this maternity program as part of their health plan have access to a new online resource beginning in late July 2010.

Located on Blue Access® for Members, a secure member website, the online resource offers:

- A pregnancy calendar to help keep track of the pregnancy and what to expect in each trimester
- A pregnancy due date calculator
- Videos about pregnancy and childbirth with professionals such as clinical psychologists and registered nurses
- Educational articles
- An overview of the support your patients will receive from the Special Beginnings program

Additional features will be added later this year.

The Special Beginnings maternity program can help guide your patients through their pregnancy and postpartum care. This confidential program provides support and education, pregnancy risk factor identification and ongoing communication/monitoring from early pregnancy until six weeks after delivery. Our staff can help your patients better understand and manage their pregnancies and help coordinate their care with you.

Help your patients get off to a healthy start! Encourage them to enroll in the maternity program by calling 888-421-7781, 8 a.m. – 6:30 p.m., CT. Members should enroll in the program before 12 weeks of gestation but are accepted until week 34 of their pregnancy.

Availity®' Launches CareProfile®' hurricane awareness campaign

To prepare for the upcoming hurricane season, Availity*' has launched an awareness campaign to Texas health care providers called "In the Calm After the Storm." The campaign promotes awareness of the Availity CareProfile (ACP), an electronic health record that offers access to patient medical records in the event of a disaster, or when this information is otherwise unavailable.

Five years ago, Blue Cross and Blue Shield of Texas (BCBSTX) and MEDecision** led the way in providing the nation's first electronic patient clinical summary for members displaced by Hurricane Rita. BCBSTX is again leading the way this hurricane season by ensuring access to valuable clinical information for BCBSTX members and health care professionals through multiple electronic channels.

The Availity CareProfile provides a summary of a patient's last 27 months of claims data collected from physician visits, pharmacies, labs and other health care visits. MEDecision applies robust clinical intelligence and analytics to the data to create a summary that shows both preventive care and treatment opportunities, plus inpatient facility admissions, emergency room visits, a list of the patient's providers, medical

conditions and prescribed medications. The ACP now displays lab results for certain tests conducted in the last 12 months, to help monitor chronic conditions such as diabetes and hypertension.

BCBSTX continues to focus on making member health information more accessible to our health care professionals. The same electronic health record is also available at no cost to health care professionals through MEDecision/iEXCHANGE and branded as the Patient Clinical Summary.

An Availity CareProfile Tip Sheet is available in the Electronic Commerce section of the BCBSTX website at bcbstx.com/provider. Registered users can also attend free Availity webinars about using the ACP and other Availity applications. For webinar dates and times, click on "Free Training" on any page after logging on to the Availity portal.

To register with Availity, access the free ACP or find out about more online time and money-saving processes and tools, visit availity.com. You may also contact Availity Client Services at 800-AVAILITY (800-282-4548) for assistance.

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*** MEDecision is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company.*

Appropriate billing when a patient has reached a benefit max

Members covered under our BlueChoice, BlueChoice Solutions and HMO Blue® Texas benefit plan may elect policies that could limit specific services to a maximum dollar amount per calendar year.

Some examples for services that may include maximum dollar amounts are:

- Well-child
- Immunizations
- Routine or periodic exams
- Chiropractic / PT / OT services

In the event that benefits are exhausted, the provider may continue to treat the patient if the member agrees in writing to pay for the services provided.

Note: The provider may not charge the member more than the amount included as described in the provider's contract.

BCBSTX implements online member liability estimator

The new Availity®'* CareCost Estimator℠ (CCE) helps physicians and other professional providers improve billing accuracy and efficiency for Blue Cross and Blue Shield of Texas (BCBSTX) member claims. Developed jointly with Availity, the tool analyzes BCBSTX members'** primary

diagnoses, procedures, benefits and contractual allowances. It then calculates the estimated out-of-pocket costs for their office and outpatient services.

In addition to this greater transparency, the CCE tool also gives physicians and other professional providers the opportunity to collect the member's share at the point of service. And, best of all, the tool is free.

Though the CareCost Estimator is exactly that – an "estimator" – it quickly and reliably:

- Estimates members' costs at the time of care in real-time***
- Facilitates accurate member payments
- Helps streamline the accounts receivable process
- Helps reduce claim adjustment requests
- Prints the results for patients' and doctors' records

An Availity CareCost Tip Sheet is available in the "Electronic Commerce" section of the BCBSTX website at bcbstx.com/provider. Registered users can also attend free Availity webinars that introduce users to the CCE tool and other Availity applications. For webinar dates and times, click on "Free Training" on any page after logging onto availity.com.

To register with Availity, access the free CCE tool (you must be registered to access this tool) or learn about more online time and money-saving processes and tools, visit availity.com. You may also contact Availity Client Services at 800-AVAILITY (800-282-4548) for assistance.

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*** See the CCE Tip Sheet for a brief list of exceptions.*

**** Benefits are subject to all contractual limits and member's status on the date of service. Accumulated amounts such as deductible may change as additional claims are processed.*

Share the wealth by sharing the *Blue Review* newsletter

Did you know that beginning Jan. 1, 2011, Blue Cross and Blue Shield of Texas (BCBSTX) will manage behavioral health services for all non-HMO members? Or that we will accept National Drug Codes for billing of all drugs? Or that there's a fantastic new tool, Availity®', that enables fast, secure access to information for patients and providers free of charge?

Every issue of the *Blue Review* newsletter carries a wealth of information that you need to know. Our goal is to disseminate the most current, reliable information in an effort to increase provider satisfaction and reduce their administrative costs.

Check out just a few things you'll find in recent issues of the *Blue Review*:

- System and coding updates
- Billing and reimbursement
- New account groups
- The latest electronic solutions
- Innovative health care products and services

- Medical management initiatives

You can find recent issues of the *Blue Review* on the BCBSTX website at bcbstx.com/provider. Look for the *Blue Review* link in the upper right-hand corner of the page. Want to sign up to receive the *Blue Review* via e-mail? Follow this link or click on the "Pick Paperless" icon on the website to sign up.

Check reissue request for providers

Please allow 30 days from the payment date of issue before requesting a stop pay and reissue for payment. Availity®, allows you the opportunity to review claim status, related payment history and much more online. You may register with Availity at availity.com.

Want to receive payments electronically? Sign up for Electronic Funds Transfer (EFT) at the Blue Cross and Blue Shield of Texas website at bcbstx.com/provider. Click on the "Electronic Commerce" tab and then the "EFT/ERA" link in the left-hand navigation column. Or, you can click here to access the EFT Agreement and ERA Enrollment forms directly.

For more information, call the Electronic Data Interchange (EDI) Hotline at 800-746-4614.

Hospital room rate notification

It is imperative Blue Cross and Blue Shield of Texas (BCBSTX) has the correct room rate on file. Please notify us at least 30 days prior to the planned effective date of any room rate change. You can find the Room Rate Update Notification form on the BCBSTX website, bcbstx.com/provider [BCBSTX/provider/forms/general/forms]. The completed form can be faxed to your Facility Provider Network Representative at:

Austin, Corpus Christi, San Antonio, El Paso	**210-357-5273**
Dallas/Fort Worth Metroplex, East & West Texas	**972-766-1103**
Houston, Beaumont, Victoria, Lufkin, Nacogdoches	**713-663-1250**

If you have not provided this information to BCBSTX in the last 12 months, please do so. This information will allow us to update our claims payment system or confirm that we have your current room rate loaded in the system. If you have any questions or concerns, please contact your Facility Provider Network Representative.

Significant edits related to ClaimCheck®" denials

Prior to calling Provider Customer Service (PCS) on your ClaimCheck denials, please check our "Significant Edits" list located on the Blue Cross and Blue Shield of Texas (BCBSTX) website at bcbstx.com/provider and see if your code is listed. Under "General Reimbursement Information," click on "Significant Edits" and then click on "Significant Edits" again under "All Product News."

This brings up a list of codes that are incidental when billed in conjunction to other procedures. Also listed are re-bundled and mutually exclusive procedures. Keep in mind this list is not all inclusive. The codes listed are those most reported by volume.

Reminder

Clear Claim Connection* (C3) is a **free online reference tool** that mirrors the logic behind BCBSTX code-auditing software. You can use C3 to help **determine how coding combinations on a particular claim may be evaluated** during the adjudication process.

To gain access to C3, you must be registered with Availity®'* or RealMed®.

- Register with Availity or contact Availity Client Services at 800-AVAILITY (800-282-4548)
- Register with RealMed or call 877-REALMED (877-732-5633)

** Clear Claim Connection is a registered trademark of McKesson Information Solutions, Inc. RealMed is a registered trademark of RealMed Corporation. Availity is a registered trademark of Availity L.L.C. McKesson Information Solutions, Inc., RealMed Corporation and Availity, L.L.C. are independent contractors and are solely responsible for their products and services.*

The principles of medical-record documentation

Principles of Medical Record Documentation	The following *Principles of Medical Record Documentation* were developed jointly by representatives of the American Health Information Management Association, the American Hospital Association, the American Managed Care and Review Association, the American Medical Association, the American Medical Peer Review Association, the Blue Cross and Blue Shield Association and the Health Insurance Association of America. Although their joint development is not intended to imply either endorsement of or opposition to specific documentation requirements, all seven groups share the belief that the fundamental reason for maintaining an adequate medical record should be its contribution to the high quality of medical care.
What is Documentation and Why is it Important?	Blue Cross and Blue Shield of Texas requires medical records to be maintained in a manner that is current, detailed and organized, and that permits effective and confidential patient care and quality review.

How does the Documentation in Your Medical Record Measure Up?	1. Is the reason for the patient encounter documented in the medical record? 2. Are all services that were provided documented? 3. Does the medical record clearly explain why support services, procedures and supplies were provided? 4. Is the assessment of the patient's condition apparent in the medical record? 5. Does the medical record contain information on the patient's progress and on the results of treatment? 6. Does the medical record include the patient's plan for care? 7. Does the information in the medical record, describing the patient's condition, provide reasonable medical rationale for the services and the choice of setting that are to be billed? 8. Does the information in the medical record support the care given in the case where another provider must assume care or perform medical review? 9. Does the information in the medical record include communication between providers?

Principles of Documentation

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam; review of lab, X-ray data and other appropriate ancillary services; assessment and plan for care (including discharge plan, if appropriate).
3. Past and present diagnoses should be accessible to the treating and/or consulting physician.
4. The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record.
5. Relevant health risk factors should be identified.
6. The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance, should be documented.
7. The written plan for care should include, when appropriate: treatments and medications specifying frequency and dosage; any referrals and consultations; patient/family education; and specific instructions for follow-up.
8. The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision-making.
9. All entries to the medical record should be dated and authenticated.
10. The CPT/ICD-9 codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

Such documentation is expected in all medical records, to include electronic medical records, of all members for whom the provider is billing for services.

EFT, ERA and EPS: *Beyond the Basics, Part 1*

In June, we shared feedback from an online tutorial and survey regarding Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS). Participants were asked if they had any questions that had not yet been addressed in other provider communications, and that may have prevented them from enrolling. To follow up, we're presenting a three-part "EFT, ERA and EPS: Beyond the Basics" article series, beginning with this month's article, which focuses on preliminary enrollment details and prerequisites.

Our office uses an older software package that may not be able to utilize ERA. Can I still enroll for EFT and EPS?
Yes! You can still enroll for EFT, and when you enroll for the ERA, you'll automatically receive the EPS, which you'll be able to use right away. Talk to your software vendor about updating to ERA-compatible and auto-posting software so that your office will be equipped to take full advantage of all three transactions.

I am already registered with Availity®' for billing. Do I still need to register and enroll for ERA/EPS?
If you are registered with Availity*, you are one step ahead of the game, as you will need an Availity User ID to complete your ERA Enrollment form. While you are already submitting claims electronically, the ERA enrollment process is necessary to establish an ERA account and identify an authorized "Receiver" for your ERA and EPS files.

Is there anything else I have to do besides submitting the enrollment forms?
No. Once your completed materials are received and processed, you will receive a letter from Electronic Commerce Services to confirm your enrollment and related details. Please note that, if you utilize a billing service or clearinghouse, we do recommend that you contact your vendor to ensure they are aware and supportive of your electronic preferences.

Do I need to enroll for EFT, ERA or EPS in order to file claims electronically?
No. Taking advantage of EFT, ERA and EPS is not a prerequisite to electronic claim filing. However, if you are interested in increasing administrative efficiency, cost effectiveness, accuracy and security of information throughout the entire claims process, it is highly recommended that you take advantage of all electronic options available to BCBSTX providers.

I don't know what it means to contact a software vendor to ascertain whether my system will receive payment information. I don't really understand what changes I need to make to receive data.
We commend you for sharing these comments. Upcoming articles and other resources are in development to assist non-technical staff with learning what they need to do—and what questions they need to ask—to be able to conduct business electronically with confidence.

Ready to move on to the next level?
Watch for the next "EFT, ERA and EPS: Beyond the Basics" article, which will delve deeper into how you will actually receive your payment and remittance information. If you are ready to enroll, visit the Electronic Commerce section of the BCBSTX website at bcbstx.com for the EFT and ERA Enrollment forms. For more information, refer to the Electronic Options Tutorial, answers to Frequently Asked Questions and other resources on our website, or contact our Electronic Commerce Center at 800-746-4614 for enrollment assistance.

We look forward to helping you discover the benefits of participating in these electronic transactions!

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NOTICES AND ANNOUNCEMENTS

Interactive Voice Response (IVR) System

IVR enhancements coming soon – look for more details in our August issue.

Electronic claims with NPI-related errors set to reject August 1, 2010

In June 2008, we published a complete listing of electronic claim edits that were implemented in support of an NPI-Only claims processing environment. This document provided the three-digit error code along with a defining message indicating the severity level of the error and the resulting impact on the claim – "W" for Warning and "R" for Rejection.

An updated NPI-only Electronic Claim Submission Edits listing has been posted in the Electronic Commerce "Alerts" section of the BCBSTX website at bcbstx.com/provider. ***Please be advised that most of the edits/error listings that were formerly set at the Warning level will be set to Reject as of Aug. 1, 2010.*** The only two error types that will continue to remain at the Warning ("W") level are as follows:

Error Code	Message	Status
BA6	Rendering NPI is not on file (Claim Level Error Message)	W
CA6	Rendering NPI is not on file (Service Line Level Error Message)	W

If you are currently receiving Warning message(s) on your electronic claim reports denoting a lack of NPI-related information, it is imperative that you make the necessary correction(s) immediately, as most of these claims will reject commencing Aug. 1, 2010.

It is important to ensure that you and/or all of your electronic trading partners (billing services, clearinghouses and software vendors) are aware of and responsive to these messages. If you have any questions on these edits, please contact our Electronic Commerce Center at 800-746-4614.

If your office refers to a printed copy of the 2008 NPI-only Electronic Claim Submission Edits listing, please replace it with the updated version posted in the Electronic Commerce "Alerts" section of the BCBSTX website at bcbstx.com/provider.

Supervision of Physician Assistant, Advanced Practice Nurse or Certified Registered Nurse First Assistant

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

AS Modifier: A physician should use this modifier when billing on behalf of a PA, APN

or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS to be used *ONLY* if they assist at surgery)

SA Modifier: A supervising physician should use this modifier when billing on behalf of a PA, APN, or CRNFA for **non-surgical** services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that *DOES NOT* include surgery.)

Note: 80 Modifier: PAs, APNs, and CRNFAs billing with their own National Provider Identifier (NPI) AND acting as an Assistant Surgeon, must use modifier 80 appended to the surgical code.

For additional information on modifiers for professional claims, visit the Blue Cross and Blue Shield of Texas website at bcbstx.com/providers in the "General Reimbursement" section under "All Product News."

New clotting factor management initiative

Patients with bleeding disorders such as hemophilia need immediate access to clotting factor and related products to manage bleeding episodes. Therefore, it is important that physicians who prescribe clotting factors prescribe amounts appropriate to the patient's clinical situation.

Blue Cross and Blue Shield of Texas (BCBSTX) recommends the *Medical and Scientific Advisory Council Recommendation Concerning Prophylaxis* as a helpful resource in managing these patients. In addition, BCBSTX has implemented a review of prescription data to identify high utilization of clotting factors and related products. If high utilization is identified, a form requesting key clinical information and medical rationale may be sent to the prescribing physician. Completed forms are reviewed by a medical director, who will contact the prescribing physician with any questions or concerns. For additional information, visit bcbstx.com/provider/clotting_factor.htm.

Clear Claim Connection™ available to BCBSTX providers

Clear Claim Connection (C3)*, a web-based code auditing reference tool, is now available to all contracted Blue Cross and Blue Shield of Texas (BCBSTX) providers. You may access this tool through the secure provider portal at bcbstx.com.
C3 mirrors the ClaimCheck®'** auditing rules that BCBSTX has adopted as part of its claim adjudication process. It provides easy access to ClaimCheck payment policies and rules in addition to clinical rationales, clarifications and source information for ClaimCheck edits. Certain claims, such as Medicare Primary and BlueCard, are exempt from ClaimCheck auditing.

The BCBSTX ClaimCheck database is updated periodically and upgraded to a new version annually, which may result in certain edit combinations being modified. Appropriate notice of such modifications will be provided on our website and through this *Blue Review* newsletter.

As of April 19, 2010, BCBSTX-contracted providers are able to access the C3 web link via Availity, in addition to RealMed. Registration with RealMed or Availity is required prior to the first time you access C3. Instructions for registering with RealMed or Availity

are located with the link to the respective portal. Once your registration process is completed, you will have access to C3.

To use C3, log on to the BCBSTX website at bcbstx.com and click on the "Providers" tab. You will find Clear Claim Connection in the "General Reimbursement Information" section under Bundling Information.

ClaimCheck audit results obtained on the BCBSTX website are specific to BCBSTX. Another carrier who offers C3 may have different edits, which will produce different results. This information is confidential and proprietary, and it is not to be shared.
If you need more information, please contact your local Professional Provider Network (PPN) office or Provider Customer Service at 800-451-0287.

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IN EVERY ISSUE

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 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. AIM's provider portal uses the term "Order" rather than "Preauth" or "RQI."

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 Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program.

Quest Diagnostics, Inc is new, exclusive HMO and preferred statewide PPO/POS clinical reference lab provider

Effective June 1, 2010, Quest Diagnostics, Inc. became the **exclusive** outpatient clinical reference laboratory provider for HMO Blue® Texas members* and the ***preferred statewide*** outpatient clinical reference laboratory provider for Blue Cross and Blue

Shield of Texas (BCBSTX) BlueChoice® (PPO/POS) members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free standing ambulatory surgery centers).

Quest Diagnostics Offers:

- On-line scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto QuestDiagnostics.com/patient or call **888-277-8772**.
- Convenient patient access to more than 220 patient service locations.
- 24/7 access to electronic lab orders, results, and other office solutions through *Care360®™ Labs and Meds*.

For more information about Quest Diagnostics lab testing solutions or to setup an account, contact your Quest Diagnostics' Physician Representative or call **866-MY-QUEST**.

For physicians located in the HMO capitated lab 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 all other lab services/tests performed in the physician's office will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list at bcbstx.com/provider under the General Reimbursement Information section.

Effective June 1, 2010, Laboratory Corporation of America (LabCorp) is no longer a contracted provider for HMO Blue Texas.

**Note*: *Physicians & other professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians & professional providers 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.*

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. In addition, BlueChoice Solutions is offered to individual members.

BlueChoice Solutions Large Employer Group List As of May 2010	
A.H. Beck Foundation Co., Inc.	Overland Mortgage Corporation
Air Force Villages, Inc.	Reef Industries, Inc.
Blue Cross and Blue Shield of Texas	Research Analysis & Maintenance, Inc.
Centaurus Property Management, L.L.C.	Southwest Ford, Inc.
City of Sanger	SXSW, Inc.
DCTA	The Care Group of Texas
First Co.	The City of Glenn Heights
Goodheart Specialty Meats	The CMI Group, Inc.

Health Services Management of Texas, L.L.C. Naegeli Transportation, Inc.	United Graphics

Fee schedule updates

Reimbursement changes and updates for BlueChoice® and HMO Blue® Texas (Independent Provider Network only) practitioners will be posted under "Reimbursement Changes/Updates" in the Professional Reimbursement Schedules section on the Blue Cross and Blue Shield of Texas website at bcbstx.com/provider.

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. To view this information, visit the "General Reimbursement Information" section on the provider website. Also, the Drug/Injectable Fee Schedule will be updated on the following dates: 9/1/2010, 12/1/2010, 3/1/2011 and 6/1/2011.

Improvements to the medical records process for BlueCard claims

BCBSTX is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.

As always, we will request that you submit your medical records to BCBSTX if needed for claims processing.

Requests for medical records from other Blues Plans before rendering services, as part of the pre-authorization process, should be submitted directly to the requesting Plan.

Pass-through billing

Blue Cross and Blue Shield of Texas (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 (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.

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.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

Medical policy disclosure

New or revised medical policies, when approved, will be posted on our Provider Portal 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 bcbstx.com/provider and click on "Medical Policies." After reading the disclaimer, click on "I Agree" to advance to the medical policy page. The policies can be accessed by clicking the "View Pending Policies" tab.

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 1st and the 15th of each month with a review period of approximately two weeks.

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

Urgent versus standard predeterminations

At times, a predetermination for services may need to be handled as priority.

Urgent predetermination requests include, but are not limited to:

- Procedures and/or drugs needed to relieve pain.
- Acute medical conditions.
- Continuities of care in a chronic condition.
- Treatments that need to be given within one week of the date the request is received.

Cosmetic procedures and bariatric surgery would not be considered urgent.

In order for a predetermination request to be processed as priority, check the box marked "URGENT" located at the top of the completed predetermination form and

indicate the anticipated date of service. Urgent predetermination requests only should be faxed to 888-579-7935.

Note that photographs will not be accepted via fax. They should be placed in a sealed envelope with the words “Request for Predetermination — Original Photos — Do Not Bend” written on both sides and sent to the appropriate address found on the form.

Remember, all predetermination requests are considered standard and should be mailed to the appropriate address found on the form if treatment is to be given later than one week.

No additional medical records needed

Physicians and professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from American Imaging Management (AIM) need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

Importance of obtaining pre-authorizations for initial stay and add-on days

Pre-authorization is required for certain types of care and services. It is the responsibility of the insured person to confirm that their provider obtains pre-authorizations for services requiring pre-authorization. Pre-authorization must be obtained for any initial stay in a facility and any additional days or services added on.

If an insured person does not obtain pre-authorization for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

Pre-authorization does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

Avoidance of delay in claims pending COB information

Blue Cross and Blue Shield of Texas receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our providers is a possible delay, or even denial of services, pending receipt of the required information from the member.

Here are some tips to help prevent claims processing delays when there is only one insurance carrier:

- CMS-1500, box 11-d – if there is no secondary insurance carrier, mark the “No” box.

- Do not place anything in box 9, a through d – this area is reserved for member information for a secondary insurance payer.

It is critical that no information appears in box 11-d or in box 9 a- d if there is only one insurance payer.

Billing for non-covered services

As a reminder, contracted providers may collect payment from subscribers for supplemental charges, copayments, co-insurance and deductible amounts. The provider may not charge the subscriber more than the patient share shown on their provider claim summary (PCS) or electronic remittance advice (ERA).

In the event that BCBSTX determines that a proposed service is not a covered service, the provider must inform the subscriber in writing in advance. This will allow the provider to bill the subscriber for the non-covered service rendered.

In no event shall a contracted provider collect payment from the subscriber for identified hospital acquired conditions and/or never events.

QVT (quantity versus time) limits

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

The Blue Cross and Blue Shield of Texas Clinical Pharmacy Department is currently working on updating the QVT list for 2010. Visit bcbstx.com for an updated and detailed list under the Pharmacy section.

Preferred drug list

Throughout the year, the Blue Cross and Blue Shield of Texas Clinical Pharmacy Department team frequently reviews the preferred drug list. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

For the 2010 drug updates, visit the BCBSTX provider site under the "Pharmacy" section, or follow this link: bcbstx.com/provider/quantity_time.htm

Are utilization management decisions financially influenced?

Blue Cross and Blue Shield of Texas (BCBSTX) is dedicated to serving its customers through the provision of health care coverage and related benefit services. Our mission calls for us to respond to our customers with promptness, sensitivity, respect and dignity. In support of this mission, BCBSTX encourages appropriate utilization decisions; it does not allow or encourage decisions based on inappropriate compensation. Physicians, providers or BCBSTX staff do not receive compensation or anything of value based on the amount of adverse determinations, reductions or limitations of length of stay,

benefits, services or charges. Any person(s) making utilization decisions must be especially aware of possible underutilization of services and the associated risks.

This topic has been addressed in the *Blue Review* provider newsletter and in previous BCBSTX employee communications as a requirement of our Utilization Review Accreditation Commission accreditation. This serves as a reminder for all providers in the BCBSTX provider network.