

Issue 2, 2009

When a patient loses coverage

When a patient loses health care coverage, you may have to consider the implications to your practice's financial stability — especially if your practice is based on numerous patients from a local company or industry that has had significant layoffs.

Several issues weigh into the decisions you make. There are possible legal risks in turning a patient away. And if you continue with the patient's care, you must take into account both financial and legal considerations.

Financial considerations

Faced with a patient who has lost health insurance coverage, you may be tempted to reduce fees, waive fees or make adjustments in billing and payment procedures. There are instances when you should not.

For instance, the Health Care Financing Administration (HCFA) requires that you bill accurately for services provided to Medicare and Medicaid recipients. For example, you may not bill Medicare for a minor visit when the patient was, in fact, granted an extended visit. Accurate coding of services is mandatory.

It's especially important to avoid waiving copayment or coinsurance charges. Doing so is a violation of the Medicare and Medicaid anti-kickback statutes.

If you claim that the charge for a service is \$100 but waive a \$20 copayment, it could be considered a false claim because Medicare pays out the full sum rather than 80 percent of the full sum.

By and large, the private insurance sector has adopted these standards as well. You could be using unfair business practices if you reduce fees beyond the usual and customary charge or if you do not bill at all. Waiving fees becomes a violation if you somehow profit from it, directly or indirectly.

Legal considerations

In continuing care for a patient who loses health insurance, not providing care or not providing the usual "standard of care" could make you legally liable.

For instance, you might think about skipping an expensive diagnostic test when you feel sure of the patient's diagnosis. However, if harm to your patient resulted, the patient could claim breach of duty. You can be liable for breach of duty either when you fail to do what you should have done or when you have done what you should not have.

Should you turn away a patient who cannot pay, you expose yourself to liability for abandonment. Abandonment charges apply when harm comes to a patient with whom

you have established a physician/patient relationship — and for whom you failed to provide necessary medical care without giving them ample time to find a comparable doctor.

Court decisions have made it clear that you cannot dismiss patients from treatment if they require immediate treatment, particularly in regards to emergency care.

You also cannot terminate treatment when a patient has had an adverse change in health status; because the patient's expected future cost of treatment is high; or when the patient has displayed drug-seeking behavior not previously addressed. It is advisable to exercise caution when considering the termination of a relationship with a patient who is in the acute stage of a chronic illness or the final stages of pregnancy, even if you know providing the care could have an adverse financial impact to your practice.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Americans with Disabilities Act (ADA) also restrict you from denying care or from ending treatment due to a person's inability to pay in certain circumstances.

Terminating the relationship

If your patient does not require immediate, ongoing or emergency treatment, you can end the physician/patient relationship. But you should protect yourself by developing a specific step-by-step process that you document in the patient record.

When in doubt about ending the physician/patient relationship, you should always seek risk management assistance from your professional liability carrier.

This information is provided for informational purposes only and with the express understanding that Blue Cross and Blue Shield of Texas is not engaged in providing legal advice.

Thinking outside the mailbox: Survey examines provider perspective on paperless transactions

In February and March, our provider network representatives met with a number of provider offices to assess awareness and satisfaction related to electronic transactions. Specifically, they asked providers about their experiences with Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS).

Of the providers who were already enrolled at the time of the survey, most gave high marks to these transactions. Here are the top three reasons participants cited for using EFT and ERA/EPS:

1. Decreased risk of identity theft through lost mail.
2. Reduced paper handling and storage.
3. Ease of use.

Participants noted that these transactions have helped them save time by standardizing office processes. Providers also commented on the efficiency, convenience and environmentally friendly aspects of EFT, ERA and EPS.

In addition to positive feedback from current EFT, ERA and EPS users, survey participants who were not yet enrolled at the time of the survey contributed valuable

input that helped us identify opportunities for improvement. This constructive dialogue resulted in a comprehensive frequently asked questions document, which was posted on our provider Web site in May.

If you haven't yet enrolled, we look forward to helping your office discover the benefits of participating in EFT, ERA and EPS. Please visit the Electronic Commerce section of our website at bcbstx.com/provider to access the enrollment forms and view our FAQs. You can also contact our Electronic Commerce Center at 800-746-4614 for additional assistance.

New online tool for managing refunds launches this month

Electronic Refund Management (ERM) is a new online tool to help you with your refund management. The tool became available July 1 and includes these features:

- **Electronic notification of overpayments** — You can choose to replace the paper requests for claim refunds (RFCRs) you receive today with a daily or weekly e-mail summarizing overpayment requests per National Provider Identifier (NPI). This will help reduce the cost of maintaining overpayment records.
- **Single sign-on** — If you are currently using Availity or RealMed, you can access ERM through their site. Just complete an online on-boarding form (see procedures below) to be granted access. If you are not using those systems, you can sign up at any time (see procedures below). The ERM application is available at no additional charge.
- **View overpayment requests** — View and search/filter all new, outstanding and closed refund requests that contain an NPI related to your provider/facility. You can also view details of each request (claim, patient account number, service dates, overpayment reason, etc.) — more details than what are currently on the letters. See a real-time transactional history for each refund request, showing a complete audit trail of when an action was taken on a particular item and who performed it (including closed requests). You can always see what's going on and will avoid delays in getting the info you need.
- **Inquire/dispute/appeal requests** — If you have any disagreements or would like more information about a request, you will have the ability to submit that request online.
- **Deduct from future payments** — You can settle your overpayment request by letting Blue Cross and Blue Shield of Texas (BCBSTX) deduct the dollars from a future claim payment. You will still see the information on the Patient Clinical Summary (PCS) or Electronic Payment Summary (EPS) as well as the details in the transaction history to assist with all recoupment reconciliations.
- **Pay by check** — You can select one or more requests and submit a refund to BCBSTX by sending a check. ERM will generate a remittance form showing the detail of your refund for you to include. When BCBSTX receives your

refund check, you will see the check number that you sent to settle your overpayment.

- **Submitting unsolicited refunds** — If you have a credit balance, you can submit it online and refund your payment by check or we can deduct the refund from a future claim payment. No other contact (such as phone inquiries) is necessary for credit balance/overpayment situations.
- **Alerts** — There will also be alerts within the ERM system, such as when BCBSTX responds to your inquiry or if a claim check has been stopped.

If your office currently uses Availity or RealMed – here's how to access the HCSC Refund/Financial Management link where the online on-boarding form is located:

- **Availity** – You'll find the link under the Claims Management tab. If you don't have access to the HCSC Refund Management tool, please contact your primary access administrator (PAA). If you do not know who your PAA is, click the Who controls my access? link at the top of the Availity home page.
- **RealMed** – The link is in the Administration tab. If you don't have access to the HCSC Refund Management tool, contact your RealMed customer account manager or call 1-877-REALMED to reach the Customer Service Center.

For more information and/or how to sign up for Availity or RealMed, go to bcbstx.com/provider.

Care Comparison tool supports transparency initiative

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to sharing information with our members in a way that is easy for them to access, understand and put to use, because we believe that a well-informed consumer will make better health care decisions.

As early as Sept. 1, 2009, we plan to implement a new online Care Comparison tool that will allow our members to review and compare health care and service costs for a number of procedures performed at hospitals, ambulatory surgery centers and freestanding radiology centers in the BCBSTX provider network.

This tool is a component of a transparency program that will initially focus on reporting the costs related to specific procedures rendered to BCBSTX members, as well as the total volume of each procedure performed for all payers.

Communications introducing the Care Comparison tool have been mailed to hospitals, ambulatory surgery centers and freestanding radiology centers in the BCBSTX provider network. Please watch the What's New section of our provider Web site at bcbstx.com/provider for additional announcements and information regarding this and other BCBSTX initiatives.

Fee schedule updates effective in August

As you have already been notified, the ParPlan, BlueChoice® and HMO Blue® Texas (Independent Provider Network only) maximum allowable fees for practitioners will be 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. To view this information, visit the General Reimbursement Information section on the website.

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.

No network changes planned for BlueChoice® Solutions

We are continuing the analysis to find ways to enhance our high-performance network, including review and consideration of new national evaluation standards that have been established by organizations such as the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF) for reporting physician performance. In the future, changes may be implemented in the way we determine provider eligibility for the BlueChoice Solutions network.

While we are assessing these changes, there will be no Solutions evaluation performed in 2009 to determine eligibility for the 2010 BlueChoice Solutions network. The BlueChoice Solutions network in 2010 will not change and will remain the same as the existing 2009 network. This means there will be no removals or additions to the 2009 and 2010 BlueChoice Solutions networks, other than for normal provider turnover and addition activity. Thus, our members should experience minimal network disruption in both years.

Normal provider turnover and addition activity are defined as follows:

- We will continue to have normal disruption from BlueChoice network activity. For example, if a physician or professional provider cancels their BlueChoice contract, then they will also be removed from BlueChoice Solutions.
- We will continue to add the following providers to the BlueChoice Solutions 2009 and 2010 networks:
 - o Providers that join an existing BlueChoice Solutions group.
 - o Providers that practice in a specialty that was not modeled.

Blue Care Connection® program for the management of diabetes

According to the Centers for Disease Control and Prevention, diabetes now affects nearly 24 million people in the United States — almost 8 percent of the U.S. population. Additionally, 57 million more people are estimated to have pre-diabetes.

A new diagnosis of diabetes yields many emotions as well as questions. The Blue Care Connection® Program has registered nurses available to educate members about appropriate diagnostic tests and their results, symptom identification and management, health maintenance, and most importantly, making the appropriate choices to prevent diabetic complications. Complications can be as small and manageable as slight hyperglycemia or hypoglycemia, or as devastating and costly as myocardial infarction, cardiovascular accident, blindness, renal failure or amputation of extremities.

Wellness coaches are also available to encourage weight loss, as well as tobacco cessation and stress management when indicated. The wellness coaches will motivate members to make such difficult decisions as taking action to achieve a more optimal weight and instill a healthy process for achievement. Patients will learn about food choices, portion size, the importance of drinking water and keeping a food diary.

Members can contact the Blue Care Connection Program at 866-412-8795 to speak with a Blue Care advisor and wellness coach.

Improvements to the medical records process for BlueCard claims

Blue Cross and Blue Shield of Texas 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 request that you submit your medical records to Blue Cross and Blue Shield of Texas if needed for claims processing.

If you receive requests for medical records from other Blue Plans before rendering services as part of the pre-authorization process, please submit them directly to the requesting Plan.

New process for using out-of-network providers

It is essential that Blue Cross and Blue Shield of Texas (BCBSTX) PPO and POS enrollees fully understand the benefits impact of using a hospital, ambulatory surgery center (ASC) or other facility that does not have a contractual relationship with BCBSTX.

A network physician must complete the Facility Out-of-Network Care Enrollee Notification Form when presenting an out-of-network provider option to a BCBSTX PPO or POS enrollee for future treatment if such services are also available through a BCBSTX in-network provider. The network physician must provide a copy of the

completed form to the enrollee and should also maintain a copy of the form in their records.

The Facility Out-of-Network Care Enrollee Notification Form is posted in the Forms section of the Provider Portal on our Web site at bcbstx.com/provider. This form was implemented effective June 1, 2009 in Harris County.

If the reason for using an out-of-network provider is lack of availability/accessibility of network providers, you can request authorization for the service to be reimbursed at the in-network benefit level. This request must be made before services are rendered by contacting the Utilization Management Department at the phone number listed on the back of the member identification card.

NDC number key to proper reimbursement for J-code drugs

As previously communicated on our Web site in November 2008 and in the December 2008 issue of Blue Review, we advised physicians and providers that effective Feb. 1, 2009, Blue Cross and Blue Shield of Texas (BCBSTX) began checking National Drug Code (NDC) numbers against the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPSC) when reviewing billing of unclassified drugs/injections under "Not Otherwise Classified (Unclassified)" drug/injection codes (e.g. J3490, J3590, etc.).

In an effort to properly adjudicate claims and reimburse physicians and providers for these procedure codes, BCBSTX continues to enhance its capabilities for NDC processing to reduce underpayments and overpayments to our physicians and providers. We are currently using average wholesale pricing supplied by Prime Therapeutics to properly adjudicate unclassified drugs/injections.

It is important that physicians and providers supply the necessary information for BCBSTX to properly adjudicate and reimburse claims for these procedures. Our claims processing units may have called your office requesting additional information about these unclassified drugs/injections when billed by your physicians. This is done in an effort to properly adjudicate the claim without having to request additional information in writing, which could delay the processing of the claim.

To minimize these calls to your office, please be sure to include the following information on your claims when billing for unlisted drugs/injections:

- NDC number
- Drug name
- Dosage administered (e.g. 5 mg, 10 mg, etc.)
- How the number of units billed on the claim is being administered (e.g. 5 mg = 1 unit, 10 mg = 5 units, etc.)
- Strength of drug administered (e.g. 25 mg/ml, 10 mg/ml, etc.)
- Single- or multidose vial

Note: An NDC number can only be used for a maximum of two years before it becomes obsolete.

If you have any questions, contact our Provider Customer Service department at 800-451-0287 to speak with a customer advocate.

Are you billing for compound drugs?

Drug compounding is the process of mixing, combining or alternating ingredients to create a customized medication. This is considered experimental, investigational and unproven in most cases, according to the Blue Cross and Blue Shield of Texas (BCBSTX) Medical Policy on Compounded Drugs.

The properties of certain drugs may be altered and combined by a compounding pharmacy to create a customized medication for use in a pain pump or for progesterone therapy as a technique to reduce preterm delivery in high-risk pregnancies. Please review the following BCBSTX medical policies related to progesterone therapy (RX501.062) and implantable infusion pumps (SUR707.008) by going to bcbstx.com/provider and clicking the Medical Policies link.

Compound drugs should be filed under the appropriate "Not Otherwise Classified" procedure code with the Modifier KD.

Effective Aug. 15, 2009, in an effort to more effectively and consistently price those drugs approved under medical policies for progesterone therapy and implantable infusion pumps, BCBSTX is adopting the same methodology as the Centers for Medicare and Medicaid Services (CMS).

On the Provider Web site under Reimbursement, you'll find a table that shows the drug name, concentrations and BCBSTX reimbursement amounts that will become effective on Aug. 15, 2009.

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

Submitting CPT 99000 with Modifier 59

Blue Cross and Blue Shield of Texas (BCBSTX) regularly evaluates the coding practices of physicians and other providers who submit claims for services. This includes issues such as bundling and use of CPT modifiers.

BCBSTX recently studied the use of Modifier 59 (distinct procedural service) with the submission of CPT 99000 (handling and/or conveyance of specimen for transfer from the physician's office to a laboratory). Because CPT 99000 is purely an **administrative** service and not a procedure, BCBSTX considers use of Modifier 59 for this code to be inappropriate.

This inappropriate use of Modifier 59 results in an override of a claim system edit that considers CPT 99000 **incidental** to any other service performed on that date of service, including CPT 36415 for routine collection of venous blood, and results in overpayment. Please do not submit claims for CPT 99000 with Modifier 59.

Medical record documentation guidelines (predeterminations/claims)

Medical record documentation is frequently required to determine the medical necessity for services described in Blue Cross and Blue Shield of Texas (BCBSTX) medical policies.

Medical record documentation should be relevant to the member's medical condition for the service(s) requested and should always include any specific documentation requirements as outlined in the coverage section of the applicable medical policy.

Standard medical record documentation may include — but is not limited to — the following:

- Comprehensive medical history and physical examination
- Office or clinic notes
- Physician notes
- Laboratory reports

Documentation may be submitted upon claims submission in order to help expedite claims review and processing; however, we encourage providers to request a predetermination review before rendering the services. A predetermination review allows BCBSTX to determine the medical necessity of a proposed service based on BCBSTX medical policy and the member's contract benefits.

Although no group or individual contract requires a predetermination review, BCBSTX offers predeterminations in order to help members, physicians and other professional providers become knowledgeable about potential coverage issues.

To facilitate timely and accurate medical record reviews, BCBSTX has developed a number of medical policy documentation forms. These forms should be used as a supplement to — and not a replacement for — medical record documentation.

You can access the predetermination request form and instructions, all medical policies, and a current listing of available medical policy documentation forms on the BCBSTX Provider Web site at bcbstx.com/provider.

Medicare Part D pharmacy update TARCEVA (erlotinib) safety alert

On May 8, 2009, the FDA made public a letter that Genentech and OSI, the makers of TARCEVA (erlotinib) sent in April 2009 to health care professionals notifying them of new safety information added to the Warnings and Precautions section of the medication's prescribing information.

Incidents of gastrointestinal (GI) perforation; bullous, blistering and exfoliative skin conditions (suggestive of Steven-Johnson syndrome/toxic epidermal necrolysis); and ocular disorders including corneal perforation or ulceration have been reported through routine pharmacovigilance activities during clinical studies or through post-marketing reports. These safety monitoring reports included a number of undisclosed fatalities.

TARCEVA (erlotinib) monotherapy is currently indicated for the treatment of patients with locally advanced or metastatic non-small-cell lung cancer after failure of at least one prior chemotherapy regimen. In combination with gemcitabine, TARCEVA (erlotinib) is also indicated for the first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer.

Patients known to be at a higher risk of experiencing these side effects include:

- Patients receiving concomitant anti-angiogenic agents (e.g. GLEEVEC, SPRYCEL, TASIGNA, TYKERB) corticosteroids, NSAIDs, taxane-based chemotherapy, or who have a prior history of peptic ulceration or diverticular disease.
- Patients with other ocular disorders including abnormal eyelash growth, keratoconjunctivitis sicca or keratitis, as these conditions are known risk factors for corneal ulceration/perforation.

Medical providers are asked to monitor patients taking TARCEVA (erlotinib) carefully for unusual GI, Skin, and ophthalmic signs and symptoms and to report all suspected adverse drug reactions to the FDA's MedWatch Program by phone at 800-FDA-1088; by fax at 800-FDA-0178; by mail at MedWatch, HF-2, FDA, 5600 Fishers Lane, Rockville, MD 20852-9787; or on the MedWatch Web site at fda.gov/medwatch.

For more information, see

fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm150596.htm.

RAPTIVA (efalizumab) withdrawn from market

On April 8, 2009, Genentech and the Food and Drug Administration (FDA) notified health care professionals of the voluntary, phased withdrawal of RAPTIVA (efalizumab), a medication for treatment of psoriasis, from the U.S. market due to a potential risk to patients of developing progressive multifocal leukoencephalopathy (PML). PML is typically seen in patients with compromised immune systems and has been previously reported in both RITUXAN (rituximab) and TYSABRI (natalizumab).

The move comes only about six months after the company updated the drug's labeling to carry warnings regarding links to PML. A total of four cases of PML (three confirmed, one suspected) have been reported. Regulators in the European Union recommended banning the drug therapy in February.

The company estimated that about 2,000 patients in the U.S. were taking the drug at the time of the announcement and accounted for \$108 million out of Genentech's \$13.42 billion sales in 2008.

As of June 8, 2009, RAPTIVA (efalizumab) is no longer available in the United States. Prescribers are being asked not to initiate RAPTIVA (efalizumab) treatment for any new patients. Prescribers should immediately discuss the transition to alternative therapies with patients currently using RAPTIVA (efalizumab).

For more information, see

fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm149675.htm.

TRS-ActiveCare benefit change for bariatric surgery effective Sept. 1

The Teacher Retirement System of Texas (TRS) will implement a significant benefit change for TRSActiveCare, the health care benefits program for active public education employees.

Effective Sept. 1, 2009, all bariatric surgical procedures, such as lap band and gastric bypass for weight loss, will be covered only if performed at one of the Blue Distinction® Centers for Bariatric Surgery. Currently, coverage is available at any facility.

Coverage restrictions apply to all bariatric surgery procedures performed on or after Sept. 1, 2009, including those with predeterminations and preauthorizations issued for bariatric surgery before Sept. 1, 2009.

Any medically necessary bariatric procedures performed on or after Sept. 1, 2009 must be performed at one of the Blue Distinction Centers for Bariatric Surgery, or the expenses will not be covered by TRSActiveCare.

Travel expenses to and from the Blue Distinction Centers will not be covered by the plan. Complications of surgery will be covered as any other illness.

Blue Distinction is a designation awarded by Blue Cross and Blue Shield to medical facilities that have demonstrated expertise in delivering quality health care, resulting in better overall outcomes for bariatric patients. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgery care services, including inpatient care, postoperative care, outpatient follow-up care and patient education.

Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, and is subject to periodic reevaluation as criteria continue to evolve.

On the next page is the current list of Blue Distinction Centers for Bariatric Surgery in Texas. This list is subject to change without notice. To search for Blue Distinction Centers for Bariatric Surgery online, go to bcbs.com/innovations/bluedistinction/blue-distinction-bariatric/.

Blue Distinction Centers for Bariatric Surgery Location

- Baylor Regional Medical Center of Plano – Plano
- Baylor University Medical Center – Dallas
- Del Sol Medical Center – El Paso
- Doctors Hospital – Dallas
- Houston Northwest Medical Center – Houston
- Memorial Hermann Hospital – Houston
- Mother Frances Hospital – Tyler
- Presbyterian Hospital of Dallas – Dallas
- Providence Memorial Hospital – El Paso
- Rio Grande Regional Hospital – McAllen
- Scott and White Memorial Hospital – Temple
- The Methodist Hospital – Houston
- Trinity Medical Center – Carrollton

- United Regional Health Care System, Inc. – Wichita Falls
- UT Southwestern University Hospital - Zale Lipshy – Dallas
- Wadley Regional Medical Center – Texarkana

The TRS-ActiveCare PPO plans are administered by Blue Cross and Blue Shield of Texas; the program includes more than 340,000 members throughout the state.

EDS initiatives

Reaching out to our members — whether they are ill with a chronic condition or healthy and just need preventative guidance — is all part of the standard telephonic outreach by the Health Advocates at Blue Cross and Blue Shield of Texas (BCBSTX). Our alternative approaches provide outreach opportunities for those members who would not normally be identified through the claims processing system, chronic condition management program, or hospital or disease management referrals.

A few of the initiatives that the Electronic Data Systems (EDS) custom account uses to identify healthy members are the WebMD Health Questionnaire (healthy population that responded with no chronic conditions), Full Service Unit (Customer Service) referrals, the Campaign Manager initiative and referrals from the 24/7 NurseLine.

Pre-/post-call program initiative

The Pre-Admit/Post-Discharge Call Program provides telephonic outreach to members in the Custom Blue Care Connection® Health Advocate EDS Program with all scheduled elective inpatient procedures. Preadmission outreach is completed within four business days before the member's admission for all preadmissions that the plan is aware of, while the postdischarge call is completed within four business days after the member's discharge from the hospital.

During a preadmission call, the Health Advocate contacts the EDS member to obtain permission to call the member during their hospital stay to offer educational support and discuss discharge planning needs. The nurse or case manager also conducts a depression screen during the post call.

As part of the initiative, the Health Advocates mail educational materials as part of the preadmission outreach. These materials include information regarding both pre- and postoperative care, hospital safety, and medication compliance. The goal of the program is to prevent hospital readmission through member education.

In 2008, the Standard, Enhanced and Custom Blue Care Connection Programs together experienced an outreach rate of 90 percent and a contact rate of 40 percent, with participants very eager to participate.

PPIs added to City of Houston step therapy program

As of May 1, an additional category of medications was added to step therapy for City of Houston members: proton pump inhibitors (PPIs) for GERD, heartburn or stomach ulcers.

Providers must prescribe a generic PPI before the member can receive a brand name. This is the case even if the member is currently taking a PPI. This began with the first refill after May 1.

NOTICES AND ANNOUNCEMENTS

Each issue, we publish brief notices and announcements you may need. For the latest updates, visit our Provider website at bcbstx.com/provider.

Professional charges for services performed by a physician in a hospital setting

Blue Cross and Blue Shield of Texas (BCBSTX) does not reimburse facilities for clinic services, such as professional services by emergency room physicians or physicians operating out of a clinic. These services are considered professional in nature and would be billed under the physician's National Provider Identifier.

Billing professional charges on a UB04 will generate a denial message instructing you to resubmit the charges on a CMS-1500 (08-05) form. Professional charges will be allowed on a UB04 when Medicare is primary for the member.

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.

Identifying primary insurance when seeing BCBSTX members over Age 65

The Medicare Secondary Payer (MSP) provisions of the Social Security Act are similar to the coordination of benefits clauses in group health plans. The MSP regulations determine the order of payment (primary, secondary, etc.) when an individual has coverage under both a group health plan and Medicare.

When the group health plan is primary, the individual must follow the group health plan's rules to obtain the highest payment. If this is not done, Medicare will carve out what the group health plan would have paid, and pay as secondary.

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 on 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 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.

Medical policy disclosure

New or revised medical policies, when approved, will be posted on our provider portal on the first or 15th 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 posted.

To view pending policies, go to the General Reimbursement Information section at bcbstx.com/provider and click on Medical Policies. After reading the disclaimer, click on I Agree to advance to the Medical Policies page. The policies are accessible by clicking the View Pending Policies tab.

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 May 2009:

- Air Force Villages, Inc
- Alamo Iron Works, Inc.
- Applied Aerodynamics, Inc.
- Asgard Lantern Drilling Company
- 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
- Connally Memorial Medical Center
- Crestview RV
- DCTA
- Epic Medstaff Services, Inc.
- First Co. Taylor & Hill

- Gabriel Holdings, LTD
- Geodynamics, Inc.
- Good Fulton & Farrell
- Guido Management Services, Inc.
- Hays CISD
- Health Services Management of Texas, L.L.C.
- Hi-Tech Plastics
- John Burns Construction Co. of Texas
- John L. Wortham & Son, L.P.
- M. Hanna Construction Co., Inc.
- Mass Group Marketing, Inc.
- MHMR Authority of Brazos Valley
- MHMR Services of Texoma
- Mike Calvert Toyota
- Odyssey Aerospace Components, L.L.C.
- Poulos Automotive Group, Inc.
- Reef Industries, Inc.
- Research Analysis & Maintenance, Inc.
- Six Day Dental & Orthodontics-North TX, P.A.
- Southwest Ford, Inc.
- TEI & Associates, L.L.C.
- The Care Group of Texas
- United Graphics
- VLSIP Technologies, Inc.
- Wal-Mart
- Yantis Company

Updates to procedure codes

The chart below summarizes the enhancements made to BCBSTX processing of professional claims and associated payment-auditing logic since our last notice. These actions are not retroactive to claims processed before the effective date listed.

Denied procedure Code	Allowed procedure code	Customization edit applied	BlueChip date to production
Q9958-Q9964	Various radiological procedure codes	Edit removed	6/29/2009
90700-90719	90696	Edit removed	6/29/2009

The five-character codes included in this article are from the Physician's Current Procedural Terminology® (CPT), copyright 2009 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five-character identifying codes and modifiers for reporting medical services and procedures performed by physicians. CPT is a registered trademark of the AMA.

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.

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. 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. 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 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.

Billing for non-covered services

In the event that BCBSTX determines in advance that a proposed service is not a covered service, a physician or other professional provider may inform the member/subscriber in writing in advance of the service rendered. The member/subscriber must acknowledge this disclosure in writing and agree to accept the stated service as a non-covered service billable directly to the member/subscriber.

To clarify, if you contact BCBSTX and find out that a proposed service is not a covered service, you have the responsibility to pass this along to your patient (our member/subscriber). This disclosure protects both you and the member/subscriber. The member/subscriber is responsible for payment to you of the noncovered service if the member/subscriber elects to receive the service and has acknowledged the disclosure in writing.

Reminder — Contracted providers must file claims

As a reminder, providers must file claims for any covered services rendered to a member, spouse or covered dependent enrolled in a Blue Cross 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.

Billing for allied professionals

Appending the appropriate modifier when billing for services rendered in collaboration with a physician by a PA, ANP and RNFA will ensure more timely and accurate reimbursement. The following information provides the modifiers and their descriptions, as well as details explaining when to use them.

When the supervising physician bills PA, ANP and RNFA services, the supervising physician must submit claims with one of the following modifiers listed below:

Modifier	Description	Use When
SA	Nurse practitioner rendering service in collaboration with a physician	Billing any service other than assistant to surgery
AS	Physician assistant acting as assistant in surgery	Supervising physician is billing for PA, ANP or RNFA when acting as assistant at surgery

When billing for their own services rendered as assistants at surgery, PAs, ANPs and RNFAs should use Modifier 80 – Assistant Surgeon.

Simple rule: include the onset/occurrence date

Blue Cross and Blue Shield of Texas (BCBSTX) asks that you routinely include the **Date of Current Illness** or **Occurrence Code** and the associated date in your claim submissions. This will help eliminate the need to contact Customer Service when a claim denies unexpectedly needing this information.

When submitting the CMS-1500, enter the **Date of Current Illness** (also known as the onset date) into **Box 14** to indicate the first date of the symptom, illness, accident or injury, or last menstrual period (LMP) for pregnancy. If the patient has had the same or similar illness, enter the first date into **Box 15**.

When submitting the UB-04, enter the **Occurrence Code** and associated date in **fields 31-36**; this defines a significant event related to the claim. The most commonly recognized **Occurrence Codes** by BCBSTX are listed below:

Occurrence Code	Definition
01	Auto Accident
04	Accident – Employment Related
05	Other Accident
10	Last Menstrual Period (LMP)
11	Onset of Symptom/Illness
33	First Day of Medicare Coordination Period for End Stage Renal Disease (ESRD)

Remember that the first date of service is not always the onset/occurrence date. Claims may process differently depending on what date is entered. Be sure that you are entering the actual date on all claims.

