All Product News

Information applicable to all lines of business for Blue Cross and Blue Shield of Texas and HMO Blue Texas.

HMO Blue® Texas

Southwest Texas HMO, Inc.

Southwest Texas HMO, Inc. offers HMO plans and does business as HMO Blue Texas.

BlueChoice®

BlueChoice is a PPO and POS product provided or administered by Blue Cross and Blue Shield of Texas with networks for contracting PPO and POS providers.

BLUE CROSS AND BLUE SHIELD LISTENS!

Blue Cross and Blue Shield of Texas continues to make enhancements to the professional claims process and associated payment-auditing logic. Below are highlights of enhancements with their effective date that have been made since our last notice. This action is not retroactive to claims processed prior to the effective date listed.


- Subtraction in conjunction with contrast studies (76550) will bundle to Angiography radiological procedures (70496-8, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75600-5, 75625, 75650, 75658-65, 75671, 75676, 75680, 75685, 75705-10, 75716, 75722, 75724-26, 75731-56, 75741-46, 75756, 75774, 75790, 75898). Digital Subtraction Angiography is considered part of the conventional arterial angiography and does not warrant separate reimbursement. PPO/POS effective Aug. 9, 2002, HMO effective Aug. 30, 2002.


- Application of hot or cold packs (97010) will no longer bundle to Therapeutic procedures (97012, 97110-97140, 97520-97530, 97545-6, 98705-43). PPO/POS effective Aug. 9, 2002, HMO effective Aug. 30, 2002.


Future enhancements will be announced through this publication. If you have any questions, please contact Provider Customer Service at 1-800-451-0287.

NEW ACCOUNT: TEXAS INSTRUMENTS

Blue Cross and Blue Shield of Texas is pleased to announce that Texas Instruments is a new national account. The Group Number is 80946 and the alpha prefix is AJL for PPO members. The effective date for this account is Jan. 1, 2003.
HIPAA CHANGES LOCAL CODE SETS

The Health Insurance Portability and Accountability Act (HIPAA) legislation dated Aug. 17, 2000 mandates the use of standard code sets in covered transactions. The standard medical code sets as defined by the HIPAA legislation are:

- ICD-9-CM Volumes 1-5 for diagnosis
- AMA CPT 2002 for procedures codes
- HCPCS Level II for procedures, services and supplies

The legislation further states that local codes may not be used in transactions after the effective date of the regulation. Effective Oct. 16, 2002, BCBSTX will no longer accept claims that are submitted with local codes for dates of service on or after Oct. 16, 2002.

NATIONAL CODE SETS BECOME THE STANDARD

As Blue Cross and Blue Shield of Texas works toward HIPAA readiness, some changes are being made in response to regulations that require providers and payers to use only national standard code sets for electronic transactions. The following changes went into effect Oct. 16, 2002:

Anesthesia Billing
When submitting electronic or paper claims for anesthesia services, you must use CPT 4 Anesthesia Codes. In all cases, the appropriate anesthesia modifier should be used, if indicated.

Ambulatory Chemotherapy Daily Pump Rental
When submitting claims for ambulatory infusion pump rental, you must use E0779. BCBSTX will not support the use of local code H00990. NOTE: Ambulatory infusion pump rental may be billed only when the patient leaves the office with the pump for a prolonged chemotherapy infusion.

BILLING TIPS FOR DENTAL SERVICES PAYABLE UNDER THE MEDICAL CONTRACT

Certain Blue Cross and Blue Shield of Texas plans may provide benefits for dental services for the following:

- For the correction of damage caused solely by external, violent accidental injury to healthy, unrestored natural teeth and supporting tissues, but only if treatment is sought within 24 hours of the accident* and limited to treatment provided within 24 months of the initial treatment.
- Covered oral surgery.
- Services provided to a newborn child that are necessary for treatment or correction of a congenital defect.
- Medically necessary in-patient dental services unless excluded in the Medical Limitations and Exclusions portion of the contract.

If you are billing for one of these situations on paper, use a HCFA 1500 claim form with appropriate valid HCPCS or CPT codes.

Do not use the ADA (American Dental Association) CDT dental procedure codes published in the Level II HCPCS Code Book as they can only be accepted on a dental claim form for services payable under a dental coverage plan. These services may also be submitted electronically using the HCPCS/CPT procedure codes.

* Treatment under HealthSelect and HealthSelect Plus must be sought within 24 months of the date of the accident.
**UNDERSTANDING THE MEDICARE CROSSOVER PROCESS**

Blue Cross and Blue Shield of Texas (BCBSTX) receives numerous inquiries concerning the Medicare crossover claim process. In an effort to shed some light on this process, we offer the following information.

On a weekly basis, BCBSTX creates an eligibility file that includes all members and subscribers based on certain criteria within membership records — at that time. This criteria includes a Medicare ID on file, the member’s age, employment status and other indicators within the files that generally indicate Medicare entitlement. This eligibility file includes all BCBSTX plans (NASCO, FEP, PPO, HMO, etc.). This file is then distributed electronically to TrailBlazer Health Enterprise (Medicare Part A and Part B), Mutual of Omaha (Medicare Part A Intermediary) and Palmeto (BCBS–South Carolina) which is the DMERC carrier for this region.

These carriers and/or intermediaries forward processed claims electronically to BCBSTX on a daily or weekly basis, depending on the carrier or intermediary. If the processed claim is crossed over to us based on this eligibility file, a message appears on the Medicare EOMB indicating that this crossover has occurred. These claim files are then loaded into the BCBSTX claims processing applications.

We are continually working to improve the Medicare crossover claim process. If you have any questions, contact the Provider Customer Service area at (903) 954-7124.

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**Why do some claims crossover to BCBSTX when there appears to be no policy with BCBSTX?**

This could be the result of an old policy that is still in the records or it could be an error in the membership files (Medicare ID number where numbers are transposed, spouse’s number on the membership file, etc.).

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**Why don’t some member claims automatically crossover?**

There are some claim exclusions for this process which include:
- Member’s Medicare ID on membership files is missing
- Claims totally denied
- Adjustments – additional payment or payment of a previously processed claim
- Assigned claims paid at 100%
- Non-assigned claims paid at 100% of the Medicare allowed charge
- Claims for dates of service outside the policy effective and termination dates
- Medicare secondary claims
- Claims for members where Medicare records indicate Medicare is secondary

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**What can a provider do to ensure a patient’s claims automatically crossover?**

- Encourage patients to provide BCBSTX with their Medicare ID numbers. This is the most accurate method of ensuring the process is successful.
- Immediately contact BCBSTX customer service areas when claims are processed incorrectly. The sooner we are made aware of issues, the sooner our records will be corrected and the information propagated to the carriers and intermediaries.
- Do not automatically mail paper secondary claims. This only increases provider office expenses and slows down the BCBSTX mailroom and claims processing.
PREPARING FOR HIPAA

The HIPAA transactions and code set standards implementation deadline is Oct. 16, 2003. This is an important time for providers to evaluate their practice management systems. If providers intend to submit claims and conduct other HIPAA transactions electronically, it is essential that they understand the costs involved in complying with the standard formats. As providers begin to construct their HIPAA compliance strategy, we want to emphasize the importance of maintaining flexibility in the electronic transaction options regardless of whether they intend to use a clearinghouse service, submit the transactions directly to a payer or some combination of both.

Practice management system vendors generally have two approaches to HIPAA compliance:

1) Selling an add-on module that creates compliant transactions at final bill, which allows for direct submission to payers or to a clearinghouse the provider chooses.

An add-on module, while requiring an initial investment in software and configuration services, provides the provider with substantially greater business flexibility. It also gives the provider a higher degree of control over the ongoing costs of submitting claims and conducting other HIPAA transactions electronically.

2) Providing external mapping services via a clearinghouse, which is typically owned by the same vendor.

Vendors in this category are not required to – and may not support – HIPAA compliant modules. These vendors are approaching their clients with “all-payer” HIPAA transaction solutions that require translation at the vendor’s clearinghouse. In this arrangement, the provider effectively turns over control of the transaction. Since the transaction must be translated by the vendor to become compliant, the provider forfeits the option of sending the transaction to another clearinghouse or directly to the payer, both of which may be less expensive options. In addition, such an exclusive relationship may put the provider at a disadvantage when negotiating the transaction fee structure with the practice management system vendor.

Questions for Practice Management System Vendors

In light of the circumstances described above, it is essential that the provider become acutely aware of the cost implications of HIPAA compliance. We encourage providers to initiate candid discussions with their practice management system vendors about these issues. The following questions are meant as a guide:

- When will the HIPAA software upgrade be ready?
- Will there be any additional cost for this software upgrade?
- Will I be in breach of my contract if I use another vendor’s software to extract claims data from my system?
- Will I be able to submit HIPAA compliant transactions directly to payers if I choose to do so?
- Will I be able to use the clearinghouse service of my choice?
- When are you going to start the necessary testing of the software, and who will be certifying the results of the testing?
- Will you be working directly with any insurers or clearinghouses to ease the transition to HIPAA standards and to test the messaging systems?
- Will you be notifying physician clients of your progress?
- Can you assure me that all transactions and data transmitted will be handled according to the HIPAA privacy and security regulations?
- Will the HIPAA software update include all of the standard transactions and edits for the required data content (i.e., claim status, eligibility, electronic remittance)?

If the practice management system vendor will not provide the requisite transaction flexibility, there are alternatives available that do not require switching to a new office management system. Several vendors offer software packages that will extract claims from practice management systems and (1) perform the necessary ANSI translation, edit, and route the claim directly to a payer or (2) create an expanded national standard format, edit, and route the claim directly to the clearinghouse of the providers choice for translation.

If you have any questions, please contact the THIN EDI Helpline at (972) 766-5480 or your Provider Automation Representative.
On Sept. 1, 2002, 45,000 members moved from HealthSelect Plus (HMO) to HealthSelect (POS). All state employees switching from HealthSelect Plus to HealthSelect will need to obtain a new referral from their PCP. Any prior referrals obtained with HSP will not be valid with HealthSelect.

HealthSelect claims submitted electronically should reflect the Blue Cross and Blue Shield of Texas payer ID #84980. To ensure proper routing, please include the correct prefix of “ZGB” for HealthSelect.

REFERRALS AND ELECTRONIC FILING

On Sept. 1, 2002, 45,000 members moved from HealthSelect Plus (HMO) to HealthSelect (POS). All state employees switching from HealthSelect Plus to HealthSelect will need to obtain a new referral from their PCP. Any prior referrals obtained with HSP will not be valid with HealthSelect.

HealthSelect claims submitted electronically should reflect the Blue Cross and Blue Shield of Texas payer ID #84980. To ensure proper routing, please include the correct prefix of “ZGB” for HealthSelect.

PHARMACY UPDATE ON QUANTITY VERSUS TIME LIMITS

Quantity vs. Time (QVT) Limits prevent claims from being processed and paid by the health plan if the member is receiving more than the appropriate amount of medication over a stated period of time. QVT Limits are based upon the drug manufacturer’s recommendations, FDA guidelines, and review by the Blue Cross and Blue Shield of Texas Pharmacy and Therapeutics Committee.

QVT Limits are not new and have been implemented through Blue Cross and Blue Shield of Texas for several years. QVT Limits also serve an important purpose by improving the quality of pharmaceutical care through obtaining appropriate outcomes and addressing inappropriate utilization at the time of dispensing to minimize health risks and reduce overall costs.

On Jan. 1, 2003, two new drug categories, Proton Pump Inhibitors and Pain Management, will be added to the Quantity Versus Time Limits List. The Proton Pump Inhibitors category includes the drugs Aciphex, Prilosec, Nexium, Protonix and Prevacid. The Pain Management category includes the drug OxyContin.

For the latest information on QVT Limits and to access an updated QVT Limits List, please visit the Provider section of the Blue Cross and Blue Shield of Texas Web site at www.bcbstx.com.

CDS Letter Program

In addition to the QVT program, BCBSTX also has in place a drug utilization review (DUR) program. The Controlled Drug Substance (CDS) Letter Program, an extension of the DUR process, identifies situations in which it appears that prescription drugs are potentially used in dangerous combinations or quantities. It also identifies situations where patients may be potentially abusing or misusing prescription drugs.

Prescribing physicians who have HMO Blue Texas members who meet the specified criteria will receive a CDS overview/drug utilization report and a controlled substance questionnaire based on a query of paid prescription claims data. CDS letters are mailed on a quarterly basis and the provider is requested to review the report and indicate on the questionnaire whether or not the member’s prescription history matches the member’s medical chart. Physician questionnaire responses assist the Clinical Pharmacy department in capturing and reporting cases of potential abuse or misuse of prescription drugs.

PROVIDER NUMBER UPDATE

BCBSTX will not change, add or delete information related to your provider number on a retroactive basis. All changes to your provider number will be effective with a future date.

Please contact your local network representative with at least 50 days advance notice when you make changes affecting your status with our ParPlan, BlueChoice and HMO Blue Texas networks, especially in the following areas:

- Requesting new provider numbers
- Physical address (primary, secondary, tertiary)
- Billing address
- TIN/SS number changes
- Moving from Group to Solo practice
- Moving from Solo to Group practice
- Moving from Group to Group practice
- Backup/covering providers
REQUESTING NON-NETWORK REFERRALS FOR POS AND HMO MEMBERS

There are times when your patient may require specialty care that is not available through the Blue Choice or HMO Blue Texas network of providers. If access to necessary care is not available through network providers, there is a process for requesting an “out-of-network” or “out-of-plan” referral.

To request such a referral, please Fax your request to the following toll-free numbers:

**Blue Choice** 1-800-572-0864
**HMO Blue Texas** 1-800-252-8815

Include the patient’s name, identification number, subscriber’s group number as well as the name, address and phone number of the out-of-network physician/provider to whom you are requesting a referral. You also must include the reason for the out-of-network referral request.

*If you are an HMO Blue Texas network provider participating in a Limited Provider Network, you must refer to specialists in the same Limited Provider Network. You should contact your Limited Provider Network for referral requests to specialists outside of the Limited Provider Network.*

If you have questions about the process for obtaining out-of-network referrals, please contact your BCBSTX Professional Provider Representative.

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**2001 CONDENSED CONSOLIDATED STATEMENT**

Health Care Service Corporation, a Mutual Legal Reserve Company, does business through its corporate divisions, Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Texas and Blue Cross and Blue Shield of New Mexico. Health Care Service Corporation is an independent organization governed by its own Board of Directors and is solely responsible for its own debts and other obligations.

The Blue Cross and Blue Shield Association licenses Health Care Service Corporation to offer certain products and services under the Blue Cross and Blue Shield brand names.

Neither the Association nor any other organization using the Blue Cross or Blue Shield brand names acts as a guarantor of Health Care Service Corporation’s obligations.

A copy of Health Care Service Corporation’s most recent audited financial statement is available upon written request to Public Affairs/Consolidated Balance Sheet, Health Care Service Corporation, 300 East Randolph Street, 19th Floor, Chicago, Illinois 60601.

<table>
<thead>
<tr>
<th>Health Care Service Corporation and Subsidiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condensed Consolidated Balance Sheet, December 31, 2001 (In Thousands of Dollars)</td>
</tr>
</tbody>
</table>

**ASSETS**

- Cash & Investments: $2,861,010
- Premiums & Other Receivables: 1,045,423
- Property & Equipment: 257,977
- Other Assets: 624,987

Total Admitted Assets: $4,789,397

**LIABILITIES & NET WORTH**

- Claim Reserves: $1,162,026
- Aggregate Reserves: 1,000,378
- Accounts Payable & Other Liabilities: 1,046,079
- Debt: 400,000

Total Liabilities: $3,608,483

- Statutory Net Worth: $1,180,914

Total Liabilities & Net Worth: $4,789,397

*This statement is for information only. No action is required.*
**WELLNESS GUIDELINES AVAILABLE ON THE WEB**

Beginning in December, the Clinical Practice Guidelines (CPG) for Congestive Heart Failure and for Diabetes will be posted on the Blue Cross and Blue Shield of Texas Web site (www.bcbs.tx.com/provider). The posting of other guidelines such as Prenatal Care and Management of Cholesterol will follow early next year.

These guidelines are updated, at a minimum, on an annual basis and changes will be posted on the Blue Cross and Blue Shield of Texas Web site. When revisions are made, files listed in the table of contents will have a special message noting which sections and pages have been revised. This offers the option of printing only the updated pages. As part of the site, we will offer an interactive application where network physicians can comment on the CPGs adopted. Product specific Health Plan Employer Data and Information Set (HEDIS) results related to the CPGs will also be posted on an annual basis and compared to the National Committee for Quality Assurance (NCQA) and Texas Health Care Information Council (THCIC) results. Future issues of Blue Review will feature articles regarding the availability of the CPGs and Disease Management Programs offered to all HMO members and selected PPO/POS members whose employer group has purchased the programs. Disease management programs are available for asthma, diabetes, congestive heart failure and high risk pregnancy. If you have a patient whom you feel would benefit from one of the above mentioned programs, please call 1-800-462-3275 to enroll them today.

**DISCLOSURE NOTICE**

There are new regulations in Texas Administrative Code 11.901(10) and 3.3703 (20) regarding disclosure of fee schedule information and reimbursement policies to HMO and PPO contracting providers. In addition to the information in this regard which is already made available by Blue Cross and Blue Shield of Texas and HMO Blue Texas, we are developing tools that will provide HMO and PPO contracting providers access to additional information on or before January 7, 2003. More information will be provided in the next Blue Review newsletter.

**CLINICAL PRACTICE GUIDELINES FOR MAJOR DEPRESSIVE DISORDER IN ADULTS**


The full set of guidelines is available on the Magellan Behavioral Health Web site at [http://www.magellanprovider.com/handbook](http://www.magellanprovider.com/handbook) under Clinical Practice Guidelines. If you would like a hard copy of the Clinical Practice Guidelines, you may contact the BCBSTX Quality Improvement Programs Department at 1-800-863-9798.
HEDIS® Data Collection Upcoming

All HMOs are mandated by the State of Texas to collect HEDIS data. HEDIS is a group of measures used to compare health plan performance. Some areas included in the comparison are accessibility and use of services, effectiveness and cost of care, member satisfaction and health plan stability.

By standardizing the data collection and reporting methodology, HEDIS offers consumers a side-by-side comparison of the value of managed care products. It also provides health plans with the ability to identify potential areas for improvement.

The continued cooperation of providers in submitting medical records for Health Plan Employer Data and Information Set (HEDIS) data collection has been greatly appreciated. Now, it is time to think about 2003 HEDIS data collection. From March through May 2003, you may receive a request for medical record data. Information may be submitted in one of three ways:

1) Complete a short questionnaire regarding the patient's medical history and services received,
2) Mail or fax medical records, or
5) Schedule an on-site review with a health plan representative.

Medical record information collected for HEDIS purposes is kept confidential and reported to external agencies only in aggregate form. Tips which may decrease medical information requests are:

- Ensure patients receive preventive care services as outlined in the Blue Cross and Blue Shield of Texas Adult, Adolescent and Childhood Wellness Guidelines.
- Complete and submit claims and encounter data in a timely manner. Medical record review is only necessary on members for whom a claim or encounter has not been filed for the service being measured.

PHysician Requests To Terminate Physician/Member Relationship

Under certain circumstances, an HMO physician may terminate his/her professional relationship with a member as provided for, and in accordance with, the provisions outlined in the HMO Blue Texas Provider Manual. However, it is important to note that a physician may NOT terminate his/her relationship with a member because of such member’s medical condition or the amount, variety or cost of covered services that are required by the member. All such requests must first be sent to the applicable HMO Blue Texas Medical Director for consideration (do not send requests to the member). Please refer to the guidelines, procedures, and list of HMO Blue Texas Medical Directors’ Fax numbers outlined on Pages B-13 through B-16 of the HMO Blue Texas Provider Manual.


Please note the following correction to the Houston/Golden Triangle Fax number on Page B-15: (713) 665-1226.
CAHPS HMO Member Survey Results for 2002

HMO Blue Texas members recently rated their overall health plan experience by participating in the Consumer Assessment of Health Plans Survey (CAHPS). CAHPS is part of the NCQA accreditation process and is also required by state law. Members continue to be satisfied with the relationship they have with their health care provider and office staff. Significantly more members report that they received the help they needed when they called a provider’s office this year.

Following are the results of the HMO Blue Texas statewide 2002 CAHPS survey compared to the NCQA national averages:

<table>
<thead>
<tr>
<th>Composite Category</th>
<th>HMO Blue Texas</th>
<th>NCQA National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care1</td>
<td>68%</td>
<td>77%</td>
</tr>
<tr>
<td>Getting Care Quickly2</td>
<td>74%</td>
<td>80%</td>
</tr>
<tr>
<td>How Well Doctors Communicate2</td>
<td>88%</td>
<td>91%</td>
</tr>
<tr>
<td>Courteous &amp; Helpful Office Staff2</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>Customer Service1</td>
<td>58%</td>
<td>67%</td>
</tr>
<tr>
<td>Claims Processing2</td>
<td>76%</td>
<td>84%</td>
</tr>
<tr>
<td>Rating of Health Plan3</td>
<td>55%</td>
<td>62%</td>
</tr>
</tbody>
</table>

1 Percentage of members surveyed who answered “Not a Problem”
2 Percentage of members surveyed who answered “Usually or Always”
3 Percentage of members who rated the health plan 8, 9 or 10 on a scale from 1 to 10 with 10 being the highest
CLAIMS PAYMENT
AVOID DELAYS WITH PROPER SUBMISSIONS

HMO Blue Texas is committed to providing prompt payment of claims and complying with the requirements of Texas prompt pay laws and regulations (Texas Insurance Code Article 20A.18B and 28 Texas Administrative Code 21.2801 – 21.2819). Delays in claims payment can be avoided by submitting claims to the appropriate address.

If a member's primary care physician is affiliated with a capitated independent practice association (IPA) or medical group, claims for certain types of services must be submitted to the IPA or medical group rather than to the normal address used for HMO Blue Texas claims. If a claim should have been sent to an IPA or medical group, but was incorrectly submitted to HMO Blue Texas, the claim will be rejected and you will receive notice to re-file it with the appropriate IPA or medical group.

To determine the appropriate IPA or medical group for claims submission, refer to the member's HMO Blue Texas ID card to obtain the physician organization (POrg) code. Then refer to the table below for the claims filing address, claims and Utilization Management (UM) phone numbers for the capitated IPAs and medical groups in your area.

Note: It is important that you have the most current copy of the member's ID card.

<table>
<thead>
<tr>
<th>Physician Organization Code (POrg)</th>
<th>Capitated IPA/Medical Group Name</th>
<th>IPA/Medical Group Claims Filing Address</th>
<th>IPA/Medical Group Claims Inquiry and UM Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>HERT</td>
<td>Heritage Physician Networks</td>
<td>Heritage Physician Networks P.O. Box 744920 Houston, TX 77274</td>
<td>713-965-9444 Claims 713-965-9444 UM</td>
</tr>
<tr>
<td>HNIN</td>
<td>Intercultural Physicians Network (formerly Houston Network, Inc.)</td>
<td>Intercultural Physicians Network Attention: Claims P.O. Box 27479 Houston, TX 77227</td>
<td>713-986-1600 Claims 713-986-1600 UM</td>
</tr>
<tr>
<td>KELS</td>
<td>Kelsey-Seybold Clinic</td>
<td>Kelsey-Seybold Clinic Claims Administration P.O. Box 500568 Houston, TX 77250</td>
<td>713-442-5440 Claims 713-442-5339 UM</td>
</tr>
<tr>
<td>PFHC</td>
<td>People 1st Healthcare Network, Inc.</td>
<td>People 1st Healthcare Network, Inc. P.O. Box 5687 Houston, TX 77255</td>
<td>713-759-0154 Claims Ext. 16 713-759-0154 UM</td>
</tr>
<tr>
<td>RNPO</td>
<td>Renaissance Physician Organization</td>
<td>Renaissance Physician Organization P.O. Box 922001 Houston, TX 77292-2001</td>
<td>852-555-3535 Claims 852-555-3500 UM</td>
</tr>
<tr>
<td>ARCL, ARCN</td>
<td>Austin Regional Independent Associates</td>
<td>MediView Claims P.O. Box 26727 Austin, TX 78755-0727</td>
<td>512-420-2700 Claims 512-420-2777 UM</td>
</tr>
<tr>
<td>PIPA</td>
<td>Preferred Independent Physicians Association</td>
<td>Preferred Independent Physicians Association 5445 Executive Center Drive, Ste 150 Austin, TX 78751</td>
<td>512-538-1551 Claims 512-538-1551 UM</td>
</tr>
</tbody>
</table>
Claims Payment – continued

If the physician organization (POrg) code that appears on the member’s ID card appears in the table on the previous page, claims for physician, other professional services and outpatient diagnostic testing services should be filed with the IPA or medical group. If the POrg code that appears on the member’s ID card does not appear in the table or if the claim is not for the services stated above, the claim should be filed with HMO Blue Texas or HealthSelect Plus (Group #58000):

Claims for HMO Blue Texas EXCEPT HealthSelect Plus (Group #38000):

<table>
<thead>
<tr>
<th>HMO Blue Texas</th>
<th>P.O. Box 660044</th>
<th>Dallas, TX 75266-0044</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1-877-299-2377</td>
</tr>
</tbody>
</table>

Claims for HealthSelect Plus (Group #38000):

<table>
<thead>
<tr>
<th>HealthSelect Plus (ERS)</th>
<th>P.O. Box 833804</th>
<th>Richardson, TX 75083-3804</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1-888-585-9393</td>
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</tbody>
</table>

If you have questions about which services should be filed with the capitated IPA or medical group and which services should be filed with HMO Blue Texas, call your local area provider network office.

Note: Behavioral health claims, regardless of the member’s PCP or physician POrg code, should be sent to Magellan Behavioral Health Providers of Texas, Inc. at:

<table>
<thead>
<tr>
<th>Magellan Behavioral Health</th>
<th>P.O. Box 1659</th>
<th>Maryland Heights, MO 63043</th>
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<tr>
<td></td>
<td></td>
<td>1-800-729-2422</td>
</tr>
</tbody>
</table>

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**HMO BLUE TEXAS STATEWIDE CLAIMS FILING ADDRESS**

P.O. Box 660044
Dallas, TX 75266-0044

**HMO BLUE TEXAS CUSTOMER SERVICE**

1-877-299-2377

**HEALTHSELECT PLUS℠ – ERS CLAIMS FILING ADDRESS & CUSTOMER SERVICE NUMBER**

P.O. Box 833804
Richardson, TX 75083-3804
1-888-585-9393
IMPROVEMENTS IN HMO BLUE TEXAS CUSTOMER SERVICE

The HMO Blue Texas Customer Service area understands the concerns in the provider community. With the recent changes in the provider network in the Houston area, the introduction of the injectable drug program and the automatic recoupment process, many questions have been raised. We would like to assure you that we have taken note of all concerns and are addressing the issues through a number of different avenues.

To better service our customers, both members and providers, we are continuing to be proactive in our communication of changes before they occur. We are re-educating as well as keeping our staff up-to-date on all changes to ensure the accuracy of the data that is being communicated to our customers. We have established internal teams to monitor performance and enhance processes where necessary to ensure customer satisfaction.

We have made significant improvements in the areas of timely processing for both claims and inquiries. Improved performance has been seen in our accuracy results as well.

As always, we welcome your feedback on any issues as we strive to continually improve our customer service. If you have any questions, please call 1-800-855-5518.

HMO MULTIPLE SURGERY PRICING GUIDELINES UPDATE

1) When billing bilateral procedures using modifier “50”, providers should only bill the CPT code once. The line should reflect two units, to indicate the procedure was performed on both sides. If only one unit is billed with modifier “50”, HMO Blue Texas will assume the procedure was performed on only one side. Additionally, please enter modifier “50” in the primary (first) modifier field. If you prefer to bill using alternate modifiers reflecting a specific side (i.e. “RT” and “LT”), you must bill the CPT code twice. On each line billed, enter one unit and the specific modifier representing the side the procedure was performed on.

2) Effective Aug. 1, 2002, procedures billed with modifier “59” will be reimbursed in accordance with HMO Blue Texas multiple surgery guidelines.

5) When a provider bills with modifier “51” or HMO Blue Texas identifies the service as multiple surgery, HMO Blue Texas will reimburse based on operative areas. For example, if the additional procedure is in the same operative area as the primary procedure, HMO Blue Texas will reimburse at 50% of the allowable rate for the second and any subsequent procedures. If, however, the additional procedure is performed in a separate operative area, HMO Blue Texas will reimburse at 100% of the allowable rate.

For more information or questions about these guidelines, please contact HMO Blue Texas Customer Service at 1-877-299-2377. NOTE: Providers who deliver services to a member whose PCP is a member of a capitated IPA/Medical Group must submit claims to the capitated IPA/Medical Group. The multiple surgery pricing guidelines may vary by IPA/Medical Group.

UPDATED HMO BLUE TEXAS PROVIDER MANUAL AVAILABLE ONLINE

The latest update of the HMO Blue Texas Provider Manual can be found at www.bcbsnt.com/providermanuals (password: manual). Simply view the document Online or download and print sections of the manual as needed.

For those with hard copies, we do have one correction. On page B-15 of the manual, the Fax number listed for “Houston or the Golden Triangle” is incorrect. The correct Fax number is 713-663-1226. The Online version of the manual has been updated with the correct Fax number.

Additional updates to the manual will be made as necessary and posted Online, so be sure to check future issues of Blue Review for notices on the latest revisions.

If you do not have Internet access or have trouble opening the files Online or accessing the site, contact your Network Management Representative for either a CD version of the manual or a hard copy.
INJECTABLE DRUG PROGRAM EXPANDS

Effective Aug. 1, 2002, providers participating in HMO Blue Texas were given the option to obtain certain injectable drugs through McKesson Specialty Pharmaceuticals for their HMO Blue Texas patients.

For injectable drugs obtained through McKesson, HMO Blue Texas reimburses McKesson directly and the provider is then relieved of the financial burden associated with inventory control and billing of high cost injectable therapies. Any claims paid to a provider for injectable drugs provided by McKesson are subject to the autorecoupment process. Providers must still bill for administrative services.

The list of injectable drugs included in the program will be expanding as of Jan. 1, 2003. The new injectables to be added to the list include:

**Hyate:C**
**Bioclate**
**ProfIlnine SD**
**Rebif**
**Refacto**
**Proplex T**
**Tev-Tropin**
**Polygam**
**Pegasys**
**Rhogam**
**Depo Provera**
**AlphaNine SD**
**Synvisc**

For the latest information on the Injectable Drug Program and an updated Injectable Drug List, please visit the Provider section of the Blue Cross and Blue Shield of Texas Web site, which can be found at www.bcbstx.com.

**Note:** In October, Pharmacia Corporation began voluntarily recalling Lunelle™, a monthly contraceptive injection, due to a lack of assurance of full potency and possible risk of contraceptive failure.

THREE-TIER COPAYMENT PHARMACY DESIGN

According to reports, drug expenditures have been growing at a disproportionate rate compared to the rise in overall health care costs. In this age of new, more effective and more expensive medications, it is even more critical that we take an active role to ensure members receive appropriate interventions.

BCBSTX and HMO Blue Texas have implemented a pharmacy plan designed to encourage cost-effective drug selection, while offering flexibility to our participants. This three-tier pharmacy copayment plan design offers:

- **Brand name drugs as well as the choice of medications that are less costly, but equally effective, and**
- **Plan coverage for nearly all prescription drugs, available at different copayment levels.**

An example of a typical plan design would be:

- **$15 copayment for generic drugs,**
- **$30 copayment for preferred brand name drugs,** and
- **$45 copayment for non-preferred brand name drugs.**

All participants enrolled in fully insured HMO Blue Texas or Blue Cross and Blue Shield of Texas plans with pharmacy program benefits will have the three-tier pharmacy copayment as part of their benefit plans. Groups with alternate funding arrangements (AFA) and administrative services only (ASO) will have the option of selecting the three-tier pharmacy benefit or an updated two-tier pharmacy benefit.

The preferred brand name drug list may be accessed on the Blue Cross and Blue Shield of Texas Web site at www.bcbstx.com/pharmacy.

The current standard prescription drug benefit allows prescriptions written for up to a 90-day supply to be dispensed at a network pharmacy or through mail order for one copayment per 30-day supply.

For more information on pharmacy benefits contact Pharmacy Programs at (972) 766-1015.
HEALTHSELECT PLUS® SERVICE AREA REDUCED

On Sept. 1, 2002, the service area was reduced for the State of Texas’ self-funded HMO-type plan, HealthSelect Plus (HSP). Although 80% of the HSP counties were eliminated from the service area,* leaving 22 counties in major metropolitan areas of Texas, 75% of the HSP membership remains in the plan.

Eligibility for the State of Texas’ health plans, including HSP, is determined by the county in which the employee lives or works. With this choice, even if a physician or provider is located in a county no longer in the HealthSelect Plus service area, they may be seeing and caring for HSP patients. Since dependents’ coverage is determined by the state employee’s eligibility, providers may also be seeing HSP dependents in these non-HSP counties.

Tips for Electronic Filing

To submit claims electronically for HealthSelect Plus, the Blue Cross and Blue Shield of Texas payer ID #84980 should be used. To ensure proper routing, please include the correct prefix of “ZGZ” for HealthSelect Plus. When specifying the member I.D. number, also include the patient’s two-digit dependent number printed on the members I.D. card.

* HealthSelect Plus was eliminated in the cities of Abilene, Alpine, Amarillo, Beeville, Burnet, Corpus Christi, El Paso, Lubbock, Midland-Odessa, Palestine-Jacksonville, San Angelo, and Tyler and their surrounding counties.

PATIENT APPOINTMENT ACCESS YEAR-TO-DATE SURVEY RESULTS

Blue Cross and Blue Shield of Texas and HMO Blue Texas have developed patient appointment access standards and performance goals which are measured through the Physician Office Review Program and member satisfaction surveys. The following table includes the access indicator, established standard and performance goals as well as the year-to-date outcomes from the January through September physician office reviews compared to year-end 2001 results.

<table>
<thead>
<tr>
<th>ACCESS INDICATOR</th>
<th>STANDARD</th>
<th>2001 AVERAGE</th>
<th>2002 YTD AVERAGE</th>
<th>PERFORMANCE GOAL</th>
<th>2001 OUTCOME</th>
<th>2002 OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
<td>6 hours</td>
<td>8 hours</td>
<td>90%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Routine Symptomatic Care</td>
<td>Within 5 days</td>
<td>2 days</td>
<td>2 days</td>
<td>90%</td>
<td>97%</td>
<td>99%</td>
</tr>
<tr>
<td>Preventive Care/Annual Physical Exam</td>
<td>Within 30 days</td>
<td>10 days</td>
<td>10 days</td>
<td>90%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Initial New Patient Visit</td>
<td>Within 30 days</td>
<td>8 days</td>
<td>7 days</td>
<td>90%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>In-Office Wait Time</td>
<td>30 minutes or less</td>
<td>20 minutes</td>
<td>19 minutes</td>
<td>90%</td>
<td>96%</td>
<td>97%</td>
</tr>
</tbody>
</table>

After Hours Care:

- Emergency Care Method for directing patients to emergency care after hours. NA NA 90% 98% 98%
- Alternative Care Method for directing patients to alternative care for non-emergent symptoms after hours. NA NA 90% 99% 99%

With the exception of after-hours care, network physicians are meeting the established standards and performance goals. To comply with the after-hours care requirements, as outlined by the Texas Department of Insurance, primary care physicians must be available to their patients 24 hours a day, 7 days a week. The patient must be given the opportunity to speak with the physician or an appointed designee if desired. To meet the after-hours care requirements, BCBSTX and HMO Blue Texas recommend physicians use one of the following:

- An answering service to direct patients in the event of an emergency or a contact number for an on-call clinician.
- A message machine, which directs patients in the event of an emergency and provides a telephone or pager number for an on-call clinician.
FIRST OBSTETRIC VISIT

Effective Oct. 1, 2002, providers must discontinue the use of Texas-created code 04014 (INITIAL OB VISIT). This is not a nationally recognized code published in a HIPPA compliant code set. Please refer to the 2002 edition of the Current Procedural Terminology in the Maternity Care and Delivery section for guidelines for billing. If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, see the antepartum and postpartum care codes 59425-59426 and 59450. For one to three care visits, see the appropriate Evaluation and Management code(s).

BLUE CHOICE PROVIDERS RATE BEHAVIORAL HEALTH SERVICES

Results of the 2002 Blue Choice Provider Satisfaction Survey for Behavioral Health Services are now available. This annual survey is a joint project of Blue Cross and Blue Shield of Texas (BCBSTX) and INROADS™ Behavioral Health Services of Texas, L.P. (INROADS). Telephone interviews were conducted earlier this year from a random selection of 150 providers who had seen at least five Blue Choice patients in the previous 12 months. An independent vendor administered the survey.

A deficiency was noted concerning network representative processes and a Corrective Action Plan is currently in development. The corrective action will be reported in a future newsletter.

Survey Highlights

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>% Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>INROADS Customer Service Representative Knowledge</td>
<td>96%</td>
</tr>
<tr>
<td>Initial referral process does not delay patients’ access to treatment</td>
<td>96%</td>
</tr>
<tr>
<td>Inpatient Care Manager does not delay patients’ access to treatment</td>
<td>80%</td>
</tr>
<tr>
<td>Peer Reviewer provides timely review determination</td>
<td>94%</td>
</tr>
<tr>
<td>Ease of contacting Network Representative</td>
<td>50%</td>
</tr>
<tr>
<td>Claims payment promptness</td>
<td>85%</td>
</tr>
<tr>
<td>Claims payment accuracy</td>
<td>81%</td>
</tr>
</tbody>
</table>

If you have any questions about the study or would like a copy of the survey, please contact Valerie Hermes, Senior Research Analyst for Blue Cross and Blue Shield of Texas at (972) 766-6902 or by email at Valerie_Hermes@bcbstx.com

NEW MAILING ADDRESS

FOR FEDERAL EMPLOYEE PROGRAM CLAIMS:

Blue Cross and Blue Shield of Texas
Federal Employee Program
P.O. Box 660044
Dallas, TX 75266-0044

Customer Service Number:
1-800-442-4607

FOR HEALTHSELECT CLAIMS:

Blue Cross and Blue Shield of Texas
HealthSelect™
P.O. Box 660044
Dallas, TX 75266-0044

Customer Service Number:
1-800-252-8039
MEDTRONIC — NEW NATIONAL ACCOUNT

Effective Jan. 1, 2003, Medtronic will become a new account of Blue Cross and Blue Shield of Minnesota (BCBSMN). Medtronic employees in Texas have two plan designs, PPO & EPO, both of which utilize the BlueCard PPO network. The alpha prefix for the Medtronic account will be "MDC,"

As members prepare for the change to Blue Cross Blue Shield, they may ask providers if they participate with BCBSTX. Texas Medtronic members will receive the highest level of benefits when seeking services from BlueCard PPO participating providers.

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