Creating a greater state of satisfaction

Have you recently joined our provider network(s), added a new line of business, added a physician to your practice or hired new staff members in your office?

The Blue Cross and Blue Shield of Texas (BCBSTX) Provider Access and Servicing Strategy (PASS) group is proud to continue the tradition of offering complimentary workshops, webshops, education sessions and Web sessions to our contracting physician/provider community. Every seminar is evaluated by attendees to better establish physician's/provider's needs in the realm of education.

PASS is committed to providing workshops, webshops, education sessions and Web sessions that will maximize your effectiveness and satisfaction in the BCBSTX networks by offering a variety of agenda topics. What is the difference between a workshop, a webshop, an education session and a Web session?

Workshops

Workshops are training seminars conducted by our trainers throughout the state of Texas for physicians/providers. Workshops generally last approximately four hours depending on the number of topics covered. You may browse our workshop schedule for a training session in your area at www.bcbstx.com/provider.

Webshops

Webshops are Web-based training available to you in the convenience of your own office. These interactive courses are a combination of a conference call and online training of the educational materials being presented. Webshops generally last approximately one to four hours depending on the number of topics covered. Webshops also offer the added convenience of logging in to attend the desired educational piece that will benefit your specific office needs. After registering for a webshop, you will receive an agenda and instructions for logging into the webshop. Assistance will be available for logging in.

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Education sessions

Education sessions include one to three topics that have been requested by your office. These sessions are conducted face-to-face to provide personal attention to address your specific educational needs. Education sessions generally last approximately one to two hours depending on the number of topics covered.

Web sessions

Web sessions include one to three topics that have been requested by your office. These sessions are a combination of a conference call and Web-based training of the specific educational topics requested. Web sessions generally last approximately one to two hours depending on the number of topics covered.

For any of these training opportunities, please visit our Web site at www.bcbstx.com/provider and fill out the “Training Request” form to request the specific training needs for your office.

In the near future, we will offer many new training experiences to our physician/provider community.

We are excited to introduce more advanced training for your staff members that includes, but is not limited to:

- Automated Office Module
- Coordination of Benefits Module
- “Talk to Blue” Module

Current training available

Provider Education 101

This session addresses basic workshop topics that BCBSTX has provided in the past:

- Review of ID Cards
- National Provider Identifier (NPI)
- Brief introduction to iEXCHANGE
- Guided tour of our Physician/Provider Web site
- Contact information for future questions
- Interactive Voice Response (IVR) Automated Phone System
- Availity
- AIM
- BlueCard
- Clear Claim Connection
- Refunds and Recoupments
- Predeterminations
- Appeals/Reconsideration Process

To sign up for this training and to monitor for future training changes, log onto www.bcbstx.com/provider and click on our “Provider Training” icon.
Availity optimizes information between health care providers, health plans and other health care stakeholders through the Availity® Health Information Network, a secure, collaborative exchange. Transactions are supported in both real-time and batch via a Web portal and via electronic data interchange (EDI) connections with several practice management system (PMS) vendors.

On the Availity Web portal, you can conduct real-time transactions at no charge with Blue Cross and Blue Shield of Texas (BCBSTX) and several other payers. Transactions include eligibility and benefits, authorizations and referrals, claims, claim status and remittance. If your organization hasn’t already done so, register today at www.availity.com to get access to this time-saving, free tool.

Availity also offers a comprehensive claims clearinghouse solution with more than 1,000 payers. Claims can be submitted via the Web portal or via your existing PMS. Due to The Health Information Network (THIN) and Availity joining forces in 2006, Availity is currently working with most PMS vendors to migrate claims from the THIN platform to the Availity platform. Your PMS vendor will notify you when their migration is complete.

Advantages of using Availity include:

- **Multiple Payers** — Transact with multiple health plans on one user-friendly Web portal.
- **No Charge** — Health plan transactions are available at no charge to providers.
- **Cleaner Claims** — Availity helps improve clean claim rates and turnaround times.
- **Accessible** — Availity functions are available 24 hours per day from any computer with Internet access.
- **Compliant** — Availity is compliant with the Health Insurance Portability and Accountability Act (HIPAA) regulations.
- **Training** — Free live Web-based training seminars (webinars) are available to you. Simply log into the Availity portal and register to attend the webinars of your choice. Demonstrations, Frequently Asked Questions and comprehensive Help Topics are available online as well.
- **Support** — Availity Client Services is available at 800-AVAILITY (282-4548) Monday through Thursday 8:00 a.m. to 6:00 p.m. CT and Friday 8:00 a.m. to 5:00 p.m. CT to answer your questions.

For more information about Availity, including an online demonstration, please visit www.availity.com.
The **iEXCHANGE** System has replaced BlueLINK as the automated pre-certification and referral system for Blue Cross and Blue Shield of Texas (BCBSTX). **iEXCHANGE** offers both interactive voice response (IVR) phone application as well as a Web-based application.

**iEXCHANGE** will continue to support the direct submission and processing of referrals and pre-certifications by network physicians, professional providers and facilities within Texas. The **iEXCHANGE** Case ID number will look different than the BlueLINK confirmation number. A sample **iEXCHANGE** Case ID number is 07219-AAAA. Please refer to the following information below to navigate through the **iEXCHANGE** IVR and **iEXCHANGE** Web applications:

<table>
<thead>
<tr>
<th>Function</th>
<th><strong>iEXCHANGE</strong> IVR (phone)</th>
<th><strong>iEXCHANGE</strong> Web</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>24 hours a day, 7 days a week</td>
<td>24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>Phone Number/Web Address</td>
<td>800-413-0869</td>
<td><a href="http://www.bcbstx.com/provider">www.bcbstx.com/provider</a></td>
</tr>
<tr>
<td>User ID/iEXCHANGE ID</td>
<td>n/a</td>
<td>Set up by Office Administrator designated by the physician/professional provider or facility</td>
</tr>
<tr>
<td>Provider Identifiers for Submitting Provider, Referred-to Provider, Attending Provider and Facility Provider</td>
<td>Obtain applicable provider’s NPI or MCO ID from BCBSTX Online Provider Directory, Provider Finder at <a href="http://www.bcbstx.com/onlinedirectory/index.htm">www.bcbstx.com/onlinedirectory/index.htm</a></td>
<td>Select from drop down menus available in the <strong>iEXCHANGE</strong> Web application</td>
</tr>
<tr>
<td><strong>Caution:</strong> Many physicians/professional providers have the same first and last name. Please be sure to verify name, address and specialty when making a selection. The same applies to facilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ID Number (previously referred to as Confirmation Number) issued following the entry of a Referral or Inpatient Certification</td>
<td><strong>SAMPLE</strong> Case ID Number = 07219-AAAA</td>
<td><strong>SAMPLE</strong> Case ID Number = 07219-AAAA</td>
</tr>
<tr>
<td>Texas <strong>iEXCHANGE</strong> Support Desk</td>
<td>800-441-9188, select option 1, then select option 4 Monday – Friday, 8:00 a.m. – 5:00 p.m. (CST)</td>
<td>800-441-9188, select option 1, then select option 4 Monday – Friday, 8:00 a.m. – 5:00 p.m. (CST)</td>
</tr>
</tbody>
</table>

*continued on page 5*
Effective Oct. 9, the processing of Modifier 62 has been automated in the claims payment system. It is no longer necessary to attach medical records to your co-surgery claims. Reimbursement for co-surgery will remain at 60 percent of the code allowance for each co-surgeon. The allowable(s) for the code(s) that are billed with Modifier 62, plus an additional 20 percent, are divided equally between the co-surgeons. Contractual multiple procedure reductions will apply to co-surgery claims. For more information on Modifier 62, refer to the most current edition of the American Medical Association’s Current Procedural Terminology Manual (CPT®).

**When to use Modifier 62**

- Both surgeons share the work and responsibility equally for the surgical procedure billed on the code and any add-on codes
- A procedure requires the skills of two surgeons (usually of different specialties) in order to complete the procedure and any add-on codes
- Both surgeons are working together as primary surgeons

**Incorrect use of Modifier 62**

- Surgeons of different specialties are each performing different procedures as a “team” (refer to the CPT manual for Modifier 66 definition)
- Using Modifier 62 to describe the services of an assistant-at-surgery
- Billing an assistant on a code when two surgeons billed with Modifier 62 on that same code

For more information or for assistance in using the iEXCHANGE applications, visit the BCBSTX Provider Web site at [www.bcbs.tx.com/provider/reference_guides.htm](http://www.bcbs.tx.com/provider/reference_guides.htm) or contact your local Professional or Facility Provider Network Office. The Web site provides the following resources:

- iEXCHANGE IVR Reference Guide
- iEXCHANGE Web Reference Guide — Office Administrator responsibilities and instructions are included in the Web Reference Guide

The iExchange Web application also allows professional providers and facilities to request referrals and inpatient pre-certification for BlueCard members.

For online application users

Your office is required to assign an Office Administrator to handle the following tasks:

- Setting up or adding new physicians/professional providers or facilities
- Maintaining and editing physician/professional provider or facility information
- Adding or inactivating users as needed
- Setting up frequently-used physician/professional provider and facility lists and procedure and diagnosis code lists
- Resetting user passwords

Changes to Modifier 62 co-surgeon payment

www.bcbs.tx.com/provider
The Blue Care Connection® Program (BCC) is a voluntary program designed specifically for those eligible BCBSTX members who are at-risk or have been diagnosed with a chronic condition such as asthma, diabetes, cancer, congestive heart failure, chronic obstructive pulmonary disease, low back pain, metabolic syndrome (high blood pressure, high cholesterol and obesity) or coronary artery disease.

In addition, the multidisciplinary team of Blue Care Advisors (RNs, Licensed Professional Counselors, Master-level Social Workers and Certified Diabetic Educators) assists members engaged in the BCC Lifestyle Management Program to have the tools available to face the many challenges of one or more of the following conditions: weight management, stress management or tobacco cessation.

Key elements of the BCC Program include, but are not limited to:

- Enhancing health care awareness and the connection with the health care system
- Addressing health care from a multidisciplinary approach
- Empowering the member to access health care opportunities available to them and to manage their health and wellness in a collaborative partnership with their physician and the health plan
- Reducing the total health care monetary and productivity costs to all stakeholders

The BCC Program provides an innovative approach to wellness, promoting proactive, collaborative health care management for members identified to be at-risk. Using motivational interviewing skills, inquiries are made to assess gaps in care, to inspire and facilitate ideas for healthy behavioral change(s).

The Blue Care Advisors use tools such as:

- **Assessments** — records change in care and health across time

- **Milestone tools** — track the member’s:
  - quality of life, level of pain
  - productivity as measured by number of work days missed
  - emotional functioning
  - proactive self-care through consistent lab check-ups
  - number of gaps in care that are open or have been closed

- **Self-reported values** — track values such as:
  - self-reported gaps
  - BMI
  - fat, fiber and water intake
  - stress management
  - behavioral and eating habits conducive to weight management
  - progress of weight loss
  - medication compliance
  - exercise patterns
  - psychosocial support accessibility
  - updated wellness checks with the physician

*continued on page 7*
Promoting partnerships and coordinating care with the physician is important. The BCC Program facilitates a collaborative relationship between the member and the physician for wellness screenings, clinical metrics, medication compliance issues, diet considerations, and (perhaps) recommendations for the appropriate amount of exercise and water intake. Members are provided education to enhance the physician-member relationship with encouragement for treatment collaboration, cooperation and compliance.

Through outreach mailings, faxing and phone calls, physicians are informed and encouraged to collaboratively engage with members who have enrolled in the BCC program to monitor clinical metrics and address treatment opportunities based on nationally recognized clinical practice guidelines. By including the physician as part of the BCC outreach process, care coordination is promoted. The member is encouraged to complete all routine health and wellness check-ups, as well as disease-specific related treatment/testing through their physician. This process assists in creating the collaborative partnership between the member, the physician and BCBSTX.

Unfortunately, in many cases the BCC staff has tried numerous times to contact our member, but may have been unsuccessful in reaching the member. If you have been identified by the member as their primary physician, the staff of the BCC Program would like the opportunity to speak with you. You may receive our request via a faxed request or a phone call. Please take a few moments to call us back at 866-412-8795 to speak with the Blue Care Advisor. We sincerely appreciate your assistance.

BCBSTX will be regularly communicating enhancements made to processing of professional claims and associated payment-auditing logic within this newsletter. 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.

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<tr>
<th>DENIED PROCEDURE CODE</th>
<th>ALLOWED PROCEDURE CODE</th>
<th>BUNDLING APPLIED</th>
<th>BLUECHIP DATE TO PRODUCTION</th>
</tr>
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<td>77057</td>
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</tr>
<tr>
<td>62194</td>
<td>62230</td>
<td>Remove edit</td>
<td>02/25/08</td>
</tr>
</tbody>
</table>

The five character codes included in this article are obtained from the Physician’s Current Procedural Terminology (CPT®), copyright 2008 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.
The ParPlan, BlueChoice® and HMO Blue® Texas (Independent Provider Network only) maximum allowable fees for practitioners will be updated to reflect 2008 CMS values effective July 1, 2008.

Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.

HMO Blue Texas, BlueChoice and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility). The Drug/Injectable Fee Schedule will be updated on the following dates: 6/1/2008, 9/1/2008, 12/1/2008, 3/1/2009 and 6/1/2009.

For BlueChoice, HMO Blue Texas and ParPlan, a multiple procedure payment reduction will be made on the technical component (TC) of certain diagnostic imaging procedures.

The reduction applies to TC-only services and the TC portion of global services for the procedures listed on the Blue Cross and Blue Shield of Texas Provider Web site. The reduction does not apply to professional component (PC) services. The highest priced procedure will be allowed at 100% and each additional procedure, when performed during the same session on the same day, will be allowed at 75%. Please see the Blue Cross and Blue Shield of Texas Provider Web site for additional information.

Blue Cross and Blue Shield of Texas provides general reimbursement information policies, request forms for allowable fees and fee schedule information at www.bcbs.tx.com/provider. To view this information, visit the General Reimbursement Information section on this Web site. The password is “manual.”

If you would like to request a sample of maximum allowable fees or if you have any other questions, please contact your local Professional Provider Network office.

Reimbursement changes will be posted under “Reimbursement Changes” 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.
There are new medical devices on the market that advertise the ability to utilize “spinal decompression traction therapy” for the treatment of low back pain. This advertisement has generated many questions.

**Spinal Decompression Traction Therapy** is an expensive high-tech form of mechanical traction. This Traction Therapy is performed by using a specially designed computer-driven table to control the level of disc decompression.

**There are several names for Spinal Decompression Traction Therapy such as:**
- Vertebral Axial Decompression (VAX-D) Therapy
- Internal Disc Decompression (IDD) Therapy
- Orthopedic Decompression Therapy

**In addition, there are some common devices and/or tables used in the health care industry today such as:**
- VAX-D
- The DRS System
- The Lordex Lumbar Spine System
- The DTS (Dynamic Traction System)
- DRX9000
- The Accu-Spina System
- SpineForce
- SpineMED Traction

The **Center for Medicare and Medicaid Services (CMS) Technology Advisory Committee** does not recommend coverage for this type of therapy because of the absence of scientific evidence to support its effectiveness.

The **National Coverage Determination (NCD) Manual** specifically refers to treatment which combines pelvic and/or cervical traction connected to a special-traction table as a non-covered benefit. Also, Medicare will not pay for special table traction therapy or any therapy associated with these special tables because they consider it to be experimental, investigational and unproven.

Blue Cross Blue Shield of Texas does not cover Spinal Decompression Traction Therapy. Please refer to **Medical Policy THE803.021**, effective date 8/15/2007. You can find our medical policies listed on our website at [www.bcbstx.com](http://www.bcbstx.com).
Life enhancement and performance (LEAP) testing

LEAP testing, also known as the mediator release test (MRT), utilizes blood serum to determine if a patient shows intolerance to certain foods. This intolerance may manifest itself in the form of irritable bowel syndrome, migraines or other symptomatology.

The treating/ordering physician prepares the blood sample(s) for shipment to an out-of-state clinical laboratory for analysis. Once the analysis is completed, the performing clinical laboratory returns the results to the treating physician in the form of a booklet listing specific foods that the patient has shown to be intolerant. The physician uses this information to identify the foods that the patient should eliminate or reduce in his/her dietary regime.

Blue Cross and Blue Shield of Texas has become aware of providers billing for LEAP testing under CPT® codes 83516 (Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method) and/or 83520 (Immunoassay, analyte quantitative; not otherwise specified).

LEAP testing is a non-covered benefit as it is considered to be experimental and investigational and is not a reimbursable service.

BCBSTX is responsible for review and oversight of claim payments and the eligibility for coverage of services. Every health benefit contract has exclusions from coverage, the basis for which includes, but is not limited to, a service being considered experimental/investigational.

Continuation of billing for this service may result in an overpayment. Please advise your billing staff and/or billing service that LEAP testing is a non-covered benefit. Your patients should be informed that LEAP testing is a non-covered benefit and therefore will be liable for the payment of this service.

For further information and clarification, please reference medical policies MED206.001 Allergy Management and MED206.003 Idiopathic Environmental Intolerance or Illness (IEI) Management. These medical policies may be accessed via the internet at www.bcbs.tx.com.
Pass through billing

Pass through billing is not permitted by BCBSTX. 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 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, or

2) The service is provided by an employee of a physician or other professional provider. (e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered First Assistant, who is under the direct supervision of the ordering provider and the service is billed by the ordering provider.)

Treating immediate family members — no claims submitted

When a member of your immediate family is ill, what do you do? Many physicians/providers treat their family members, typically without obligation for payment.

According to the standard BCBSTX member benefit booklet, benefits are not available for services rendered by physicians to their immediate family members.* Therefore, BCBSTX does not expect to receive claims for these services.

Remember — many professional medical organizations advise their membership against treating themselves or family. An immediate family member could be a husband or wife, natural or adoptive parent, child or sibling, stepparent or stepchild, stepbrother or stepsister, father-in-law or mother-in-law, brother-in-law or sister-in-law, grandparent or grandchild, or the spouse of a grandparent or grandchild.

BCBSTX will not make benefit payments on claims submitted for services rendered by or for immediate family members. Should it be determined that a benefit payment has been made in error, BCBSTX will request a refund of the original payment.

*This applies to all our fully-insured accounts and the majority of our self-insured customers.

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Reminder — contracted providers must file claims

As a reminder, claims must be filed for any covered services that are rendered to a subscriber or covered dependent enrolled in a Blue Cross and Blue Shield of Texas (BCBSTX) health plan. A provider may collect the full amounts of any deductible, coinsurance, or copayment due, and then must file the claim to BCBSTX.

Arrangements by a provider to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violates the requirements of your provider contract with BCBSTX.

Medical policy disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX Web site on the first or the fifteenth day of each month. Those policies requiring disclosure will become effective 90 days from the posting date. Policies that do not require disclosure will become effective 15 days after the posting date.

The specific effective date will be noted for each policy that is posted. To view pending policies, go to the General Reimbursement section at www.bcbstx.com/provider and click on “Medical Policies.” After reading the disclaimer, click on “I Agree” to advance to the Medical Policy page. The policies can be accessed by clicking on the “View Pending Policies” tab.

Photo documentation that is not required per the medical policy, or is not requested by Blue Cross and Blue Shield of Texas, is no longer necessary for the review or adjudication of health care claims.

Medical policy review

In an effort to streamline the medical policy review process, you can view draft medical policies on the BCBSTX Web site and provide your feedback online. The documents will be made available for your review on the first and the fifteenth of each month with a review period of approximately two weeks.

To view draft policies, go to www.bcbstx.com/provider, refer to the General Reimbursement Information section (within the body of the main provider page) and click on “Draft Medical Policies”. After reading the disclaimer, click on “I Agree” to advance to the Medical Policy page.
Provider demographic changes — keep your information current

If you are changing your address or need to add additional addresses to the provider directory, please send written notification by mail or fax to your local Professional Provider Network office at least 30 days in advance of the change.

If your demographic information (specialty, practice information/status, board certification, etc.) is not correct on BCBSTX’s Provider Finder or you would like to have a sub-specialty added, contact your local Professional Provider Network office.

Reminder to Use Network Facilities and Providers

With respect to the care of your patients, Blue Cross and Blue Shield of Texas understands that you have the ultimate and sole responsibility for, and professional authority over, your professional practice with respect to the care of your patients.

As a reminder, your participating provider agreement requires that you utilize participating network facilities. As a network physician, you have a contractual obligation to utilize, and to refer or direct the member to, the network facilities to which you have admitting privileges to help the member take full advantage of their network benefits. If a case should arise where you do not believe we have an adequate network facility available, you must obtain prior approval from BCBSTX before utilizing a facility that is not network. When this is done, the claim will process at the network level of benefits for the member. However, the member may be subject to balance billing unless the provider is a ParPlan provider.

If you have any questions regarding the participating facilities in your area, please visit our Web site at www.bcbstx.com/onlinedirectory/index.htm or contact your local Professional Provider Network Representative.

www.bcbstx.com/provider
Blue Cross and Blue Shield of Texas and HMO Blue® Texas are happy to announce that they have entered into a new agreement with Hemophilia Health Services, a division of Accredo Health Group Inc., to provide clotting factor to its hemophilia members. Effective Jan. 15, 2008, Accredo is the exclusive HMO provider* and the Preferred BlueChoice® PPO/POS provider for all factor products. HMO members requiring factor products must be directed to Accredo by their physician. PPO subscribers should be directed to Accredo as the preferred provider, however subscribers can continue to receive factor products from contracted PPO providers based on the terms of their PPO provider agreement.

The list of factor products is detailed below and is also identified in the Home Infusion Therapy Drug Schedule posted on the BCBSTX Provider Web site (the list is subject to change in accordance with the terms of your agreement).

**Factor Products**

<table>
<thead>
<tr>
<th>J7187</th>
<th>J7189</th>
<th>J7190</th>
<th>J7192</th>
<th>J7193</th>
<th>J7194</th>
<th>J7195</th>
<th>J7198</th>
</tr>
</thead>
</table>

*Exception: Factor products may be provided by an HMO member’s treating physician or by other specific providers identified by BCBSTX.

To refer your members to Accredo, please contact Accredo at 800-800-6606 and ask to speak with a pharmacist.

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Electronic commerce — online resources

Did you know that visiting the Electronic Commerce section of our Provider Web site will provide you with answers to many common questions about electronic claims filing? In order to obtain quick and up-to-date information, visit www.bcbstx.com/provider. Click on “Electronic Commerce” in the top navigation menu, then “Alerts” on the side menu.

The Alerts page is used as a notification tool to communicate when EDI Transaction issues occur and how these issues were resolved. We encourage you to visit the Alerts page often throughout the NPI transition for the latest news and Web-based applications you need to better service our members and your patients.

**Remember to include your TIN on all claims!**

The NPI does not replace your federal Taxpayer Identification Number (TIN), which must continue to be used in standard transactions for tax reporting purposes. Your TIN (EIN, SSN or ITIN) is required by BCBSTX as a secondary identifier on all electronic and paper claims. Paper claims may not be rejected but may incur processing errors and significant delays if submitted without this important information.

Avoid processing errors and claim rejections — continue to use your TIN on all claims submitted to BCBSTX.
Effective July 1, 2008, the Radiology Quality Initiative (RQI) program for outpatient high-tech diagnostic imaging services will no longer apply to BlueChoice® Solutions subscribers.

To the right is a sample of a BlueChoice Solutions ID card to assist in identifying a BlueChoice Solutions subscriber.

As a reminder, BlueChoice 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 or PET scan.

To obtain a BlueChoice RQI number, just log onto AIM’s Provider Portal at www.americanimaging.net or call AIM’s Call Center at 800-859-5299. Calls are answered from 6 a.m. to 6 p.m. (CST) Monday through Friday, and 9 a.m. to noon on Saturdays, Sundays and holidays. If criteria are met, you will be given an RQI number. If criteria are not met or 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 makes it easy for your office staff to enter an order for a high-tech diagnostic imaging exam via the Web. The Web-based Provider Portal gives you 24/7/365 access to the RQI and eligibility information. Best of all, not only can you enter an order for an exam, but you can receive an RQI number online in real time (as long as no additional clinical information is needed).

Note: Facilities cannot obtain an RQI number from AIM on behalf of the ordering physician. Also, the RQI program does not apply to BlueCard subscribers or Medicare primary subscribers with BCBSTX Medicare supplement. Medicare Primary subscribers with BCBSTX commercial PPO/POS coverage are included in the program.
For your reference, the following is an alphabetical list of large employer groups currently enrolled in BlueChoice Solutions. Please note, the employer groups listed below include both 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, Blue Cross and Blue Shield of Texas, HEB, Vought Aircraft Industries, Inc. and Wal-Mart offer BlueChoice Solutions as an optional network for their employees. In addition, BlueChoice Solutions is being offered to individual members.

### BlueChoice Solutions Large Employer Groups

<table>
<thead>
<tr>
<th>A/W Mechanical Services, L.P.</th>
<th>Elite Energy Services, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACG Texas, L.P.</td>
<td>Ernie Guzman Pontiac, GMC, Hyundai</td>
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<tr>
<td>Air Force Villages, Inc.</td>
<td>Family Practice Foundation of Brazos Valley</td>
</tr>
<tr>
<td>Ameri-Tech Kidney Center, P.A.</td>
<td>First Operations, L.P.</td>
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<tr>
<td>Angels PHH Corp.</td>
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<td>Bert Ogden Olds, Nissan &amp; BMW, Inc.</td>
<td>Gabriel Holdings, Ltd.</td>
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<td>Blue Cross and Blue Shield of Texas</td>
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<td>Brazos Higher Education Service Corp., Inc.</td>
<td>H.E. Butt (HEB) Grocery Company</td>
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<td>Brock Enterprises Inc.</td>
<td>Hi-Tech Plastics</td>
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<td>C &amp; H Die Casting, Inc.</td>
<td>Houk Air Conditioning, Inc.</td>
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<td>Chacon Investments</td>
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<td>City of Pharr</td>
<td>John L. Wortham &amp; Son, L.P.</td>
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<td>City of Sanger</td>
<td>Julian Gold</td>
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<td>Classic Chevrolet</td>
<td>Kidney &amp; Blood Pressure Center, P.A.</td>
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<td>Community Health Service Agency</td>
<td>L&amp;S Plumbing Partnership, LTD</td>
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<td>Connally Memorial Medical Center</td>
<td>Lantern Drilling Company</td>
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<td>Cornerstone Regional Hospital, L.P.</td>
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<td>Dicentral Corporation</td>
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<td>Navarro Pecan Company, Inc.</td>
<td>NTRM Management, L.P.</td>
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<td>Parexlahabra, Inc.</td>
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<td>Serving Children and Adolescents In Need, Inc.</td>
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<td>The Butler Weldments Corporation</td>
<td>Talley Rents, LLC</td>
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<td>Texatronics, Inc.</td>
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<td>Tubular Instrumentation &amp; Controls, L.P.</td>
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<td>Vought Technologies, Inc.</td>
<td>Vought Aircraft Industries, Inc.</td>
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<td>Wal-Mart</td>
<td>Xpress Clinical Laboratories, L.P.</td>
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www.bcbstx.com/provider
Each member ID card includes the BlueChoice Solutions logo for easy recognition. The Network No., **PSNOA**, is also specific to BlueChoice Solutions. The standard member number developed for BlueChoice Solutions begins with the **alpha prefix ZGO**. However, there are exceptions to the **ZGO** prefix for certain BlueChoice Solutions employer groups. **Note:** In Texas, BlueChoice Solutions members must use BlueChoice Solutions physicians and professional providers for network benefits.
Blue Precision

Blue Precision is the new umbrella name for all high performance networks (HPNs) within the Blue Cross and Blue Shield System. Plans will not change the name of their HPNs, but rather refer to them as their Blue Precision network offerings. The Blue Precision offering in Texas is the BlueChoice Solutions network.

Blue Precision is a branded national account offering that provides members with open access to health care services while accessing the greater cost efficiencies from HPNs. In most states, Blue Precision also includes access to BlueCard providers where HPNs are not available. In Texas, BlueChoice Solutions/Blue Precision members must use BlueChoice Solutions physicians, professional providers, ancillary providers and facilities for network benefits.

One example of a Blue Precision network with members located in Texas is the Blue Precision, Performance Plans and High Performance Network (HPN) for Wal-Mart. Wal-Mart members elective Blue Precision are limited to the BlueChoice Solutions network in Texas.

Please note that Wal-Mart’s Blue Precision alpha prefix is WRB. Wal-Mart refers to the BlueChoice Solutions network as Blue Precision, Performance Plans and High Performance Network (HPN).

Samples of the front and back of Wal-Mart’s BlueChoice Solution/Blue Precision ID card are provided below-left. Each member ID card will include the Blue Precision logo for easy recognition.

Blue Precision facts

- Offers a cost-driven strategy that makes available open-access provider networks, other than the BlueCard designated networks, to national accounts through existing HMO, POS, or PPO networks developed specifically for cost or quality performance.

- Blue Precision provides a consistent name to clients for HPNs and additional cost savings over what is currently available through BlueCard.

- Members access Blue Precision provider information through the BlueCard Doctor and Hospital Finder Web site and the BlueCard Call Center. The member will need the alpha prefix, geographic location and provider specialty to receive information on Blue Precision providers.

For additional information about BlueChoice Solutions and Blue Precision, please visit the BCBSTX Web site at www.bcbstx.com/provider; click on “Learn More About BlueChoice Solutions.”
Claims will be automatically submitted to the secondary Blue Plan

Effective Jan. 1, 2008, Medicare will crossover claims to all Blue Plans for services covered under Medigap and Medicare Supplemental products. This will result in automatic claims submission of Medicare claims to the Blue Plan secondary payer, and reduce or eliminate the need for the provider’s office or billing service to submit an additional claim to the secondary carrier.

How do I submit Medicare primary/Blue Plan secondary claims?

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member’s ID card for additional verification.

- Include the alpha prefix as part of the member identification number. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, determine if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to BCBSTX.

- If the remittance indicates that the claim was not crossed over, submit the claim to BCBSTX with the Medicare remittance advice.

- For claim status inquiries, contact BCBSTX at 800-451-0287.

When should I expect to receive payment?

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare Intermediary. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14-30 business days for you to receive payment from the Blue Plan.

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What should I do in the meantime?
If you submitted the claim to the Medicare intermediary/carrier, and haven’t received a response to your initial claim submission, don’t automatically submit another claim. Rather, you should:
- Review the automated resubmission cycle on your claim system.
- Wait 30 days.
- Check claims status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Who do I contact if I have questions?
If you have questions, please call BCBSTX at 800-451-0287.

The Medicare Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D, that went into effect in 2006. The drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PD), such as HMOs, that cover all Medicare benefits including drugs. For 2008, Part D plans are allowed to offer either a defined standard benefit, an alternative equal in value (“actuarially equivalent”), or a plan with enhanced benefits. The standard benefit in 2008 has a $275 deductible and 25% coinsurance up to an initial coverage limit of $2,510 in total drug costs, followed by a coverage gap (the so-called “doughnut hole”) where enrollees pay 100% of their drug costs until they have spent a total of $4,050 out of pocket, excluding the Part D premium paid to the plan. Once out-of-pocket costs exceed $4,050, enrollees pay 5% of total drug costs.

Coverage gap
The coverage gap was included by Congress in the Part D program because the cost of providing continuous coverage with no gap would have exceeded the budgetary limit imposed by the legislation when the Medicare drug benefit was established. In 2008, the coverage gap totals $3,216 for plans offering the standard Medicare Part D benefit; by 2016, it is projected to exceed $6,000. Nationally, most PDPs, however, do not help pay for prescriptions in the coverage gap. Among the 29% of PDPs with some gap coverage, all but one plan covers generic drugs only. About half of the PDPs with gap coverage in 2008 are covering only “preferred” or “some” generics. The increase in the share of MA-PD plans offering gap coverage is mainly among plans covering all generics and “some” brand-name drugs in the gap.

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In 2007, as in 2006, more than 80% of Part D enrollees (both PDP and MA-PD plans) had no gap coverage. As a consequence, nearly 4.2 million Medicare beneficiaries reached the coverage gap threshold in 2006, the first year of the program. If history is a reliable guide (i.e. only about 10% of beneficiaries switched plans from 2006 to 2007) there will not be a significant change in volume of beneficiaries reaching the coverage gap threshold in 2008 as well. One reason for the low volume of beneficiary plan changes from year to year is the additional beneficiary cost-sharing that plans charge to provide these and other extra benefits. For example, PDPs that provide gap coverage have monthly premiums that are about double that of PDPs with no gap coverage. In 2008, average monthly premiums are $63.29 for PDPs that offer some gap coverage, $30.14 for PDPs with basic benefits and no gap coverage, and $31.97 for PDPs with enhanced benefits but no gap coverage. Lastly, if that was not enough of a strain on the budget of the average Medicare beneficiary, the Part D plan member is still required to pay the monthly Part D premiums even as they struggle to pay for their medications out-of-pocket while in the coverage gap.

Encouraging the use of low-cost generic drugs

While federal assistance is available to help the poorest patients with Part D plan cost-sharing, including premiums, deductibles and copays, those who fall just above the poverty guidelines and cannot get extra help sometimes simply stop taking their medications, cut their dose in half to stretch their supply of medication further, or rack up big credit card debt to pay for them.

Despite the general unpopularity of the coverage gap with older consumers, some experts see a positive public policy trend evolving. Because the existence of the coverage gap may require a Medicare enrollee to pay more than $3,200 out of their own pocket during the gap period, the strategy is helping to curb growth in the nation’s drug spending by encouraging the use of low-cost generic drugs. By the first quarter of 2007, the generic dispensing rate in Medicare Part D programs averaged 61.5% while some plans report rates higher than 70%.

A generic drug is manufactured and sold by a company other than the original patent holder. “A” rated generic medications (bioequivalent to the brand-name drug) must meet the same rigid standards as the brand-name drug but because the manufacturer is not attempting to recoup research and development costs and pay for expensive marketing campaigns, the cost of generic medications based on conservative estimates is 60% less than brand-name medications.

Some of the recent entries into the generic drug market include some former popular brand-name products such as: simvastatin (ZOCOR), sertraline (ZOLEFT), amlodipine (NORVASC), zolpidem (AMBIEN), risperidone (RISPERDAL), cetirizine (ZYRTEC) and carvediol (COREG). Others expected in 2008 include: DEPAKOTE, LAMICTAL, DYNACIRC, TOPAMAX, IMITREX and ALTACE.
It has been reported that in 2006 and 2007 alone, Medicare Part D drug costs could be reduced nationally by $5 billion due to patents exclusivity expiring on just 11 major branded pharmaceuticals.

**Pharmaceutical assistance programs**

Less preferable strategies employed by some physicians to prevent patients from falling into the coverage gap include:

- **a)** switching to potentially less-effective but cheaper alternatives,
- **b)** use of samples,
- **c)** pharmaceutical assistance programs and
- **d)** utilizing over-the-counter (OTC) medications.

All these alternatives have significant drawbacks and may present unacceptable options for physicians and their patients. As noted above, for those patients with limited financial resources the choice between essentials such as food and expensive medications may lead many to forego needed medical therapies. Patients and providers may find that they have to compromise on a less effective therapy (e.g. aspirin in place of PLAVIX) when non-adherence to the gold standard medication is the most likely outcome.

Samples are also commonly used to provide patients with short-term therapies or test a patient’s tolerance to a new therapy without taking the risk of having to discard a 30-day supply of an expensive medication.

Certainly the use of samples fills a therapy niche that helps many patients. However, providers often run the risk that their patient becomes stabilized on a medication that is not available on their formulary, or requires trials of therapeutically equivalent alternatives or is simply too expensive to be continued once the supply of samples is exhausted. Pharmaceutical assistance programs are commonly available for selected medications from most manufacturers for those patients who meet rigid acceptance criteria. However, the application process can often be quite confusing and cumbersome, especially for older patients, and many drugs are simply not available.

Additional information on pharmaceutical assistance can be found at the respective company Web site. Lastly, there are OTC medications (e.g. PRILoseC, ibuprofen, etc.) that can reasonably replace similar prescription medications in some cases, but these examples of therapeutic interchanges are limited and cannot replace important maintenance medications for many chronic diseases such as hypertension, diabetes and hyperlipidemia.
Inappropriate use of fentanyl transdermal (DURAGESIC) patches

Fentanyl transdermal patches are in the news spotlight again. Unfortunately it is for all of the wrong reasons. On Dec. 21, 2007, the FDA issued an update highlighting important information on the appropriate prescribing, dose selection and safe use of the fentanyl transdermal system. This was a follow-up to a previous FDA Public Health Advisory and Information for Healthcare Professionals released in July 2005.

Repeated warnings from professional and patient safety organizations, FDA alerts for similar fentanyl-based products, as well as the manufacturer's Dear Health Professional letters and updated prescribing information has failed to slow the steady stream of reports of serious adverse events with fentanyl patches that included fatalities. These adverse events are caused by inappropriate prescribing, dispensing and administration of the drug. Most alarming is the fact that this is not a new concern.

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Cost-effective formulary alternatives are readily available

A study by Express Scripts, the pharmaceutical benefits manager, found that 23% of those who fell into the coverage gap in 2006 could have avoided it by utilizing generics to reduce their out-of-pocket drug costs. Such planning, though, requires that patients talk to providers about their ability to afford their medications as prescribed by their provider. Many people avoid such discussions and many physicians never broach the subject with their patients. Recent studies found that 80% of patients wished that their providers would discuss the cost of medications but less than one in five doctors did. With the fear of falling into the coverage gap ever present, providers need to be diligent in their review of their patient’s medication therapies. In many instances, cost-effective formulary alternatives are readily available for beneficiaries without a noticeable loss of efficacy. Local retail pharmacists and medical personnel at your patient's health plan can be a great resource to help keep your patient out of the coverage gap that older Americans love to hate.

If you have any questions regarding this article, please contact Richard G. Reynolds, MS, RPh, at richard_g_reynolds@bcbsnm.com.

References:

FDA Issues updated Safety Warning

www.bcbsnx.com/provider
As an example of the persistence of this important safety issue, the Institute for Safe Medication Practices (ISMP) reported that it has outlined the dangers of inappropriate use of fentanyl-containing products in at least seven newsletter articles dating back to September 2001. In order to lessen the potential for further patient harm, it is imperative that all healthcare providers involved in prescribing and dispensing of these potent pain medications take time to review the latest FDA update and incorporate all of the recommendations into their everyday practice. Please take a minute to review important highlights from the FDA update listed below regarding the safe use, storage and disposal of fentanyl transdermal patches.

Prescribers should:

• Be knowledgeable in the treatment of cancer and other chronic pain situations as well as the appropriate use of fentanyl-containing products.

• Utilize fentanyl transdermal patches for those patients who are OPIOID-TOLERANT ONLY! Patients are considered opioid-tolerant when they have a history of receiving opioid therapy for at least a week with a minimum total daily dosage equivalent to fentanyl 25 mcg/h patch (e.g. 60 mg morphine, 30 mg oxycodone, or hydromorphone 8 mg daily).

• Utilize fentanyl transdermal patches for the management of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration and which cannot be managed by other means (e.g. NSAIDs, opioid combination products or immediate release opioids).

• Be cautious of dosing patches every 48 hours since discarded patches pose a significant safety concern as well as a potential for abuse.

Fentanyl transdermal patches are contraindicated in patients:

• Who are opioid-intolerant

• For the management of acute, post-operative, mild or intermittent pain

• Who have acute or severe bronchial asthma or other instances of significant respiratory depression

• With initial doses exceeding 25 mcg/h because of the need to individualize dosing

Patients and their caregivers should be educated to:

• Store fentanyl patches in a safe place out of the reach of children to prevent both accidental exposure and possible diversion

• Avoid applying a fentanyl patch in front of children as children learn by example and equate applying a patch with putting on a sticker, bandage or temporary tattoo

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• Avoid exposure to direct heat sources (e.g. heating pads, saunas, hot tubs, heated water beds, etc.) while wearing a fentanyl patch as heat exposure may increase fentanyl absorption.

• Maintain a dosing calendar to keep track of the location and time of patch application. Old patches should always be removed prior to the application of a new patch.

• Do not cut or physically alter the patch in any way as this will destroy the controlled release system.

• Be aware of the signs of fentanyl overdose (e.g. respiratory distress, shallow breathing, tiredness, extreme sleepiness, sedation, inability to think, talk or walk normally).

• Properly handle and dispose of used patches by folding the patch upon itself and immediately flushing the patch down the toilet to prevent accidental exposure or diversion.

You can report any significant adverse events related to the inappropriate use of fentanyl to the FDA-MEDWATCH program at 800-FDA-1088 or online at www.fda.gov/medwatch/how.htm.

If you have any questions regarding this article, please contact Richard G. Reynolds, MS, RPh, at richard_g_reynolds@bcbsnm.com.

References:


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, please call LabCorp’s automated phone system toll-free at 888-LABCORP or visit their Web site at www.labcorp.com. Both systems will prompt you for your ZIP code and will provide those service centers nearest that ZIP code location.

You may find a complete list of participating providers by using the Provider Finder® search tool at www.bcbs.tx.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 may access the county listing and the Reimbursable Lab Services list at www.bcbs.tx.com/provider under the General Reimbursement section. The password for the General Reimbursement section is “manual.”

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.