Eduardo J. Sanchez, M.D., has been named vice president and chief medical officer for Blue Cross and Blue Shield of Texas (BCBSTX). The former commissioner of the Texas Department of State Health Services (TDSHS) and the Texas Department of Health (TDH), Sanchez most recently served as director of the Institute for Health Policy, School of Public Health, at The University of Texas Health Science Center at Houston.

Sanchez succeeds Paul Handel, M.D., who has been promoted to Chief Medical Officer of Health Care Service Corporation, the health benefits company that operates through its Blue Cross and Blue Shield plans in Texas, Illinois, New Mexico and Oklahoma.

In his new role, Dr. Sanchez will oversee the Texas Division’s medical policy and strategy as well as the company’s new initiative to improve member wellness and public health.

Sanchez served from 2004 to 2006 as TDSHS commissioner, where he oversaw operations of the 11,500-employee state agency responsible for public health, mental health and substance abuse, including Texas’ health and medical responses to Hurricanes Katrina and Rita.

As TDH commissioner from 2001 to 2004, Sanchez oversaw the development of the TDH bioterrorism preparedness operations following 9/11 and the anthrax scare, directed the agency’s efforts to heighten awareness about overweight and obesity issues in Texas, and led the formation of the TDSHS by combining four separate state agencies.

Dr. Sanchez, who has been a member of the BCBSTX Affiliate Board and the Caring for Children Foundation of Texas Board, has received honors from many health-related organizations, including the Texas Health Institute, American Heart Association and American Academy of Family Physicians. Currently, he is chair of the National Commission on Prevention Priorities, chair of the Advisory Committee to the Director of the Centers for Disease Control and Prevention, and a member of numerous professional associations.

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Dr. Sanchez received his medical degree from UT Southwestern Medical School in Dallas. He also holds a master's degree in public health from The University of Texas Health Science Center and a master's in biomedical engineering from Duke University.

“We are pleased Dr. Sanchez has joined our management team,” says BCBSTX President Darren Rodgers. “He will play a key part in helping us fulfill our mission of improving the health and well-being of our members and of communities across the state.”

All the changes we have implemented recently at BCBSTX could not have been possible without the cooperation and patience of the physicians, hospitals and ancillary providers who make up BCBSTX’s provider networks.

Our special thanks goes out to you for helping us improve the process of caring for our members while making it less complicated for them to navigate the health care system. From the transition to the exclusive use of NPI provider codes, to the changes in the way you send and receive information about claims, benefits, eligibility and other issues, we hope you agree that the changes we’ve made will improve your ability to provide quality service to our members.

We appreciate you and value the work you do on behalf of BCBSTX members.

BCBSTX has added a new online update form for physicians and other professional providers. Click on the “Change Your Information” icon at www.bcbstx.com/provider to electronically submit a change to your name, office or payee address, e-mail address, telephone number, tax ID or other information. You should submit all changes at least 30 days in advance of the effective date of the change.

If your specialty, practice information/status, board certification, etc., is not correct on BCBSTX Provider Finder or you would like to have a sub-specialty added, you can enter the information in the “Other” field, or contact your Professional Provider Network office.
Register today to begin taking advantage of the many free services offered on the secure Web portal for Availity Health Information Network, including real-time eligibility and benefits, claim submissions, claims status and much more for multiple health plans, including Blue Cross and Blue Shield plans nationwide.

To register, go to www.availity.com and click the “Easy as 1-2-3 Register Now” link. Upon receipt of a signed agreement, Availity will e-mail a temporary password to a Primary Access Administrator you designate at registration. You will then have access to all the free, time-saving services available on the Availity Health Information Network.

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 you.
- **Cleaner Claims** — Availity helps improve clean claim rates and turnaround times.
- **Accessible** — Real-time information is available 24 hours a 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 each week. Simply log into the Availity portal and register to attend the Webinar of your choice. Demonstrations, Frequently Asked Questions and comprehensive Help Topics are available online as well.
- **Support** — Availity Client Services is available Monday through Thursday, 8 a.m. to 6 p.m., and Friday 8 a.m. to 5 p.m. at 800-AVAILITY (282-4548) or support@availity.com.

For more information, visit www.availity.com or contact an Availity client service representative.
The iEXCHANGE System is Blue Cross and Blue Shield of Texas’ automated pre-certification and referral system. iEXCHANGE offers both telephonic interactive voice response (IVR) and Web-based applications.

iEXCHANGE supports the direct submission and processing of referrals and pre-certifications by network physicians, professional providers and facilities within Texas. 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>iEXCHANGE IVR (phone)</th>
<th>iEXCHANGE 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>Not Available</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><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>Obtain applicable provider’s NPI and phone number 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>
</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>Allows professional providers and facilities to request referrals and inpatient certifications for BlueCard members.</td>
<td>Not Available</td>
<td>Available</td>
</tr>
<tr>
<td>Texas iEXCHANGE Support Desk</td>
<td>800-441-9188, select option 1, then select option 4 Monday – Friday, 8 a.m. – 5 p.m. (CST)</td>
<td>800-441-9188, select option 1, then select option 4 Monday – Friday, 8 a.m. – 5 p.m. (CST)</td>
</tr>
</tbody>
</table>

www.bcbstx.com/provider
For iEXCHANGE Web users

Your office will need 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

More information and assistance in using the iEXCHANGE applications is available on the BCBSTX Provider Portal at www.bcbstx.com/provider/reference_guides.htm. Or you can contact your local Professional or Facility Provider Network office. The Web site provides the following resources:

• iEXCHANGE IVR Reference Guide
• iEXCHANGE Web Reference Guide — includes Office Administrator responsibilities and instructions

Getting started with iEXCHANGE

• Webinar Training
  You can register for an iEXCHANGE training Webinar at www.bcbstx.com/provider/training.htm.

• Online Training
  The iEXCHANGE Web and IVR Reference Guide provides instructions on how to navigate through the iEXCHANGE Web or IVR application. It can be accessed 24 hours a day at www.bcbstx.com/provider/gri/iexchange.htm.

To get started, submit an iEXCHANGE Web user set-up questionnaire for a userID and password at www.bcbstx.com/provider/iexchange_questionnaire_2.

iEXCHANGE IVR is available without prior set up — just dial 800-413-0869.

For more information about iEXCHANGE, log on to www.bcbstx.com/provider/iexchange_home.htm.

Note: The relationship between BCBSTX and iEXCHANGE is solely that of independent contractors.
BCBSTX offers an online Coordination of Benefits (COB) questionnaire to help reduce the number of claims rejected for the purpose of investigating other insurance.

Obtaining COB information is especially problematic when rendering services to out-of-area BlueCard® members. Our COB questionnaire is recognized by all BCBS plans when sharing COB information collected from members. Members should be instructed to send the completed information to their BCBS plan. The member’s plan will update the shared membership database with this information to expedite claim processing.

To avoid having your claims denied for COB, download the form and give it to all BCBS members you serve, including those from other BCBS plans. You also can find the form at www.bcbstx.com/provider/downloadable_forms.htm.

Never again lose track of information you found in the Blue Review provider newsletter. We’ve made it faster and easier to access articles and notices about things you need to know as a provider in the BCBSTX network.

New tools have been created to give you more ways to find what you need on our Provider Portal. Each issue, we’ll mail you a postcard notifying you that a new issue of the newsletter has been posted on the portal. The postcard highlights the main updates you can expect to find in the current issue.

An added resource is the new e-mail notification alert. Anyone in your practice can sign up to receive an e-mail notice when a new issue has been posted. Because the e-mail alert is instantaneous, it is the fastest method for getting information from BCBSTX. It is also the easiest, as links are provided from the e-mail directly to the online newsletter. Simply click the link to an article and you will be routed to the article. From there, you can check out the rest of the newsletter and even click over to the Provider Portal.

Other links give you access to the Availity Health Information Network, the iEXCHANGE® pre-certification and referral system, the Provider Portal for American Imaging Management, and many more online resources. Get connected to BCBSTX now by sending e-mail information to bluerevieweditor@bcbstx.com.

www.bcbstx.com/provider
BCBSTX conducts medical record reviews to ensure medical records are maintained in a manner that is current, detailed and organized, and that permits effective, confidential patient care and quality review.

The medical record review conducted in 2007 identified gaps in the recording of up-to-date age/risk immunizations as recommended in the 2007 Adult Wellness Guidelines, and evidence that vaccination and disease history was requested from the patient.

The 2008 Adult Wellness Guidelines, the Infant, Child and Adolescent Wellness Guidelines, and the Suggested Prenatal Care Guidelines will be coming soon to our Provider Portal.

The previously printed guidelines will now be provided as a PDF for direct printing. They will be found at www.bcbstx.com/health/index.htm. If you have questions or comments about the guidelines, contact the Quality Improvement Programs department at 800-863-9798.

Claim Check enhancements

BCBSTX regularly communicates enhancements made to processing of professional claims and associated payment-auditing logic within this newsletter. Below are highlights of enhancements, with their effective dates, that have been made since our last notice. This action is not retroactive to claims processed prior to the effective date listed.

<table>
<thead>
<tr>
<th>DENIED PROCEDURE CODE</th>
<th>ALLOWED PROCEDURE CODE</th>
<th>BUNDLING APPLIED</th>
<th>BLUECHIP DATE TO PRODUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>28270</td>
<td>28285</td>
<td>Remove edit</td>
<td>04/14/08</td>
</tr>
<tr>
<td>20660</td>
<td>63064</td>
<td>Remove edit</td>
<td>04/14/08</td>
</tr>
<tr>
<td>11970</td>
<td>19370</td>
<td>Remove edit</td>
<td>04/14/08</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.
Have you recently received a fax from a Blue Care Advisor requesting clinical metrics on one of your BCBSTX patients?

The Blue Care Connection® (BCC) Program is a voluntary program designed specifically for eligible BCBSTX members who are at-risk or have been diagnosed with a chronic condition such as asthma, diabetes, hypertension, cancer, congestive heart failure, chronic obstructive pulmonary disease, low back pain, metabolic syndrome or coronary artery disease.

The multidisciplinary team of Blue Care Advisors consists of RNs, licensed professional counselors, master’s-level social workers and certified diabetic educators who want to support your plan of care for our members.

**Measurement in managing those at risk**

Measuring, analyzing and reporting clinical metrics allows BCC to report on movement away from or toward nationally recognized clinical practice guidelines used by the Health Care Management area to manage the BCC population. Insight into the dynamics of the BCC population allows not only measurement in managing those at risk or with a chronic disease in the movement toward a healthier lifestyle, but also affords the opportunity for quality improvement and development of additional components within the BCC program.

Using clinical practice guidelines as the gold standard of care, BCC collects, monitors, analyzes and reports on the following metrics for their associated medical conditions:

- Height
- Weight
- Body mass index
- Blood pressure
- Triglycerides
- Cholesterol (HDL and LDL)
- HgbA1C
- Blood sugar
- Foot exam
- Diabetic retinopathy eye exam
- Pain assessment scores
- Peak flow compliance
- Overall feeling of improved health
- Immunization compliance (Pneumovax/Flu Shot)
- Weight loss
- Tobacco improvement
- Preventive screening compliance
- Medication compliance

Through BCC outreach mailings, faxing and phone calls, you 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 you 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.

You may receive the Blue Care Advisor’s request via fax or a phone call. We encourage you to take a moment to fax back the form or call us at 866-412-8795 to speak directly with the Blue Care Advisor.

www.bcbstx.com/provider
We value your participation in the Blue Cross and Blue Shield Service Benefit Plan for federal employees. The Federal Employee Program (FEP) offers a fee-for-service plan through our BlueChoice® PPO, which is sponsored by the Blue Cross and Blue Shield Association and participating BCBS plans.

Types of options

The Standard Option offers benefits for covered services performed by both preferred and non-preferred providers. PPO benefits apply when the member uses a PPO preferred provider. However, if no PPO preferred provider is available, or the member does not use a PPO preferred provider, non-PPO benefits apply. Out-of-pocket expenses, such as coinsurance and copayments, are lower when members use preferred providers.

The Basic Option health benefit plan is a network-only benefit program that requires the member to use preferred providers in order to receive benefits, except in emergency situations. Basic Option offers a lower premium than Standard Option, and gives comprehensive coverage with no deductibles or referrals. There is no coverage when a Basic Option member uses a non-PPO provider. The Basic Option plan has different copays for PPO primary care providers and specialists.

Standard and basic option plan changes

In 2008, the following benefits are available:

- Hearing aids, including bone-anchored hearing aids, for children up to the age of 22, and bone-anchored hearing aids for adults when medically necessary due to traumatic injury or malformation of the external or middle ear. Benefits for these hearing aids are limited to $1,000 per ear per calendar year.

- Office visits and diagnostic tests related to the treatment of morbid obesity. Previously, benefits were not available for these type services.

- Inpatient and outpatient hospital care related to the treatment of children up to the age of 22 with severe dental caries.

- Home hospice pre-enrollment visits when provided by a physician employed by the hospice agency. Benefits were not available for this service in the past.

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• Ambulance transportation to be paid in full, after a $50 per day copayment. Previously, members were responsible for a $50 per trip copayment.

• Medically necessary emergency care provided at the scene when ambulance transport is not required. Benefits were not provided for this care in the past.

For additional information and details on both the Standard Option and Basic Option health benefit plans you may visit the FEP Web site at: www.fepblue.org.

Standard option health insurance
Card Identification

Basic option health insurance
Card Identification

Enrollment codes
104 Standard Option — Self Only
105 Standard Option — Self and Family
111 Basic Option — Self Only
112 Basic Option — Self and Family
To ensure claims are paid to you and not to the member when filing claims electronically, you must select the correct required fields and the corresponding values that must be submitted. Although these fields are often reserved for filing claims with Medicare, BCBSTX uses these values to determine whether payment is made to you or to the member.

| T0301 Format | EAO-36.0 — Provider Assignment Indicator. Valid values are: A, B, N and P. You should file with “A” (assigned) to ensure payment to your office. |
| ANSI 837 Professional Format | Loop 2300: CLM07 — Assignment Code. Valid values are: A, B, C and P. You should file with “A” (assigned) to ensure payment to your office. |
| CLM08 — Assignment of Benefits Indicator. Valid values are: Y (Yes) and N (No). You should file with “Y” (Yes) to ensure payment to your office. |

For more information, call our Electronic Data Interchange Hotline at 800-746-4614.

In an effort to help simplify the processing of claims, BCBSTX has chosen to implement the same billing procedures as Trailblazer* for Radiation Treatment Management Services billed with the following CPT Codes, effective immediately:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77427</td>
<td>Radiation treatment management, five treatments</td>
</tr>
<tr>
<td>77435</td>
<td>Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed five fractions</td>
</tr>
</tbody>
</table>

- Bill each radiation therapy management service on a separate detail line.
- CPT Code 77427: Report the date of service as the beginning date for each set of five treatments delivered. Bill one unit for five treatments.
- If there are three or four fractions beyond a multiple of five at the end of a course of treatment, report CPT Code 77427 on a separate detail line for up to an additional five treatments.
- CPT Code 77435: Report the date of service as the beginning date of the treatments.
- Indicate each treatment date within the comment field for claims billed electronically.
- When reporting on a CMS-1500 (08/05) paper claim form, attach a separate list indicating each treatment date.

*Trailblazer Health Enterprises Inc. is the Medicare Part B carrier of the Blue Cross and Blue Shield Association.
Fee schedule updates

Reimbursement changes and updates for BlueChoice® and HMO Blue® Texas (Independent Provider Network only) practitioners will be posted under “Reimbursement Changes” in the Professional Reimbursement Schedules section on our Provider Portal at www.bcbstx.com/provider. The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change posted. To view this information, visit the General Reimbursement Information section on the portal. The Drug/Injectable Fee Schedule will be updated on the following dates: 9/1/2008, 12/1/2008, 3/1/2009 and 6/1/2009.

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 otherwise approved by BCBSTX.

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

1) The service of the performing provider is performed at the place of service of the ordering provider and is billed by the ordering provider; 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.

Reminder — contracted providers must file claims

As a reminder, claims must be filed for any covered services rendered to a member, spouse or covered dependent enrolled in a BCBSTX health plan. You may collect the full amounts of any deductible, coinsurance or copayment due, and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your provider contract with BCBSTX.

Medical policy review

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

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

**Medical policy disclosure**

New or revised medical policies, when approved, will be posted on our Provider Portal on the first or the fifteenth day of each month. Those policies requiring disclosure will become effective 90 days from the posting date. Policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each policy posted. To view pending policies, go to the General Reimbursement section at [www.bcbstx.com/provider](http://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 the “View Pending Policies” tab.

**Reminder to use network facilities and providers**

With respect to the care of your patients, BCBSTX understands that you have the ultimate and sole responsibility for and professional authority over your 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 in the 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 Par Plan provider. If you have any questions regarding the participant facilities in your area, visit our Web site at [www.bcbstx.com/ondirectory/index.htm](http://www.bcbstx.com/ondirectory/index.htm) or contact your local Professional Provider Network office.
Additional fees charged by physicians and other professional providers beyond copayment and coinsurance

- **BCBSTX** and HMO Blue Texas do not support the practice of physicians charging members/subscribers additional fees beyond required copayments and coinsurance.

- Our **BCBSTX** and HMO Blue Texas physician agreements support the concept of physicians treating members/subscribers in the same manner as all other patients. **BCBSTX** and HMO Blue Texas members/subscribers should be treated in accordance with the same standards and within the same time availability as such services are provided to other patients, and without regard to the degree or frequency of utilization of such services.

- Notwithstanding the above, if a physician charges additional fees to its entire population of patients in the same manner for non-covered services, and the **BCBSTX** subscriber or HMO Blue Texas member agrees in writing to accept payment responsibility for the non-covered service prior to receiving that service, then it would be appropriate to charge the member/subscriber for the service. The member/subscriber must acknowledge this agreement in writing and agree to accept payment responsibility for the specific service to be rendered.

- A participating physician cannot require **BCBSTX** subscribers or HMO Blue Texas members to pay any type of access fee as a prerequisite to receiving services covered under member/subscriber benefit plans.

### Splitting charges on claims

When billing for services provided, select codes that best represent the services rendered. In general, bill all services provided on the same day under one electronic submission. When required to bill on paper, utilize one CMS-1500 (08/05) claim form when possible. When more than six services are provided, multiple CMS-1500 (08/05) claim forms may be necessary.

### Fraudulent billing

**BCBSTX** considers fraudulent billing to include, but not limited to:

1) deliberate misrepresentation of the services provided in order to receive payment;
2) deliberate billing in a manner that results in reimbursement greater than what would have been received if the claim were filed in accordance with **BCBSTX** billing policies and guidelines; and/or
3) billing for services that were not rendered.

### 90-day retention notice for ERA and EPS electronic files

With the migration of our Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS) files to the Availity® Health Information Network, the retention period for reinserts/reloads is now 90 days. We encourage you to download your electronic files and save/store them in a safe place for recall, as files older than 90 days will no longer be available.

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

BCBSTX does not reimburse facilities for Clinic Services, such as professional services by emergency room physicians or physicians operating out of a clinic. These services are considered professional in nature, and would be billed under the physician’s National Provider Identifier. Billing professional charges on a UB04 will generate a denial message instructing you to resubmit the charges on a CMS-1500 (08/05) form.

Note: Professional charges will be allowed on a UB04 when Medicare is primary for the member.

Improvements to the Medical Records Process for BlueCard Claims

Based on feedback from physicians and other professional providers, we have made improvements to the medical records process. BCBSTX is now able to send medical records electronically to all Blue Cross and/or Blue Shield plans. This new method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.

Continue to submit your medical records to BCBSTX, when requested. If you receive requests for medical records from other Blue plans prior to rendering services as part of the pre-certification process, submit them directly to the member’s plan that requested them.

The NPI is here. The NPI is now. Are you using it exclusively?

Using your National Provider Identifier as the sole provider identification number should have become “business as usual” starting May 23. If you are continuing to send BCBSTX legacy provider numbers, your transactions (including claims) could be rejected. Take time to make any necessary updates to submit NPI-only claims and other transactions as soon as possible to avoid any potential rejections.

Submitting claims for locum tenens

When using locum tenens to fill in for reasons such as illness, pregnancy, vacation, continuing education or even while permanent providers are recruited, it is best to submit the claims using your provider ID with the Q6 modifier (services furnished by a locum tenens physician). The Q6 modifier would be populated in one of the four modifier areas.

As covered health care providers, locum tenens are eligible to obtain NPIs. However, they may not be a contracted BCBSTX provider and, therefore, we may not have record of their NPI. Claims received with the locum tenen’s NPI would be rejected if submitted for processing in this situation.
Important Changes to the Radiology Quality Initiative Program

The Radiology Quality Initiative (RQI) program for outpatient high-tech diagnostic imaging services will no longer apply to BlueChoice® Solutions members beginning July 1.

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

For members with BlueChoice® benefit plans, contact American Imaging Management (AIM) to obtain an RQI number before ordering or scheduling the following outpatient, non-emergency diagnostic imaging services performed in your office, the outpatient department of a hospital, or a freestanding imaging center:

- CT/CTA scans
- MRI/MRA scans
- SPECT/Nuclear Cardiology studies
- PET scans

You can obtain a RQI number for BlueChoice by logging on to AIM's Provider Portal at www.americanimaging.net or calling AIM's Call Center at 800-859-5299, Monday through Friday, 6 a.m. to 6 p.m. CST and 9 a.m. to noon on Saturdays, Sundays and holidays.

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 access to the RQI and eligibility information 24 hours a day, everyday. 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 additional clinical information is not needed).

Note: Facilities cannot obtain a RQI number from AIM on behalf of the ordering physician. Also, the RQI program does not apply to Medicare primary members with BCBSTX Medicare supplement. Medicare Primary members 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. Note that employer groups listed below include insured and self-funded health plans. These employer groups may have chosen the BlueChoice Solutions network as an optional network for their employees. For example, 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 as of April 2008

<table>
<thead>
<tr>
<th>A/W Mechanical Services, L.P.</th>
<th>Dicentral Corp.</th>
<th>Navarro Pecan Company Inc.</th>
</tr>
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<tbody>
<tr>
<td>ACG Texas, L.P.</td>
<td>Efficient Hauling Systems, L.P.</td>
<td>Parexlahabra Inc.</td>
</tr>
<tr>
<td>Air Force Villages Inc.</td>
<td>Elite Energy Services Inc.</td>
<td>Raider Express</td>
</tr>
<tr>
<td>All Metals Fabrication</td>
<td>Frazier Ltd.</td>
<td>Security General International Ltd.</td>
</tr>
<tr>
<td>Ameri-Tech Kidney Center, P.A.</td>
<td>Friendly Chevrolet Co.</td>
<td>Serving Children and Adolescents In Need Inc.</td>
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<tr>
<td>AOC Senior Home Health Corp.</td>
<td>Fundcorp Inc.</td>
<td>Southern Services Inc.</td>
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<tr>
<td>Asgard</td>
<td>Gabriel Holdings Ltd.</td>
<td>Southwest Ford Inc.</td>
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<tr>
<td>Bert Ogden Olds, Nissan &amp; BMW Inc.</td>
<td>Geodynamics Inc.</td>
<td>Tabani Group Inc.</td>
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<tr>
<td>Blue Cross and Blue Shield of Texas</td>
<td>H.E. Butt (HEB) Grocery Co.</td>
<td>Takumi Stamping of Texas Inc.</td>
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<td>Brazos Higher Education Service Corp. Inc.</td>
<td>Hi-Tech Plastics</td>
<td>Texatronics Inc.</td>
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<td>C &amp; H Die Casting Inc.</td>
<td>Hook Air Conditioning Inc.</td>
<td>The Butler Weldments Corp.</td>
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<tr>
<td>Chacon Investments</td>
<td>Interstate Connections</td>
<td>The Care Group of Texas</td>
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<tr>
<td>City of Pharr</td>
<td>John L. Wortham &amp; Son, L.P.</td>
<td>Tubular Instrumentation and Controls, L.P.</td>
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<tr>
<td>City of Sanger</td>
<td>Kidney and Blood Pressure Center, P.A.</td>
<td>United Services Mechanical Corp.</td>
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<tr>
<td>Classic Chevrolet</td>
<td>L&amp;S Plumbing Partnership Ltd</td>
<td>VLSIP Technologies Inc.</td>
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<td>Community Health Service Agency</td>
<td>Lantern Drilling Co.</td>
<td>Vought Aircraft Industries Inc.</td>
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<td>Connally Memorial Medical Center</td>
<td>M. Hanna Construction Co. Inc.</td>
<td>Wal-Mart</td>
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<td>DCTA</td>
<td>Mass Group Marketing Inc.</td>
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<td>Deep Down Inc.</td>
<td>MHMR Services of Texoma</td>
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BlueCompare, a proprietary tool used by Blue Cross and Blue Shield of Texas to give consumers access to information about the care provided by our BlueChoice® PPO network physicians, will look different in the coming weeks.

Enhancements to the tool on ProviderFinder® set to launch in the second quarter of 2008 have been delayed as BCBSTX works to incorporate changes recommended in May by Texas Medical Association.

BCBSTX President Darren Rodgers and TMA President Josie R. Williams, M.D. have been in communication about the planned changes to BlueCompare and our commitment to being responsive to points made by TMA.

When completed, the changes will include the initial planned enhancements to the evidence-based measures portion of BlueCompare. In addition, BCBSTX will be discontinuing the affordability scale rankings until new standards for measuring affordability, recently proposed by the National Committee for Quality Assurance, are compared against the BCBSTX methodology. And, physicians will no longer be removed from the BlueChoice Solutions network based on the RACI (risk-adjusted cost index) methodology.

BlueCompare is part of Blue Distinction, the Blue Cross and Blue Shield Association nationwide program focused on creating an unprecedented level of health care transparency that engages consumers in making more informed health care decisions and collaborating with providers to improve quality outcomes and affordability.

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.

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Blue Precision® News

Blue Precision®
equals
BlueChoice®
Solutions

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 electing 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

• Blue Precision® 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.”
BlueChoice® News

Member-funded Product added to HCA Portfolio

BCBSTX has added a new Health Care Account (HCA) offering for our PPO members. Called BlueEdge Direct HCA, the product adds to our BlueEdge product portfolio for our employers and members who are looking for consumer-driven health plans. BlueEdge Direct HCA plans are available with the BlueChoice® and BlueChoice® Solutions networks.

With BlueEdge Direct, the member is required to pay a portion of the cost prior to accessing the HCA funds given by the employer. This differs from BlueEdge HCA, which is funded by the account first and then the member is responsible for the remaining balance. With both products, BCBSTX accesses the HCA funds, when available, to coordinate claims processing on your behalf.

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

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

1) Ask the member to show his or her BlueEdge Direct ID card. This card will list “BlueEdge Direct” in the lower right corner of the ID card, as shown in the sample to the right.

2) Call the toll-free Provider Customer Service number to verify benefits and eligibility.

3) Submit all claims to BCBSTX.

4) With BlueEdge Direct, you do not need to collect copayment or deductible amounts from the member at the time of service. You will be reimbursed from the member’s account.

5) BCBSTX will notify you of any remaining patient responsibility through distribution of the Provider Claim Summary (PCS).

6) Following receipt of the PCS, you may bill the member directly for any deductible and coinsurance amount owed.

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

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

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Have you ever felt uncomfortable about the ability of your Medicare patients to follow your instructions about medications?

As part of our Medicare Part D services, BCBSTX has designed and implemented a program to assist members with complex medication regimens called the Medication Therapy Management Program (MTMP).

This program provides select high-risk patients with a personal touch. Member support is provided at three levels utilizing call specialists, nurses and pharmacists. The three levels include:

- **Centralized telephone communication.** Calls are made by specially trained call specialists, nurses and pharmacists with expertise in geriatrics. When appropriate, our clinical pharmacists communicate directly with you to resolve important patient care issues. Educational materials are also provided.

- **MTMP coverage at the network pharmacy level.** In those instances when a network pharmacist has discovered a severe drug-drug interaction or other significant medication safety issue, the pharmacist will help to resolve these issues by communicating directly with you and the member.

- **Written communication for Medicare beneficiaries at long term care (LTC) facilities.** Information regarding specific medication issues (e.g. potential adverse drug events, over/under utilization, medications contraindicated in the elderly, etc.) in the geriatric population at LTC facilities is also provided to you as needed.

What are MTMP’s goals?

The program is designed to:

- Enhance member understanding through education and motivational counseling that promotes the appropriate use of medications and reduces the risk of potentially adverse events associated with use of medications.

- Increase member adherence to prescription medication regimens.

- Detect potential adverse drug events and patterns of over-use and under-use of prescription drugs.

- Promote improved communications with providers regarding medication issues.

continued on page 22
What quality outcome results support MTMP services?
Our program has been evaluated by various quality improvement organizations for its effectiveness and member satisfaction. Results for MTMP members are significantly higher than non-participating members in both treatment outcomes and member satisfaction.

Is there a cost for a member to participate in the MTMP?
There is no additional cost to the member to participate in the MTMP. All eligible members are invited to enroll in the program. Those members not wishing to participate have the option to decline our services. By utilizing an opt-in service model we have been able to tailor our service based on individual member needs.

Can I refer a patient to your program?
Yes, we are glad to take your referrals; however, we can only provide services to those Medicare beneficiaries who meet the following CMS-directed MTMP qualification criteria:

- Multiple chronic diseases (3 out of the following): asthma/COPD, diabetes, hyperlipidemia, osteoarthritis, depression, heart failure (CHF), hypertension, osteoporosis
- Multiple Part D drugs: six or more medications to treat chronic conditions noted above
- Drug spend threshold: member must have greater than $1,000.00 per quarter or $4,000.00 per year in anticipated spending on Part D medications

MTMP (Prime Therapeutics) contact information:

<table>
<thead>
<tr>
<th>MTMP phone number:</th>
<th>866-MTM-ACCESS (686-2223)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTMP phone line hours:</td>
<td>9 a.m. to 5 p.m. CST Monday through Friday</td>
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</tbody>
</table>

What can I do to get involved?
We mail out introduction letters to all qualified members and ask them to discuss their participation in the MTMP with their physicians. We hope you will encourage your patients to join and that MTMP supports and supplements your efforts to provide quality health care in the Medicare population.
This instruction provides clarification on Medicare Advantage billing procedures for skilled nursing facilities (SNFs) found in the CMS Medicare Claims Processing Manual, Publication 100-04, Chapter 6, Section 90.2.

If a member's Medicare Advantage plan denies coverage of a claim, the claim cannot be submitted to traditional “fee for service” Medicare for payment. You should apply the following policies to Blue Medicare PPO members who are admitted to a SNF:

- If the SNF is not participating in Blue Medicare PPO, notify the member that he/she may be considered out of network and will be required to pay a larger out-of-pocket amount than if the SNF were a participating provider.

- If the SNF is participating in Blue Medicare PPO, obtain prior certification for the care the member needs.

- If Blue Medicare PPO denies coverage and an appeal is pursued, direct the appeal to the quality improvement organization, not to the “fee for service” fiscal intermediary.

- Count the number of days paid by Blue Medicare PPO as Part A days used (this is the beneficiary’s 100 days of Medicare SNF benefits).

- Submit a claim to the “fee for service” fiscal intermediary to subtract benefit days from the Common Working File (CWF) records. Note: Blue Medicare PPO does not send claims to CWF for SNF stays. Failure of a SNF to send a claim to the “fee for service” fiscal intermediary will inaccurately show days available.

- If a member no longer requires skilled care under Blue Medicare PPO, discharge the patient (on paper) using a patient status code 04. No-payment bills to the “fee for service” fiscal intermediary are not required for members who are receiving non-skilled care and are enrolled in a Medicare Advantage plan. If the member again requires skilled care after a period of non-skilled care, you will need to obtain prior certification and begin a new admission claim to Blue Medicare PPO, as well as to the “fee for service” fiscal intermediary.

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Effective April 21, the filing deadline for HMO Blue Texas claims has been extended from 95 days to 180 days. You should submit a complete claim for any services provided to a member within 180 days from the date of service or the claim will not be eligible for reimbursement. You will receive a Provider Claim Summary notifying you that the claim has been denied if submitted after the designated cut-off date.

The member cannot be billed for these denied services. Ensure statements are not sent to HMO Blue Texas members, in accordance with the provisions of your HMO Blue Texas contract.

Laboratory Corporation of America (LabCorp) is the exclusive outpatient clinical reference laboratory provider for HMO Blue Texas members (see “note” for exceptions). To find the closest LabCorp Patient Service Center, please call LabCorp’s automated phone system toll free at 888-LABCORP (522-2677) 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 can find a complete list of participating providers by using the Provider Finder search tool at www.bcbstx.com/provider.

For physicians located in certain counties, only the lab services/tests indicated on the Reimbursable Lab Services list will be reimbursed on a fee-for-service basis if performed in the physician’s office for HMO Blue Texas members.

Please note that all other lab services/tests performed in the physician’s office will not be reimbursed.

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.