The Update is a bimonthly provider newsletter that contains up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for health care providers. It is published by the Health Network Management Services Department (HNS).

If you are a contracting BCBSNE health care provider, this newsletter serves as an amendment to your agreement and affects your contractual relationship with us. You are encouraged to file every issue of the Update within your BCBSNE Policies and Procedures manual and reference it often. You may also view the current manual in the Provider section at bcbsne.com.

Educators Health Alliance Migrates to NEtwork BLUE

The Educators Health Alliance (EHA) health care program participants now use NEtwork BLUE, effective for dates of service on and after September 1, 2010. EHA, which includes teachers, administrators, school board members and classified employees, covers approximately 35,000 subscribers/70,000 members.

New identification cards with new I.D. numbers have been issued. EHN continues to be the alpha prefix for this group’s medical and medical/dental combined. The alpha prefix for EHA members who have selected the dental only option is YEF.

Get Ahead – Get an NPI

It is becoming increasingly necessary for providers to have an National Provider Identifier (NPI) to allow for greater ease in claims processing and for a smooth transition to our new claims processing system. Starting in January 2011, Medicare will require providers to submit their NPI with claims information.

For more information on obtaining an NPI, visit the Regulations and Guidance page, located under the National Provider Identifier Standard section at cms.hhs.gov.
BlueBoard

**-SG Modifier for Ambulatory Surgery Center Claims**

The –SG modifier has been a Blue Cross and Blue Shield of Nebraska coding requirement for ASC claims for several years. Its purpose is to apply correct pricing for BluePreferred claims. ASC charges are priced on Network BLUE according to provider specialty, so the –SG modifier is not required for Network BLUE claims.

If you choose, you may drop billing the –SG modifier on Network BLUE claims. However, until the migration to Network BLUE is completed in 2012 and while claims are still being processed on the BluePreferred network, BCBSNE recommends you continue to use modifier –SG on CPT (surgery) codes and omit it from HCPCS codes (implants and fluoroscopy) for all claims. Please contact your BCBSNE HNS consultant for questions.

**Diabetes Education Billing Reminder**

When billing for diabetes education, please remember the following claim submission instructions with NPI directions.

For diabetes education, there are two types of covered providers:

1. A certified diabetes educator (CDE) who has been individually credentialed and has an individual NPI.
2. A certified diabetes program that has a signed agreement with BCBSNE. The NPI is the acute care hospital’s NPI.

All diabetes education charges are submitted to BCBSNE on a HCFA1500 with the appropriate NPI in box 24J.

**G codes to be used for diabetes education:**

- G0108 - Individual Session (one unit, per 30 minutes)
- G0109 - Group Session (one unit, per 30 minutes)

Please refer to Section 16 in our Policy and Procedure Professional manual, located on the bCBSNE Provider page under “Library” then “Policies and Procedures,” for additional information.

BlueCard Update

**Out-of-Area Blue Members’ Medical Policy and Precertification Requirements Now Available Online**

BCBSNE is excited to present a new feature on our provider website to make it easier for you to find information to help you treat your out-of-area Blue patients:

In one easy step, you will now be able to look up medical policy applicable to your out-of-area Blue patients and general precertification/preauthorization requirements, along with the contact information to initiate precertification/preauthorization.

To access medical policy and precertification/preauthorization requirements, go to the “Provider” page at bCBSNE.com, and click “Medical Policy/Pre-cert Router.”

Once you’re on the page, enter the patient’s three letter alpha prefix and click “Go.” The member’s “home” Blue Cross and Blue Shield Plan site will be displayed.

We hope this new web functionality gives you easy access to the information you need and provides a valuable supplement to the information you currently receive when verifying a patient’s benefits and eligibility.
Certification for Outpatient Visits/Psychological Testing Reminder

As of January 1, 2011, BCBSNE members are allowed 30 outpatient visits (therapy, partial hospitalization, intensive outpatient) per calendar year before a medical necessity review is required to approve additional visits. Members are allowed four units of psychological testing per calendar year before a medical necessity review is required. Medication checks (90862) are not included in the count or medical necessity review. For Intensive Outpatient Programs, each day counts as one visit.

The following are available at bcbsne.com, under the green “Provider” tab, then “Forms."

- Behavioral Health Outpatient Form (Form 4919 rev. 3-23-01)
- Psych/neuropsych Evaluation Request (Form 4974 rev. 11-18-09)

The applicable form(s) must be completed for any FEP member (prior to the first visit) and for other BCBSNE covered members needing more than 30 visits per calendar year or more than four hours of psychological testing in a calendar year.

Facility Facts

Important facts to remember when submitting claims:

- Institutional claims will calculate reimbursement per diem, DRG or transfer rates to the nearest whole dollar amount.
- The unit field for the UB04 or 837i must contain numeric values ONLY, no decimal points or alpha characters are allowed.

Countdown to 5010

The Health Insurance Portability and Accountability Act (HIPAA) requires the adoption of specific standards for electronic health care transactions (claims, eligibility inquiries, claims status requests and responses).

Per federal regulation, all health care entities (insurance plans, clearinghouses and providers) must transition from the current standard 4010A1 to 5010 on January 1, 2012.

The biggest concern for providers will be complete implementation and full functionality of 5010 transactions at or before the compliance deadline to avoid transaction rejections and subsequent payment delays.

Providers can prepare in advance for this upcoming effort by developing their own implementation plan. The following are various tasks to include in an implementation plan:

- Talk to your current practice management system vendor

The potentially largest expense is the practice management system changes that will be required for implementing the 5010 transactions. Depending on your contract with your vendor, the system upgrades may be included in your current maintenance. Some vendors may charge for the upgrades. Review your contract to determine if regulatory updates are included in your maintenance. This step should be done as soon as possible.

When reviewing your contract, be sure to ask your vendor the following questions:

- Will my current system be upgraded to accommodate the 5010 transactions?
- Can my current system accommodate both the data collection and transaction conduction for 5010?
- Will there be a charge for the upgrade?
- When will the upgrade be available?
- When will the upgrade to my system be installed?

- Talk to your clearinghouses or billing service (if you use either one) and health insurance payers

- Identify changes to data reporting requirements
- Identify potential changes to existing practice workflow and business processes
- Identify staff training needs
- Test with your trading partners (e.g., payers and clearinghouses)
- Budget for implementation costs, including expenses for system changes, resource materials, consultants, and training

If you have questions regarding BCBSNE’s transition to 5010, e-mail hipaa5010inquiries@bcbsne.com.
Upcoming Outpatient and Inpatient Consult Coding Changes

Effective for services on or after January 1, 2011, BCBSNE will follow CMS's billing change related to the use of outpatient and inpatient consult codes. BCBSNE will not accept CPT codes 99241 - 99245 or 99251 - 99255. These consultation codes will be non-covered as provider liable services. The denial reason will instruct the provider to resubmit with a more appropriate Evaluation and Management (E&M) code. The following guidelines must be followed when billing consultation services:

1. **Consults in the office or as an outpatient.** These services should be submitted using the new or established patient office or other outpatient visit codes (99201 - 99215). New and established patient visit criteria remain according to the CPT definition. Services must meet the CPT code definition.

2. **Consults in the emergency room (ER).** When a consultation takes place in the ER, the service may be submitted as either an additional ER visit or as an outpatient office visit using the appropriate place of service code (23 for ER). Documentation must support the CPT code definition.

3. **Consults during observation.** Only the admitting physician can use the initial observation care codes (99218 - 99220). Other physicians performing a consult should use the new or established patient office or other outpatient visit codes.

4. **Consults during an inpatient hospital stay.** The first time a physician sees a patient in consult, an initial hospital care code (99221 - 99223) may be billed regardless of when the visit occurs during the inpatient stay. There may be multiple initial hospital care codes on the admit date or other date depending on the physician(s) who assesses the patient in consult. However, there should never be more than one initial hospital care code per physician. Subsequent visits to the patient must be billed using subsequent care codes (99231 - 99233).

   The admitting physician may append modifier AI to the initial hospital care code to identify the admitting physician of record. There should only be one initial hospital care code with modifier AI. Any additional initial care codes with this modifier will be non-covered as a duplicate service.

   When a second physician sees a patient as an initial consult and all of the required components are performed and documented, an initial hospital care code may be used (99221 - 99223).

   If the criteria for an initial hospital care code is not met and the documentation and criteria supports a subsequent hospital care code (99231 - 99233), those codes should be used even if an initial code has not been submitted by that physician. Rarely would code 99499 (unlisted E&M service) be used if documentation does not meet criteria for subsequent care. Documentation must establish that a medically necessary service was rendered and where the service took place. Claims submitted for services with code 99499 will be individually reviewed.

5. **Consults in a nursing facility.** The first time a physician sees a nursing facility patient in consult, an initial nursing facility care code (99304 - 99306) may be billed regardless of when the visit occurs during the nursing facility stay. Multiple initial nursing facility care codes may be billed depending on the physician(s) who assesses the patient in consult. However, there should never be more than one initial nursing facility care code per physician. Subsequent visits to the patient must be billed using subsequent care codes (99307 - 99310).

   The admitting physician may append modifier AI to the initial nursing facility care code to identify the admitting physician of record. There should only be one initial nursing facility care code with modifier AI. Any additional initial care codes with this modifier will be non-covered as a duplicate service.

   When a second physician sees a patient as an initial consult and all of the required components are performed and documented, an initial nursing facility care code may be used (99304 - 99306). If the criteria for an initial nursing facility care code is not met and the documentation and criteria supports a subsequent nursing facility care code (99307 - 99310), those codes should be used even if an initial code has not been submitted by that physician. Only rarely would code 99499 (unlisted E&M service) be used if documentation does not meet criteria for subsequent care. Documentation must establish that a medically necessary service was rendered and where the service took place. Claims submitted for services with code 99499 will be individually reviewed.

6. **Consults submitted on a UB-04.** Any of the consultation codes submitted on the UB-04 will be non-covered as provider liable services. The denial reason will instruct the provider to resubmit with a more appropriate E&M code.
FEP Update

FEP Re-issues I.D. Cards

FEP members requesting I.D. cards after October 1 should be advised to present their new card at the pharmacy.

Please note that the following schedule is still on target: January 1, 2011 – March 31, 2011:

All existing and new members will receive new digital image I.D. card(s), with the exception of members who were issued new cards through December 31, 2010.

All new I.D. cards will be reissued by March 31, 2011. On your FEP members’ next visit, be sure to request their most recent I.D. card.

Card revisions include:
- New digital image I.D. card and I.D. card carrier
- New member messaging on the I.D. card carrier
- The Pharmacy Benefits Manager will no longer appear on the card
- The processing control number will be FEPRX
- The Issuer Identification Number will be 610239

$0 Cost Sharing for FEP Member Vaccinations

FEP members can receive the following vaccinations with $0 cost sharing for the member if they go to a participating FEP Vaccine Network Provider (Caremark).

- Influenza (seasonal flu)
- Herpes Zoster (shingles)
- Pneumonia
- Human Papillomavirus (HPV)
- Meningitis
When you use electronic remits and funds transfer, you gain the following benefits:

• Save money and time with electronic posting
• Save natural resources by reducing the use of paper and fossil fuels used to transport paper remits
• Electronic remits are easier to sort, view and retrieve than paper remits
• Electronic funds transfers are automatically deposited and never get lost or delayed in the mail

Providers have two options for receiving electronic remittance advices:

• Download directly from BCBSNE
• Receive remits from your clearinghouse

To begin receiving electronic remittance advices and electronic funds transfer, fill out and fax us one of the following forms, located on the Provider page at bcbsne.com, under “Forms”:

• Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form
• Electronic Funds Transfer Enrollment Form
• Electronic Remittance Advice

If you have any questions, please contact:
Sean Blair (serves offices in Omaha and South of I-80)
Phone: (402) 392-4205 or (888) 233-8351 (options 4, 1)
E-mail: sean.blair@bcbsne.com

Josh Wiens (serves offices in Lincoln and North of I-80)
Phone: (402) 982-8727 or (888) 233-8351 (options 4, 2)
E-mail: josh.wiens@bcbsne.com

Go Green with Blue Tip:
Take the Stairs
You’ll get fit and at the same time save the energy that would have been used to power the elevator.

Source: 100 Ways to Save the Planet without Leaving the Office, Simon Melhuish, Editor
Medical Policy Update – August 12, 2010

The BCBSNE Medical Policy Committee (MPC) met on August 12, 2010. This committee, composed of practicing network physicians, utilizes contract criteria summarized at the website referenced below, to determine whether a new technology or new application of an existing technology is scientifically valid or investigatory.

The following revised policies were acted upon and are now available for review. To view these medical policies as well as others developed for use at BCBSNE, go to the Provider page at BCBSNE.com, then to “Library,” “Policies and Procedures” and then click on the “Medical Policies” link. Proceed to accept the disclaimer and then go to the specific policy number.

Revised Policies

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Comments on these or other medical policies are welcomed. Please direct those comments or other inquiries to BCBSNE’s Health Program Research Administrator, Heather Scholting, at heather.scholting@bcbsne.com or (402) 982-6401.

The MPC has made the decision to discontinue use of the BCBSNE policy regarding PET scans (IV.33) and MRI of the Heart (IV.75). These imaging study requests will be going through our Radiology Utilization Management vendor American Imaging Management (AIM) effective September 7, 2010. You may request these authorizations via the AIM website at www.americanimaging.net/goweb. The AIM guidelines are available at www.americanimaging.net.
Children of Single Military Parents Visit Doctor Less Frequently
TriWest Provider Services

Pediatric care is most frequent during the early years when a child is rapidly developing. Often the care is for well checks and assessing an infant or young child’s growth and development in order to identify problems early. Preventive care is an important tool for raising healthy children and it can also be a critical time for open communication between a parent and a pediatrician, especially among military families.

A recent study conducted by researchers at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, examined medical care patterns for nearly 170,000 military children, one-third of whom had a parent that had been deployed at least once since 2007. All the children were younger than the age of 2 when the parent was deployed, and all were from families enrolled in the U.S. military’s health care system.

The researchers found that slightly more than one-quarter of all child-care visits for military children were for issues other than illness, or a “well-child” visit. Another finding reported that children from single-parent military families experienced a drop-off in both outpatient visits for illness and well-child visits after the deployment of the custodial parent. Conversely, children from two-parent homes experienced an increase in both types of visits.

Because there are so many demands on military personnel, it may be that routine care is deferred until a health concern can no longer be ignored.

Gregory Gorman, M.D., a military-based commander and assistant professor of pediatrics at the Uniformed Services University of the Health Sciences said, “The bottom line is that military deployment of parents does affect the health care of their kids.”

Gorman also reported that older couples with one parent deployed were actually bringing in their children for care more often than young, single parent families. “The younger, single group should be the group that we target to make sure that kids get the health care they need,” he said. It could be that older parents have more established support networks and the resources to carry out more frequent health care visits for their children than younger parents.

More research is necessary on the subject to discover issues like parents’ stress levels, diagnosing behavior problems in babies under one year old, and looking at comparable data of the military family experience along with a civilian population data.

Please encourage new parents in the U.S. military that well-child care and regular contact with a child’s pediatrician is preventive health care that pays off over a lifetime.

SOURCES: Gregory Gorman, M.D., department of pediatrics, Uniformed Services University of the Health Sciences, Bethesda, Md., and section on pediatric nephrology, Walter Reed Army Medical Center and National Naval Medical Center, Washington, D.C.; Alyssa Mansfield, Ph.D., M.P.H., research epidemiologist, RTI International, Research Triangle Park, N.C.; Keith Armstrong, L.C.S.W., professor of clinical psychiatry, University of California, San Francisco; June 7, 2010, Pediatrics, online
Diagnosing TBI in a PTSD World

TriWest Provider Services

Diagnosing traumatic brain injuries (TBI) can be complex, especially when some symptoms overlap with those of post-traumatic stress disorder (PTSD).

Russell Jenna, M.D., a medical director at TriWest Health Care Alliance, said taking a thorough history of the patient could mean the difference between a proper TBI diagnosis and a misdiagnosis.

“If a patient is complaining about feelings of agitation and isolation, but also mentions headaches, you could ask, ‘Since you mentioned you served, did you suffer any injuries while deployed, or were you near an explosion?’ ” Jenna said.

“You can’t necessarily put a stamp on TBI, but if you ask the right questions, the answers may be very good indicators that the patient may be suffering from TBI, as opposed to PTSD.”

Connection between TBI and PTSD

The Defense Centers of Excellence (DCoE) outlined the similarities and differences between PTSD and TBI. According to the DCoE web site, overlapping symptoms of the two include:

- Insomnia, fatigue
- Irritability, anger
- Problems thinking and remembering
- Mood swings, personality changes
- Hypersensitivity to noise
- Withdrawal from social and family activities

However, reports from the Center indicated that a TBI patient will also exhibit headaches, dizziness and vertigo, reduced alcohol tolerance and sensitivity to light.

In a study conducted by Charles W. Hoge, M.D., published Jan. 31, 2008 in the New England Journal of Medicine, Hoge concluded PTSD is strongly associated with mild TBI. In fact, about 44 percent of soldiers participating in the study who reported loss of consciousness from their injury also met the criteria for PTSD. Blake Chaffee, M.D., vice-president of Integrated Health Services at TriWest, emphasizes that oftentimes, a patient may have both.

TriWest TBI Program

TriWest has a TBI Program specifically to help active duty TBI patients and their families. After diagnosing a patient with a TBI, a referral to this program in addition to the provider’s recommended treatment may greatly help the patient and his or her family.

Anyone may refer a TBI patient to TriWest’s program by completing the TBI Program Referral Form, available at triwest.com/document_library/pdf_docs/TBI_Referral.pdf.

A fact sheet about the program is also available online at triwest.com/document_library/pdf_docs/TBI_FactSheet.pdf.

An additional training opportunity is available through PTSD 101, a web-based PTS/trauma-related curriculum presented by the U.S. Department of Veterans Affairs. It is available on-demand for professionals who provide services to individuals who have experienced trauma. CE Credits are now available free of charge. To access the training, go to www.ptsd.va.gov and select “For Providers and Researchers.”

Resources, Continuing Education

You can contact the TriWest TBI team by calling (866) 209-0390 or by e-mail at TBIsupport@triwest.com.
Two Facilities Designated as Blue Distinction Centers for Bariatric Surgery®

BCBSNE is pleased to announce that the following facilities have met the selection criteria necessary for designation as Blue Distinction Centers for Bariatric Surgery®:

- Alegent Health Immanuel Medical Center, Omaha
- The Nebraska Medical Center, Omaha

These facilities join Regional West Medical Center in Scottsbluff and St. Elizabeth Regional Medical Center in Lincoln as Nebraska’s Blue Distinction Centers for Bariatric Surgery.

Blue Distinction® recognizes facilities that meet objective, evidence-based thresholds for clinical quality, developed in collaboration with expert physicians and medical organizations. At the core of Blue Distinction® are the Blue Distinction Centers for Specialty Care®, providing Blue members with a credible, easily identifiable means of selecting facilities that meet their individual health care needs.

Blue Distinction Centers for Bariatric Surgery® have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric surgery patients. They offer comprehensive bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. To date, Blue Cross and Blue Shield has designated more than 270 facilities nationwide that meet the evidence-based selection criteria.

In determining the selection criteria for Blue Distinction®, BCBS collaborated with physician experts and medical organizations such as the American College of Surgeons, American Society for Metabolic and Bariatric Surgery and the Surgical Review Corporation.* Potential Blue Distinction Centers submit clinical data to establish that they meet the selection criteria, which include:

- An established bariatric surgery program, actively performing these procedures for the most recent 12-month period and performing a required minimum volume of 125 such surgeries annually
- Appropriate experience of its bariatric surgery team
- An acute care inpatient facility, including intensive care and emergency services
- Full facility accreditation by a CMS-deemed national accreditation organization
- A comprehensive quality management program

Detailed selection criteria are publicly available by going to BCBS.com, then clicking on the “Blue Distinction” link. This information provides consumers with support for their health care decisions and facilities with a clinically established path for quality improvement.

To maintain its Blue Distinction Center designation, each facility must reapply periodically for re-designation. This not only encourages continuing quality at the facility level, but it also provides an opportunity for The Blues to work with expert physicians and medical organizations to determine if any of the Blue Distinction quality thresholds should be raised to reflect current clinical practice. This process fosters ongoing opportunities for improving the overall quality of care.

To date, more than 1,300 of the nation’s bariatric surgery facilities have been nominated by local Blue companies for potential designation as Blue Distinction Centers for Bariatric Surgery. More than 30 percent of the facilities that submitted an application met the selection criteria and were designated as Blue Distinction Centers for Bariatric Surgery.

Blue companies continue to work proactively with facilities that do not receive the Blue Distinction designation, providing feedback reports detailing areas for improvement. The goal is to improve quality for the entire Blue network, which includes 90 percent of the nation’s hospitals.

continued on next page
Blue Distinction Centers for Bariatric Surgery, along with the Blue Distinction Centers for Cardiac Care®, Blue Distinction Centers for Complex and Rare Cancers®, Blue Distinction Centers for Knee and Hip ReplacementSM, Blue Distinction Centers for Spine SurgerySM and Blue Distinction Centers for Transplants® are a key part of The Blues’ efforts to collaborate with physicians and facilities to improve the overall quality, and resulting affordability, of specialty care.

For additional information:
To obtain more information about the Blue Distinction Centers for Bariatric Surgery®, please contact your local Blue Cross and Blue Shield company or visit www.BCBS.com/bluedistinction.**

* These organizations have provided information and input but do not formally endorse the Blue Distinction Centers program.

** Some Blue companies may already participate in local bariatric programs. The Blue Distinction Centers for Bariatric Surgery do not disrupt or replace these existing programs. Blue members (who have coverage for bariatric services) may not necessarily be required to use institutions that are part of this program.

Note: Designation as Blue Distinction Centers means these facilities’ overall experience and aggregate data met objective criteria established in collaboration with expert clinicians’ and leading professional organizations’ recommendations. Individual outcomes may vary. To find out which services are covered under your policy at any facilities, please call your local Blue Cross and/or Blue Shield Plan.
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