

**August 2015**

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## **When Is It Time to Consider Palliative Care?**

Palliative medicine consultants often receive requests from colleagues to see a patient who is finally “ready to go palliative.” Sometimes it means that a patient wants to know more about hospice. Other times, it means that the patient’s family is concerned about the patient’s suffering, and wants more attention paid to pain and symptom management. Many times, providers aren’t quite sure how to help a patient with serious illness who is struggling with the current treatment plan and is not sure what other options exist.

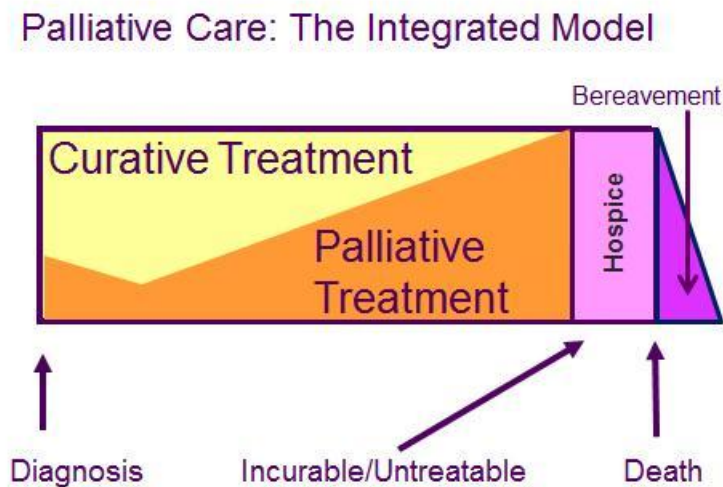
While hospice as a model of care, and as an insurance benefit, has been in existence in this country since the early 1980s, palliative care is a relatively new specialty (board certification through the American Board of Medical Specialties became official in 2008). Moreover, the vast majority of the American public has never heard of palliative medicine. Until recently, it was not a topic that was discussed until the very late stages of illness.

Palliative care refers to the active, total care of patients with life-limiting illness, with a focus on relieving or preventing suffering – in all of its forms – related to the underlying illness or related to treatment of the illness. Examples of “life-limiting illness” include COPD, heart failure, dementia and cancer.

Palliative care may be provided at any stage of a life-threatening illness. Importantly, patients can receive palliative care concurrently with disease-modifying care, and it is not limited to a particular diagnosis (like cancer) or prognosis. Palliative care typically encompasses symptom management, including both physical (such as pain, nausea, constipation, breathlessness, fatigue) and psychosocial (including delirium, anxiety, depression, spiritual distress) symptoms.

Because suffering is typically so multidimensional, excellent palliative care is usually provided by interdisciplinary teams of providers including physicians, nurses, social workers, chaplains and other allied clinicians.

**Figure: Integrated Model Concurrent Palliative Care**



Philosophically, hospice can be thought of as palliative care for patients at the end of life. The focus on symptom control, maximizing quality of life and optimizing support for the patient and family are the same. The differences are in the details (see table). A patient is eligible for hospice when the prognosis is thought to be (given the expected course of illness) six months or less and the patient has decided to forego further treatment to cure the underlying life-threatening condition (they may still receive treatment for any other illness not related to the terminal condition). A patient must elect to enroll in hospice and must give consent to enroll.

**Table: Comparing Palliative Care and Hospice\***

	<b>Palliative Care</b>	<b>Hospice</b>
<b>Goal of Care</b>	Improve Quality of Life: Provide support for patient and family	Improve Quality of Life: Provide support for patient and family
<b>Prognosis</b>	Independent of Prognosis: May be provided at any point of a life-limiting illness trajectory	Prognosis (six months or less): Patient may remain in hospice beyond six months as long as prognosis is still believed to be limited if the disease runs its expected course
<b>Funding</b>	While many BCBSTX members have benefits for services that comprise palliative care, benefits can vary and should be verified if there are questions.	While many BCBSTX members have benefits for hospice care, benefits can vary and should be verified if there are questions.

<b>Care Team</b>	Usually interdisciplinary (including any combination of physician, nurse, nurse practitioner, social worker, chaplain)	Must be interdisciplinary (including physician, nurse, social worker) May also include chaplain, volunteers, home health aides, therapists (art, music, massage, physical)
<b>Location of Care</b>	Outpatient consultation/co-management, Inpatient consultation, Inpatient unit (all if available within the community or hospital system) Home visits, if	Home, Skilled nursing facility Inpatient Hospice (either at hospital or dedicated hospice unit) is for limited time and requires documented need for specialty care
<b>24-hour home care included?</b>	No – Home visits possible, but typically much less frequent than hospice home visits	No – Hospice is a “visiting” service, with frequency determined by patient need and plan of care; families may need to consider hiring additional caregivers if needed

\*The description of what benefits may be available for the care noted above is not a guarantee of benefits. Members should refer to their certificate of coverage to determine what, if any, benefits are available and more details regarding terms, conditions, limitations and exclusions.

It is never too early to “go palliative.” Whenever a potentially life-threatening illness is affecting a patient’s quality of life, it is time to consider adding palliative care to the treatment plan. If available, an expert palliative care team can help manage symptoms, coordinate care and facilitate complex decision-making planning that may include preparing for end-of-life care, even if it may be months or years away.

*Dr. Eytan Szmuiłowicz, director of the Section of Palliative Care at Northwestern University Feinberg School of Medicine, has provided this information about palliative care for Blue Review readers.*

### **BCBSTX Implements Changes in Maximum Allowable Fee Schedule**

Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule used for Blue Choice PPO<sup>SM</sup>, HMO Blue Texas<sup>SM</sup>, Blue Advantage HMO<sup>SM</sup> (Independent Provider Network and THE Limited Network only), and ParPlan effective Nov. 1, 2015.

Changes will be implemented in the maximum allowable fee schedules used for the Blue Cross Medicare Advantage PPO<sup>SM</sup> and Blue Cross Medicare Advantage HMO<sup>SM</sup> effective Jan. 1, 2016.

- The methodology used to develop the maximum allowable fee schedule for Blue Choice PPO, HMO Blue Texas and Blue Advantage HMO will be based on 2015 CMS values posted on the CMS website as of Jan. 16, 2015, for those services for which the BCBSTX reimbursement is based on CMS values.

- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.
- Blue Choice PPO, HMO Blue Texas, Blue Advantage HMO and ParPlan relative values will consider the site of service where the service is performed (facility or non-facility).
- The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year.
- The NDC Fee Schedule will be updated monthly.

BCBSTX provides general reimbursement information policies, request forms for allowable fees and fee schedule information. To view this information, visit the [General Reimbursement Information](#) section on the BCBSTX provider website. If you would like to request a sample of maximum allowable fees or if you have any other questions, please contact your Network Management office.

Reimbursement changes will be posted under "Reimbursement Changes and Updates" in the Reimbursement Schedules section on the BCBSTX provider website. 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.

### **Medical Record Documentation Reminder**

The primary focus of medical record documentation is to communicate a patient's treatment plan and support continuity regarding their treatment. Accurate and complete documentation is an essential component of patient care that enhances quality.

Medical record documentation should provide a road map for every member of the treatment team about a patient's current state of health, preventive care, treatment interventions and planning, care delivery, progress, and discharge planning.

Minimum documentation requirements to include on each page of a medical record include, but are not limited to the following:

- Patient's full name
- Date of birth
- Unique medical record number or other identifier
- Physician's name
- Date of occurrence
- Author's identification (signature, unique electronic identifier or initials)

Medical record documentation should include, at minimum, the following components:

- Significant illnesses and medical conditions are indicated on the problem list
- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this information should be appropriately noted in the medical record.

- Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
- Working diagnoses are consistent with findings
- Treatment plans are consistent with diagnoses
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

Quality documentation enhances patient safety, justifies medical claims, fosters a patient-physician relationship, and provides physician protection. Complete and accurate documentation is critical. Additional items to address in medical record documentation can be found on the Blue Cross and Blue Shield of Texas provider website in the [Provider Manual](#), Section J Quality Improvement.

### **BCBSTX to Host a Payer-specific Overview of the Availity™ Web Portal**

Before, during and after the claim submission process, electronic options are available to help make it easier for you to conduct business with Blue Cross and Blue Shield of Texas (BCBSTX). For most electronic transactions, you will need to enlist the services of a vendor portal for the secure exchange of your patients' protected health information. Using an online vendor portal can enable providers to obtain fast, efficient, detailed claims data for BCBSTX members. Since there are many vendors to choose from, we encourage you to shop around.

Our Provider Education Consultant team is hosting BCBSTX **Back to Basics: 'Availity 101'** webinars to provide an overview of several electronic options, using the Availity Web Portal as one example of a vendor to consider. In addition to supporting standard electronic data interchange (EDI) transactions, the Availity Web Portal offers special resources for BCBSTX participating providers, such as the Claim Research Tool. General training is offered on the Availity website; however, it's important to understand payer-specific details.

During each one-hour BCBSTX **Back to Basics: 'Availity 101'** webinar, we'll discuss the following:

- Registration for new users
- Gaining access and general navigation
- How to conduct eligibility and benefits requests
- Quick preview of the Claim Research Tool
- Other tools available to BCBSTX contracted providers
- How to obtain additional training

### **Sign Up Today**

To register now for this complimentary online training session hosted by BCBSTX, visit the Education and Reference/[Physician and Professional Provider Training/Availity](#) section of our provider website. You do not have to be a registered Availity user to attend.

If you have questions or would like to request personalized training for your office, email our Provider Education Consultants at [pecs@bcbstx.com](mailto:pecs@bcbstx.com).

\*Note: If you are unable to pre-register for a webinar, please return to the Professional Provider Training page and click on the date and time for your preferred session. The “Join” button will become active at the scheduled start time of the meeting.

*Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.*

*Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.*

### **ClaimsXten™ System Edit Updates, Effective in June**

In mid-June, Blue Cross Blue and Shield of Texas (BCBSTX) enhanced the ClaimsXten code auditing tool with the following changes to the bundling logic in our claim processing system:

- Anesthetic nerve blocks will bundle to American Society of Anesthesiologists (ASA) Current Procedural Code Terminology (CPT®) codes. This is in accordance with CPT, Centers for Medicare & Medicaid Services National Correct Coding Initiative (CMS NCCI) and industry auditing guidelines.
- Surgical procedure codes submitted with any evaluation and management, anesthesia, surgical, medical or therapeutic procedure code will now be subject to CPT, CMS NCCI and industry auditing guidelines.
- Venipuncture codes 36410, 36415 and 36416 will now bundle to all medical, surgical, laboratory procedure codes.
- Evaluation and management procedure codes submitted with any anesthesia, surgical, medical or therapeutic procedure code will now be subject to CMS global surgical package bundling logic.
- Medical/therapeutic procedure codes submitted with any anesthesia, surgical, medical or therapeutic procedure code will now be subject to CPT, CMS NCCI and industry auditing guidelines.
- Radiological procedure codes submitted with any anesthesia, surgical, medical or therapeutic procedure code will now be subject to CPT, CMS NCCI and industry auditing guidelines.
- Supply codes submitted with any anesthesia, surgical, medical or therapeutic procedure code will now be subject to CPT, CMS NCCI and industry auditing guidelines.



- Therapeutic procedure codes submitted with any anesthesia, surgical, medical or therapeutic procedure code will now be subject to CPT, CMS NCCI and industry auditing guidelines.

In accordance with CPT/HCPCS guidelines, use of modifiers may impact the outcome of the final adjudication of claims for the changes listed above. Consult your CPT codebook appendix A or HCPCS codebook for guidance in the appropriate use of modifiers.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to the [Education & Reference/Provider Tools/Clear Claim Connection](#) section of our website for additional details on C3 and ClaimsXten. Information also may be published in the News and Updates, as well as upcoming issues of [Blue Review](#).

*ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent, third-party vendor that is solely responsible for its products and services.*

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*Checks of eligibility and/or benefit information are not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.*

**Effective November: Intranasal Topical Anesthetic for Headaches Is Not Covered**  
Blue Cross and Blue Shield of Texas (BCBSTX) Medical Policy MED205.039, or Topical Application Device for Anesthetic Treatment to the Sphenopalatine Ganglion for Headaches (treatment of headache or facial pain), will become effective for dates of service on or after Nov. 1, 2015.

The medical policy states that topical application of anesthetic (including, but not limited to Marcaine or Naropin), with or without steroid(s), to the sphenopalatine ganglion as a nerve block for headaches or facial pain using an applicator for nasal spray or any other similar device, is considered experimental, investigational and, as such, is not a covered benefit.

There is no Current Procedural Terminology (CPT®) code that specifically describes intranasal application of a topical anesthetic for the treatment of headache or facial pain. Per the American Medical Association (AMA), providers are instructed to use CPT code 64999 (unlisted procedure, nervous system) to identify this type of treatment, which, as noted above, is not a covered benefit for BCBSTX members.

To view the BCBSTX Pending Medical Policy for Topical Application Device for Anesthetic Treatment to the Sphenopalatine Ganglion for Headaches, refer to the Standards and Requirements/Medical Policy section of the BCBSTX provider website at

[bcbstx.com/provider](http://bcbstx.com/provider) and select the [Active and Pending Medical Policies](#) link. Pending policies are listed alphabetically – select the title of the policy you wish to view to open the document.

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*The BCBSTX Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient's health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Members should refer to their certificate of coverage or summary plan description for more complete details regarding what services are covered including, benefits, limitations and exclusions. Some benefit plans administered by BCBSTX, such as some self-funded employer plans or governmental plans, may not utilize BCBSTX Medical Policy. Members should contact the customer service number listed on the back of their identification card for more specific benefit information.*

### **Predetermination Request Form and New Texas Standard Prior Authorization Request Form**

Blue Cross and Blue Shield of Texas (BCBSTX) has revised its current Predetermination Request Form that is to be completed and submitted whenever a provider wants to request a predetermination to establish medical necessity and available benefits. The [Predetermination Request Form](#) can be found on the BCBSTX provider website in the General Forms section.

Pursuant to Texas Insurance Code Chapter 1217, effective Sept. 1, 2015, health plans that require preauthorization must accept preauthorization requests submitted using the [Texas Standard Prior Authorization Request Form for Health Care Services](#) adopted by the Texas Department of Insurance.

Please note that BCBSTX currently does not require the use of a preauthorization form, therefore BCBSTX will not require the use of the [Texas Standard Prior Authorization Request Form for Health Care Services](#), but will accept preauthorization requests using the form should a provider choose to use it. The Texas Standard Prior Authorization Request Form for Health Care Services is available on the BCBSTX website in the General Forms section.

The above referenced forms are two different and separate forms. When submitting either of these forms to BCBSTX, please use the following applicable fax # or address:

- Fax 888-579-7935.  
If unable to fax, mail to: BCBSTX, P.O. Box 660044, Dallas, TX 75266-0044.
- For Federal Employee Program members, Fax 888-368-3406.  
If unable to fax, mail to: BCBSTX, P.O. Box 660044, Dallas, TX 75266-0044



If you have any questions, please contact your Network Management office:

Network Management Office	Telephone Number	Fax Number
Austin	512-349-4847	512-349-4853
Corpus Christi	361-878-1623	361-852-0624
Dallas	972-766-8900 800-749-0966	972-766-2231
El Paso	915-496-6600	915-496-6611 915-496-6614
Houston, Beaumont, East Texas	713-663-1149 800-637-0171	713-663-1227
Lubbock, Amarillo	806-783-4610	806-783-4666
Midland, Abilene, San Angelo	432-620-1406	432-620-1428
San Antonio	361-878-1623	361-852-0624

## NOTICES AND ANNOUNCEMENTS

### Important Notice Regarding Billing for Point of Use Convenience Kits

On June 30, 2015, Blue Cross and Blue Shield of Texas (BCBSTX) notified you of reimbursement changes regarding billing for Point of Use Convenience Kits for services rendered to our members would be effective starting Oct. 1, 2015. This message is to inform you that the correct date of the change is **Nov. 1, 2015**. We apologize for any inconvenience.

BCBSTX periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our member's benefit plan and meet BCBSTX's guidelines.

Some providers are submitting claims for point of use convenience kits that are used in the administration of injectable medicines. These prepackaged kits contain not only the injectable medicine, but also non-drug components including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

Effective **Nov. 1, 2015**, reimbursement for these point of use convenience kits will be reduced and BCBSTX will reimburse for the drug only and not the point of service kit. Non-drug components included in the kits are inclusive of the practice expense for the procedure performed for which no additional compensation is warranted.

Typically, the cost of convenience kits exceeds the cost of its components when purchased individually. Services should be provided in the most cost effective manner and in the least costly setting required for the appropriate treatment of the member.

### ICD-10: Approaching the Finish Line

As mandated by the U.S. Department of Health and Human Services, all Health Insurance Portability and Accountability Act (HIPAA) covered entities must use ICD-10 codes on claims and other health care transactions as of the Oct. 1, 2015, compliance deadline.

### **Claim Submission Reminders**

ICD-10 codes must be used on all claims with dates of service on or after Oct. 1, 2015, and inpatient institutional claims with dates of discharge on or after Oct. 1, 2015. As of the Oct. 1, 2015, compliance deadline, claims without valid ICD-10 codes, as required, will not be accepted by BCBSTX. Use of other codes, such as Current Procedural Terminology (CPT®), HCPCS and Revenue Codes will not be impacted by the transition to ICD-10.

### **Testing End Date: Aug. 14, 2015**

We want to thank those providers who participated in our ICD-10 Testing Program. BCBSTX began conducting end-to-end testing of electronic claims submitted by selected providers in April 2015. Testing is scheduled to continue through Aug. 14, 2015.

### **Benefit Preauthorization Update**

In addition to claims, ICD-10 codes must also be used on other transactions, such as benefit preauthorization requests. BCBSTX will begin accepting ICD-10 codes as of Sept. 21, 2015, for benefit preauthorization requests for services that will be rendered on or after Oct. 1, 2015. Prior to submitting a benefit preauthorization request, we encourage you to check eligibility and benefits through your preferred online vendor portal.

### **Watch for Our ICD-10 'Special Edition'**

ICD-10 is really happening and we want to help increase awareness in the provider community. Later this month, we'll be publishing a *Blue Review* Special Edition newsletter to spotlight key topics, such as the importance of training and refresher training, improving your documentation, tips for small practices and resource reminders. Please share this newsletter with your staff.

For additional information, visit the Standards and Requirements/ICD-10 section of the BCBSTX provider website at [bcbstx.com/provider](http://bcbstx.com/provider). If you have ICD-10 questions, email us at [icd@bcbstx.com](mailto:icd@bcbstx.com) and we will be happy to assist. Or, contact your assigned Network Management Representative.

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### **ClaimsXten™ Adds Three New Outpatient Facility Rules, Effective Oct. 12, 2015**

Beginning on or after Oct. 12, 2015, BCBSTX will enhance the ClaimsXten code auditing tool by adding three new Outpatient Facility Rules into our claim processing system. The new facility rules will apply for any claims with dates of service on or after Oct. 12, 2015. The new rules are summarized below:

#### **Medically Unlikely Edits (MUE) Multiple Lines Facility Rule**

This new facility rule identifies claim lines where the MUE has been exceeded for a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code, reported by the same provider, for the same member, on the same date of service.

An MUE is an edit that reviews claims for unit of service for a HCPCS or CPT code for services rendered by a single provider/supplier to a single beneficiary on the same date of service.

The ideal MUE is the maximum unit of service that would be reported for a HCPCS or CPT code on the vast majority of appropriately reported claims. The maximum allowed is the total number of times per date of service that a given procedure code may be appropriately submitted by the same provider.

### **Outpatient Code Editor (OCE) CMS CCI Bundling Rule**

This new facility rule identifies claims containing code pairs found to be unbundled according to Centers for Medicare & Medicaid Services (CMS) Integrated Outpatient Code Editor (I/OCE). One of the functions of the I/OCE is to edit claims data to help identify inappropriate coding due to the following reasons: The procedure is a mutually exclusive procedure that is not allowed by the Correct Coding Initiative (CCI) and/or the procedure is a component of a comprehensive procedure that is not allowed by the CCI.

### **Unbundled Pairs Outpatient Rule**

This new facility rule identifies the unbundling of multiple surgical codes when submitted on facility claims. This rule detects surgical code pairs that may be inappropriate for one of the following reasons: one code is a component of the other code, or these codes would not reasonably be performed together on the same date of service.

The ClaimsXten tool offers flexible, rules-based claims management with the capability of creating customized rules, as well as the ability to read historical claims data. ClaimsXten can automate claim review, code auditing and payment administration, which we believe results in improved performance of overall claims management.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to our website at [bcbstx.com/provider](http://bcbstx.com/provider) for additional information on gaining access to C3.

For details regarding ClaimsXten, refer to the Education and Reference/ Provider Tools/Clear Claim Connection page on our provider website. Information also may be published in upcoming issues of the *Blue Review*.

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### **Quick Guide to Member ID Cards Now Available**

The BCBSTX Quick Guide to Blue Cross and Blue Shield Member Identification (ID) Cards\* is now available on our provider website. The new guide will offer an overview of Blue Cross and Blue Shield ID cards, including what the symbols mean and how to use

the information on printed on the ID card. Always asking to see the current member identification cards at each visit along with a picture ID will help you identify the member's product, network and health plan contact information.

This interactive document allows you to easily navigate to specific topics of interest. The guide is available in the Claims and Eligibility/ [Eligibility and Benefits](#) section of the BCBSTX provider website.

*\*Member ID cards are for identification purposes only and do not guarantee eligibility or payment of your claim. Always verify eligibility and benefits electronically through your Web vendor of choice.*

*Checking eligibility and/or benefit information is not a guarantee of payment. Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.*

### **Help Your Patients Keep Their Health on Track with Our Healthy Family App**

Healthy Family is an app that tells users, like your patients, which preventive services are recommended for them and their family. The app lets them know about important wellness screenings and immunizations, so they can take charge of their health and have informed conversations with you, their doctor.



With the BCBSTX Healthy Family app, your patients can:

- Get recommendations for them and their family based on age and gender
- Store past test information
- Set reminders for upcoming tests and add notes
- Available in English and Spanish

**To get the Healthy Family app, text\* FAMILY to 33633 or download it on the [App Store](#) or [Google Play](#).**

*\*Message and data rates may apply. ([Terms and conditions and privacy policy](#).)*

### **Online Resources Available for Claim Status**

As a reminder, claim status is no longer available through the BCBSTX Interactive Voice Response (IVR) phone system. This change became effective July 13, 2015.

While our Customer Advocates remain available to discuss claim adjustments and other inquiries, BCBSTX supports electronic options as the most convenient, efficient and secure choice for requesting claim status information.

When conducting online transactions, you will need to use an electronic vendor portal. Some electronic vendors, such as Availity™ offer online tools for enhanced claim status, payment and remittance information. Following are two online tools available to registered Availity users:

- **Claim Research Tool** offers enhanced, real-time claim status functionality to help you manage and resolve your BCBSTX claims. This online tool allows you to search for claims by Member ID, group number or Document Control Number (DCN). You can customize your search to view claims according to status (paid, pending or denied) or by a particular date range and obtain detailed line item information (amount paid, ineligible reason code and description for each service line). It also enables you to check the status of multiple claims in one view.
- **Remittance Viewer** offers providers and billing services a convenient way to view and help reconcile claim data provided by BCBSTX in the 835 Electronic Remittance Advice (ERA).

For more information on these and other electronic options available to BCBSTX independently contracted providers, visit the Education and Reference Center/Provider Tools page on the BCBSTX [provider website](#).

For answers to frequently asked questions (FAQs) concerning the above-referenced change, refer to the [IVR Claim Status Change FAQs](#) in the Claims and Eligibility/Claims Status section of the website. A [Claims Caller Guide](#) also is available to assist you with navigating menu options on the IVR system.

If you would like to schedule a training webinar to learn more about online resources for claim status and other requests, email our Provider Education Consultants at [pecs@bcbstx.com](mailto:pecs@bcbstx.com).

*Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.*

## IN EVERY ISSUE

### Blue Choice PPO<sup>SM</sup> Subscriber(s) / Blue Advantage HMO<sup>SM</sup> Rights and Responsibilities

As a provider for Blue Cross and Blue Shield of Texas (BCBSTX), you are obligated to be aware of subscribers' rights and informed of subscribers' responsibilities. Our health plan subscribers may refer to their benefit booklet for a listing of their rights and responsibilities, which are also included below; you can also access these documents on our website at [bcbstx.com](http://bcbstx.com).

**Rights****Responsibilities**

<b>Subscriber(s)</b>	<b>Subscriber(s)</b>
<b>You have the right to:</b>	<b>You have the responsibility to:</b>
<ul style="list-style-type: none"><li>• Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities.</li><li>• Make recommendations regarding the organization's subscribers' rights and responsibilities policy.</li></ul>	Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.
Participate with practitioners in making decisions about your health care.	Follow the plans and instructions for care you have agreed to with your practitioner.
<ul style="list-style-type: none"><li>• Be treated with respect and recognition of your dignity and your right to privacy.</li><li>• A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.</li><li>• Voice complaints or appeals about the organization or the care it provides.</li></ul>	Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

**HMO Blue Texas Member Rights & Responsibilities****Member Rights – You Have the Right to:**

- Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities.
- Make recommendations regarding the organization's subscribers' rights and responsibilities policy.
- Participate with practitioners in making decisions about your health care.
- Be treated with respect and recognition of your dignity and your right to privacy.
- A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.

**Member Rights – You Have the Responsibility to:**

- Meet all eligibility requirements of your employer and the Health Maintenance Organization (HMO).
- Identify yourself as an HMO member by presenting your ID card and pay the copayment at the time of service for network benefits.



- Establish a physician/patient relationship with your primary care physician (PCP) and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OBGyn.
- Provide, to the extent possible, information that the HMO and practitioner/providers need, in order to care for you. Including changes in your family status, address and phone numbers within 31 days of the change.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Notify your primary care physician or HMO plan within 48 hours or as soon as reasonably possible after receiving emergency care services.
- Communicate complete and accurate medical information to health care providers.
- Call in advance to schedule appointments with your network provider and notify them prior to canceling or rescheduling appointments.
- Read your coverage documents for information about benefits, limitations, and exclusions.
- Ask questions and follow instructions and guidelines given by your provider to achieve and maintain good health.
- Understand your health problems and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

### **After-hours Access Is Required**

BCBSTX requires that primary care physicians and specialty care physicians and professional providers provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. They must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

### **Acceptable after-hours access mechanisms may include:**

- An answering service that offers to call or page the physician or on-call physician;
- A recorded message that directs the patient to call the answering service and the phone number is provided; or
- A recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.

For more detail, please refer to the provider manuals for **Blue Choice PPO<sup>SM</sup> Physician and Professional Provider** (Section B) and **HMO Blue Texas<sup>SM</sup> / Blue Advantage HMO<sup>SM</sup> Physician and Professional Provider** (Section B) available on our provider website at [bcbstx.com/provider](http://bcbstx.com/provider). Click on the "Education & Reference" tab, then click on "Manuals" and enter the password.

### **BCBS Medicare Advantage PPO Network Sharing**

#### ***What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO<sup>SM</sup> network sharing?***

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or

living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

***What does the BCBS MA PPO network sharing mean to me?***

If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX) and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

If you are not a contracted BCBS MA PPO provider with BCBSTX and you provide services for any BCBS MA PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

***How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?***

You can recognize a BCBS MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:



The "MA" in the suitcase indicates a member who is covered under the BCBS MA PPO network sharing program. BCBS MA PPO members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID card.

***Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?***

If you are a contracted BCBS MA PPO provider with BCBSTX, you should provide the same access to care for BCBS MA members from other BCBS Plans as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

***What if my practice is closed to new local BCBS MA PPO members?***

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual

arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

***How do I verify benefits and eligibility?***

Call BlueCard Eligibility at 800-676-BLUE (800-676-2583) and provide the BCBS MA PPO member's alpha prefix located on the member's ID card.

You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:

- Log in to the [Availity Portal](#), the [Availity Revenue Cycle Management Portal](#) or your preferred vendor
- Enter required data elements
- Submit your request

***Where do I submit the claim?***

You should submit the claim to BCBSTX under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.

***What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?***

If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

***What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO Network Sharing?***

When you provide covered services to other BCBS MA PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the BCBS MA PPO claim, BCBSTX will send you the payment. However, these services will be paid under the BCBS MA member's out-of-network benefits unless for urgent or emergency care.

***What is the BCBS MA PPO member cost sharing level and co-payments?***

A BCBS MA PPO member cost sharing level and co-payment is based on the BCBS MA PPO member's health plan. You may collect the co-payment amounts from the BCBS MA PPO member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800-676-BLUE (800-676-2583).

***May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?***

No, you may not balance bill the BCBS MA PPO member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or co-pays.

***What if I disagree with the reimbursement amount I received?***

If there is a question concerning the reimbursement amount, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

***Who do I contact if I have a question about BCBS MA PPO network sharing?***

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

### **Medical Record Requests: Include Our Letter as Your Cover Sheet**

When you receive a letter from BCBSTX requesting additional information such as medical records or certificates of medical necessity, please utilize the letter as a cover sheet when sending the requested information to us.

This letter contains a barcode in the upper right corner of the page to help ensure that the information you send is matched directly to the appropriate file and/or claim. Do not submit a Claim Review Form in addition to the letter, as this could delay the review process.

Thank you for your cooperation!

### **Technical and Professional Components**

**Modifiers 26 and TC:** Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only.

**Note:** When a physician or professional provider performs both the technical and professional service for a lab or radiological procedure, he/she must submit the total service, not each service individually.

### **Surgical Procedures Performed in the Physician's Office**

When performing surgical procedures in a non-facility setting, the physician and professional provider reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the physician's or professional provider's office.

Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician's or professional provider's office. To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to the BCBSTX provider website at [bcbstx.com/provider](http://bcbstx.com/provider) for additional information on gaining access to C3.

Please note the physician and professional provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied based on the fact that the global physician reimbursement includes staff and equipment.

### **AIM RQI Reminder**

Physicians and professional providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPO members and HMO Blue Texas members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's office, a professional

provider's office, the outpatient department of a hospital or a freestanding imaging center:

- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study
- PET scan

To obtain a Blue Choice PPO or HMO Blue Texas RQI, log in to AIM's provider portal at [aimspecialtyhealth.com](http://aimspecialtyhealth.com) and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive a RQI. If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM's *ProviderPortal<sub>SM</sub>* uses the term "Order" rather than "RQI."

**Notes:**

1. *HMO Blue Texas physicians or professional providers who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group regarding outpatient high-tech diagnostic imaging services.*
2. *Facilities cannot obtain a RQI from AIM on behalf of the ordering physician.*
3. *The RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX PPO or HMO coverage are included in the program.*

*AIM Specialty Health (AIM) is an operating subsidiary of WellPoint, Inc.*

**Quest Diagnostics, Inc., Is the Exclusive HMO and Preferred Statewide PPO Clinical Reference Lab Provider**

Quest Diagnostics, Inc., is the **exclusive** outpatient clinical reference laboratory provider for HMO Blue Texas<sup>SM</sup> and Blue Advantage HMO<sup>SM</sup> members\* and the **preferred statewide** outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO<sup>SM</sup> members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

**Quest Diagnostics Offers:**

- On-line scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto [QuestDiagnostics.com/patient](http://QuestDiagnostics.com/patient) or call **888-277-8772**.
- Convenient patient access to more than 195 patient service locations.
- 24/7 access to electronic lab orders, results, and other office solutions through *Care360<sup>®</sup> Labs and Meds*.

For more information about Quest Diagnostics lab testing solutions or to establish an account, contact your Quest Diagnostics Physician Representative or call **866-MY-QUEST** (866-697-8378).

For physicians and professional providers located in the HMO capitated lab 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 or professional provider's office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician's or professional provider's office will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list at [bcbstx.com/provider](http://bcbstx.com/provider) under the General Reimbursement Information section located under the Standards and Requirements tab.

*\* **Note:** Physicians and professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians and professional providers 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.*

### **Fee Schedule Updates**

Reimbursement changes and updates for Blue Choice PPO, HMO Blue Texas (Independent Provider Network only) and Blue Advantage HMO practitioners will be posted under Standards and Requirements / General Reimbursement Information / Reimbursement Schedules and Related Information / Professional Schedules section on the BCBSTX provider website at [bcbstx.com/provider](http://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 that is posted. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule will be updated monthly.

### **Improvements to the Medical Records Process for BlueCard® Claims**

BCBSTX is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.

As always, we will request that you submit your medical records to BCBSTX if needed for claims processing.

Requests for medical records from other Blues Plans before rendering services, as part of the preauthorization process, should be submitted directly to the requesting Plan.

### **Pass-through Billing**

BCBSTX does not permit pass-through billing. Pass-through billing occurs when the ordering physician or professional provider requests and bills for a service, but the service is not performed by the ordering physician or professional provider.

The performing physician or professional provider should bill for these services unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:



- The service of the performing physician or professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician or professional provider.
- The service is provided by an employee of a physician or professional provider (physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider) and the service is billed by the ordering physician or professional provider.

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

- **AS modifier:** A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used *ONLY* if they assist at surgery.)
- **SA modifier:** A supervising physician should use this modifier when billing on behalf of a PA, APN or CRNFA for **non-surgical** services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that *DOES NOT* include surgery.)

### Contracted Providers Must File Claims

As a reminder, physicians, facilities, professional providers and ancillary providers must file claims for any covered services rendered to a patient 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.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

### Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX provider website on the 1<sup>st</sup> or 15<sup>th</sup> day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted.

To view active and pending medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to active and pending medical policies.

### **Draft Medical Policy Review**

In an effort to streamline the medical policy review process, you can view draft medical policies on the BCBSTX provider website and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1<sup>st</sup> and the 15<sup>th</sup> of each month with a review period of approximately two weeks.

To view draft medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

### **No Additional Medical Records Needed**

Physicians and professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) from AIM Specialty Health need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

Predetermination does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

### **Importance of Obtaining Preauthorization for Initial Stay and Add-on Days**

Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or professional provider obtains preauthorization for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

If an insured person does not obtain preauthorization for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

Preauthorization does not guarantee payment. All payments are subject to determination of the insured person's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

### **Avoidance of Delay in Claims Pending COB Information**

BCBSTX receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our physicians and professional providers is a possible delay, or even denial of services, pending receipt of the required information from the member.

Here are some tips to help prevent claims processing delays when there is only one insurance carrier:

- CMS-1500, box 11-d – if there is no secondary insurance carrier, mark the “No” box.
- Do not place anything in box 9, a through d – this area is reserved for member information for a secondary insurance payer.

It is critical that no information appears in box 11-d or in box 9 a-d if there is only one insurance payer.

### **Billing for Non-covered Services**

As a reminder, contracted physicians and professional providers may collect payment from subscribers for copayments, co-insurance and deductible amounts. The physician or professional provider may not charge the subscriber more than the patient share shown on their provider claim summary (PCS) or electronic remittance advice (ERA).

In the event that BCBSTX determines that a proposed service is not a covered service, the physician or professional provider must inform the subscriber in writing in advance. This will allow the physician or professional provider to bill the subscriber for the non-covered service rendered.

In no event shall a contracted physician or professional provider collect payment from the subscriber for identified hospital acquired conditions and/or serious reportable events.

### **Dispensing QVT (Quantity Versus Time) Limits**

To help minimize health risks and to improve the quality of pharmaceutical care, dispensing QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer’s package insert.

Visit the BCBSTX provider website at [bcbstx.com/provider](http://bcbstx.com/provider) to access the [2015 Standard Drug List Dispensing Limits](#) and [2015 Generics Plus Drug List Dispensing Limits](#).

### **Prescription Drug Lists**

Throughout the year, the BCBSTX Clinical Pharmacy Department team frequently reviews the prescription drug lists. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

For the 2015 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: [bcbstx.com/provider/pharmacy/index.html](http://bcbstx.com/provider/pharmacy/index.html) and click on the [Rx List/Prescribing Guides](#) offering in the left-side navigation list.

### **Are Utilization Management Decisions Financially Influenced?**

BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial

incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

BCBSTX does not specifically reward practitioners or clinicians for issuing denials of coverage, nor is there compensation based on the number or frequency of telephone calls or other contacts that occur with health care providers or members. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

### Contact Us

Click [here](#) for a quick directory of contacts at BCBSTX.

### Update Your Contact Information

Accurate provider directories are an important part of providing BCBSTX members with the information they need to manage their health.

To update your contact information, please submit your correspondence via fax to 972-231-9664 or mail to P.O. Box 650267, Dallas, TX, 75265-0267. You should submit all changes at least 30 days in advance of the effective date of change.

If your specialty, practice information/status or board certification is not correct on the BCBSTX [Provider Finder](#)<sup>®</sup>, or if you would like to have a subspecialty added, please contact your Network Management office.

In addition, BCBSTX periodically identifies providers who have not submitted claims for a period of one year. We make an effort to contact each provider to confirm their information. If the provider does not respond, we will initiate a network termination. Similarly, BCBSTX will inactivate any tax identification numbers (TINs) under which there have been no claims submitted for a period of one year.

*Blue Review* is published for Blue Choice PPO<sup>SM</sup>, HMO Blue Texas<sup>SM</sup>, Blue Cross Medicare Advantage (PPO)<sup>SM</sup>, Blue Advantage HMO<sup>SM</sup> and ParPlan contracting physicians and other health care providers. To contact the editor, email [BlueReviewEditor@bcbstx.com](mailto:BlueReviewEditor@bcbstx.com).

The information provided in *Blue Review* does not constitute a summary of benefits, and all benefit information should be confirmed or determined by calling the customer service telephone number listed on the back of the member ID card.

BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent, third-party vendors mentioned in this newsletter. The vendors are solely responsible for the products or services they offer. If you have questions regarding any of the products or services mentioned in this periodical, please contact the vendor directly.

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