‘Billing Provider Address’ must be a complete street address

Attention electronic claim submitters! Beginning Jan. 1, 2012, all HIPAA-standard electronic transactions submitted by covered entities must be exchanged using the new ANSI version 5010 standard. With the conversion to ANSI v5010, the billing provider address must be a complete street address and can no longer be a P.O. Box or lock box.

- Complete is defined as providing a physical street number address including the full 9-digit, or ZIP+4, ZIP code—this is the traditional 5-digit code plus the extra four digits for localized mail delivery.
- This change is specified in the new implementation guides for ANSI v5010, now known as Technical Reports Type 3 (TR3s).
- All claim formats, i.e., Dental, Institutional and Professional (ANSI 837D, 837I and 837P) are affected.

If you submit ANSI v4010A1 claims to Blue Cross and Blue Shield of Texas (BCBSTX) with a P.O. Box or lock box in the Billing Provider Address, Loop 2010AA, Segment N3, you will soon begin to receive the following Warning (W) message(s):

- Message ID QCA – (Addr 1 – P.O. Box Not Allowed in ANSI v5010)
- Message ID QCB – (Addr 2 – P.O. Box Not Allowed in ANSI v5010)

It is imperative that you begin submitting a complete physical address in the Billing Provider Address, Loop 2010AA. Under ANSI v5010, electronic claims submitted with a P.O. Box or Lock Box for the billing provider address will cause your claim to be rejected.

Please contact your IT staff, software vendor, billing service and/or clearinghouse to make sure they are aware of your electronic preferences and are making the necessary programming updates to your practice management system for compliance with the new ANSI v5010 standard.

If you have any questions regarding this notification, contact our Electronic Commerce Center at 800-746-4614.

For more information about the ANSI v5010/ICD-10 conversion, visit the ANSI v5010/ICD-10 page in the Standards and Requirements section of our Provider website at bcbstx.com/provider.

TR3s and TR3 Errata may be obtained through the Washington Publishing Company (WPC) at wpc-edi.com. The WPC is an independent third party vendor that is solely responsible for its products and services.
BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions regarding any of the products or services offered by a vendor, you should contact the vendor directly.

‘RQI’ program adds choices for ordering physicians

Our Radiology Quality Initiative (RQI) program helps promote the appropriate, safe ordering of diagnostic imaging studies for a given diagnosis, performed in the proper sequence with minimized exposure of the patient to radiation. As part of this important initiative, obtaining an RQI number through American Imaging Management® (AIM®) is required prior to ordering high-tech, outpatient, non-emergency imaging studies (MRI/MRA, CT/CTA, Nuclear Cardiology and PET scans) for most BlueChoice members.

Recent program enhancements have included implementation of OptiNet®—an online tool developed by AIM to collect and assess modality-specific data given by imaging providers for the purpose of determining conformance with industry-recognized standards. Collection of data from high-tech imaging providers was completed in June 2011. Areas of assessment included staff qualifications and equipment accreditation. Scores were generated for each modality registered.

Results of the OptiNet assessment will help establish accurate and current information about the capabilities of participating imaging facilities and providers. **Beginning Aug. 29, 2011,** ordering physicians will be able to view certain quality, cost and accessibility measures for high-tech imaging facilities during the “Provider Selection” component of the RQI process through AIM. Ordering physicians will be able to choose a servicing facility based on the modality score, average allowed payment amount for the procedure, and distance from a particular member’s home.

For RQI requests that are submitted online, modality scores and cost information for local facilities will be provided in a table format. Cost values are based on the allowed amount of paid claims from the previous year for both professional and technical component claims. In some instances, cost information may not be available. When this occurs, a dash will be displayed in the “PPO$” column.

This enhancement supports quality and transparency initiatives at BCBSTX, in our continued effort to implement solutions that help support better informed decisions about care and services for BCBSTX members.

For more information about the BCBSTX RQI program, administered by AIM, refer to the Clinical Resources/Radiology Quality Initiative/Preauth Program section of our Provider website at bcbstx.com/provider. Your assigned Provider Network Representative is also available to provide assistance, as needed.

**Notes:**
1) Certain employer groups may require pre-certification for imaging services from other vendors. If you have any questions, please call the number on the back of the member’s ID card.

2) Facilities cannot obtain an RQI number from AIM on behalf of the ordering physician. Also, the RQI program does not apply to Medicare enrollees with Blue Cross and Blue Shield of Texas.
Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program.

3) OptiNet is a registered trademark of AIM, an independent third party vendor that is solely responsible for its products and services. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions about the products or services they offer, you should contact the vendor directly.

Childhood immunization reminders
The state of Texas has made great strides in improving the rate of childhood immunizations. Blue Cross and Blue Shield of Texas (BCBSTX) continues to collaborate with community partners to build on the momentum to improve immunization rates in Texas. In an effort to close gaps for preventive care, the Quality Improvement Programs department of BCBSTX currently conducts several initiatives to encourage parents to talk with their child’s health care provider about their child’s current health and possible need for immunizations.

First, Childhood Immunization Reminder Cards are mailed directly to parents of four-month-old children and 14-month-old children to encourage discussion of immunizations and well-child visits with their doctor. More than 24,500 of the cards have been distributed so far in 2011.

In addition, childhood immunization letters are mailed to the child’s primary care physician if BCBSTX does not have a claims record to demonstrate that a child has received all recommended immunizations by eighteen months of age. This letter includes a “Bee Aware” reminder card that may be mailed to the parent if the physician chooses to do so. Approximately 9,000 reminder cards have been distributed so far in 2011.

Notices and Announcements
Glucose test strips reminder
Several pieces of miscommunication by non-preferred vendors regarding Blue Cross and Blue Shield of Texas (BCBSTX) coverage of glucose test strips have recently been distributed. Physicians and other professional providers and members were targeted with promotional fliers to use non-preferred brand glucose test strips and meters.

As a reminder, step therapy has been implemented for glucose test strips under the BCBSTX fully insured plans. Roche and Bayer products remain the only preferred brands. Members and physicians and other professional providers should continue to use the pharmacy benefit to obtain glucose test strips for the preferred level cost-savings.

For members (fully insured and ASO) who are currently utilizing non-preferred brand test strips, BCBSTX is offering a preferred glucose monitoring system at no charge. This offer will be available through Dec. 31, 2011. Members may call toll-free to obtain one of the glucose meters listed below:
For a Roche Accu-chek brand (Aviva and Compact Plus) meter: 877-436-9864.

For a Bayer brand (Contour and Breeze 2) meter: 877-229-3777.

Members may learn more about their meter options at Roche accu-chek.com and Bayer simplewins.com websites and by talking with their health care provider.

After-hours access provided by physician offices
BCBSTX is utilizing Physician Office Review nurses to conduct a study to determine if primary care physician offices are compliant with providing after-hours access for their patients. The Texas Department of Insurance (TDI) and BCBSTX require primary care physicians to be accessible 24 hours per day/seven (7) days per week.

The nurses are calling provider offices after regular business hours to assess compliance prior to a scheduled site visit. If a physician cannot be reached, the physician’s office is reminded of the requirement.

PCPs 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 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.

Back online: Outpatient behavioral health services benefits
Over the past several months, you may have been directed to call BCBSTX to obtain outpatient benefit information for behavioral health services. We are pleased to report that accessing these benefits online is again available to your practice through your preferred vendor solution such as Availity® or RealMed. You will be able to receive benefit information including copayment, coinsurance and deductibles (if applicable) when requesting outpatient behavioral health services.

If you are a registered Availity user, you may use the Eligibility and Benefits Tool tip sheet to assist you with selecting information for your benefit request. To find out more about other electronic options available to BCBSTX providers, please visit the Electronic Commerce section of our provider website at bcbstx.com/provider.

For registration information, visit the Availity or RealMed website for additional information. Availity is a registered trademark of Availity, L.L.C., an independent third party vendor.

Inspector General report: “Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents”
In May 2011, the Office of Inspector General – Department of Health and Human Services (OIG-HHS) released a report titled ‘Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents’. The HHS-OIG utilized Medicare claims data (Part B and D) for the eight FDA approved atypical anti-psychotic medications
during the period Jan. 1, 2007, through June 30, 2007 in elderly nursing home residents (age > 65 years).

The report was the result of a request from Senator Charles Grassley (R-Iowa) to evaluate the extent to which elderly nursing home residents receive atypical antipsychotic medications. Grassley’s primary concerns with these second-generation, anti-psychotic drugs were two-fold: a) use of atypical anti-psychotics for ‘off label conditions’ (e.g., conditions other than schizophrenia and/or mood disorders) and b) whether Medicare is paying for therapies that may be inappropriate from both a clinical efficacy (e.g., off-label use) and patient safety standpoint (e.g., FDA Boxed Warnings – April 2005 FDA public health advisory regarding the increased risk of mortality when atypical anti-psychotics are used for the treatment of behavioral disorders in elderly patients with accompanying dementia).

Other concerns for the HHS-OIG include the potential for fraud, waste and abuse (FWA) in any of the HHS programs. For example, in November 2009, the federal government reached a $98 million settlement with Omnicare (a long-term care (LTC) pharmacy) to resolve allegations that it received kickbacks from pharmaceutical manufacturers (e.g. Risperdal) for recommending certain medications for nursing home patients. The Department of Justice also filed suit against the manufacturer and two subsidiaries alleging that the companies paid kickbacks to Omnicare, Inc. to recommend Risperdal.

Lastly, the federal government has also entered into a number of settlements with other manufacturers of atypical antipsychotics to resolve allegations that the companies knowingly promoted their products for uses that were not FDA approved and thereby not reimbursable under Federal health care programs. Interestingly enough, a June 2009 CMS data analysis found that three of the top 10 medications paid for under the Medicare Part D program in 2006 were atypical anti-psychotics.

Major findings:
  a) Fourteen percent of elderly nursing home residents had at least one Medicare claim for atypical anti-psychotics (304,983/2.1 million residents).

  b) Eighty-three percent of Medicare claims for atypical antipsychotics for elderly nursing home residents were associated with off-label conditions, of which 88 percent were associated with the condition specified in the FDA boxed warning.

  c) Nearly 51 percent of Medicare atypical antipsychotic drug claims for elderly nursing home residents were considered erroneous, amounting to $116 million. As a result of an extensive medical record review, the claims were found to be utilized for either non-medically accepted indications (50.2 percent) and/or as having not been administered to the nursing home resident (0.3 percent).

  d) Twenty-two percent of the atypical antipsychotic drug claims were not administered in accordance with CMS standards regarding unnecessary drug use in nursing homes (e.g., excessive dosing or duration, etc.)

HHS – OIG Recommendations to CMS included the following:
  a) Facilitate access to information necessary to ensure accurate coverage and reimbursement determinations.
b) Assess whether survey and accreditation processes offer adequate safeguards against unnecessary antipsychotic use in nursing homes.

c) Explore alternative methods beyond survey and certification processes to promote compliance with Federal standards regarding unnecessary drug use in nursing homes.

d) Take appropriate action regarding claims associated with erroneous payments identified in our sample.

References:

In Every Issue

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 other 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 other professional provider reimbursement is all-inclusive.

Our payment covers all of the services, supplies and equipment needed to perform the surgical procedure when a member receives these services in the physician's or other professional provider’s office. Please note the physician and other 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, supplies and equipment.

AIM RQI reminder

Physicians and professional providers must contact American Imaging Management® (AIM) first to obtain an RQI number when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician’s office, a professional provider’s office, the outpatient department of a hospital or a freestanding imaging center:

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

To obtain a PPO RQI number, log in to AIM’s provider portal at americanimaging.net and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an RQI number. 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 provider portal uses the term “Order” rather than “Preauth” or “RQI.”

**Note:** Facilities cannot obtain an RQI number from AIM on behalf of the ordering physician. Also, the RQI program does not apply to Medicare enrollees with Blue Cross and Blue Shield of Texas (BCBSTX) Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO/POS coverage are included in the program.

**Quest Diagnostics, Inc., is the exclusive HMO and preferred statewide PPO/POS clinical reference lab provider**

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for HMO Blue Texas members* and the preferred statewide outpatient clinical reference laboratory provider for BCBSTX BlueChoice (PPO/POS) 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 or call 888-277-8772.
- Convenient patient access to more than 220 patient service locations.
- 24/7 access to electronic lab orders, results, and other office solutions through Care360®’ 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 other 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 other professional provider’s office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician’s or other professional provider’s office will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list at bcbstx.com/provider under the General Reimbursement Information section located under the Standards and Requirements tab.

* **Note:** Physicians & other professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians & 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 BlueChoice and HMO Blue Texas (Independent Provider Network only) 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.

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 provider website. Also, the Drug/Injectable Fee Schedule will be updated on the following dates: Sept. 1, 2011; Dec. 1, 2011; March 1, 2012; and June 1, 2012.

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 other professional provider requests and bills for a service, but the service is not performed by the ordering physician or other professional provider.

The performing physician or other 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 and other professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician and other professional provider.

- The service is provided by an employee of a physician or other 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 other professional provider) and the service is billed by the ordering physician or other professional provider.

Proper use of the AS and SA modifiers when billing
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 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 physicians and other professional providers must file claims**
As a reminder, physicians and other professional 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 physician and other professional 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 physician or other professional provider to not file a claim with the patient's insurer, the physician or other professional 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 our provider website portal on the 1st or 15th day of each month. Those policies requiring disclosure will become effective 90 days from the posting date. Policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each policy that is posted.

To view active and pending policies go to bcbstx.com/provider, click on the Policies link toward the bottom of the page and then click on the Medical Policies link. After reading and agreeing to the disclaimer, you will 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 our provider portal and provide your feedback online. The documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

To view draft policies go to bcbstx.com/provider, click on the Policies link toward the bottom of the page and then click on the Draft Medical Policies link.

**Urgent versus standard predeterminations**
At times, a predetermination for services may need to be handled as priority. Urgent predetermination requests include, but are not limited to:
- Procedures and/or drugs needed to relieve pain
- Acute medical conditions
- Continuities of care in a chronic condition
- Treatments that need to be given within one week of the date the request is received

Cosmetic procedures and bariatric surgery would not be considered urgent.

In order for a predetermination request to be processed as priority, check the box marked “URGENT” located at the top of the completed predetermination form and indicate the anticipated date of service. Urgent predetermination requests only should be faxed to 888-579-7935.

Note that photographs will not be accepted via fax. They should be placed in a sealed envelope with the words “Request for Predetermination — Original Photos — Do Not Bend” written on both sides and sent to the appropriate address found on the form.

Remember, all predetermination requests are considered standard and should be mailed to the appropriate address found on the form if treatment is to be provided more than one week from the date of the request.

**No additional medical records needed**
Physicians and other professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) number from American Imaging Management 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.

**Importance of obtaining preauthorizations for initial stay and add-on days**
Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and other professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or other professional provider obtains preauthorizations 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 other 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 other professional providers may collect payment from subscribers for copayments, co-insurance and deductible amounts. The physician or other 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 other professional provider must inform the subscriber in writing in advance. This will allow the physician or other professional provider to bill the subscriber for the non-covered service rendered.

In no event shall a contracted physician or other professional provider collect payment from the subscriber for identified hospital acquired conditions and/or never events.

QVT (quantity versus time) limits
To help minimize health risks and to improve the quality of pharmaceutical care, 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.

The BCBSTX Clinical Pharmacy and Marketing Departments have finalized the QVT list for 2011. Visit bcbstx.com/provider/pharmacy/index.html for a detailed list under the Pharmacy section.

Preferred drug list
Throughout the year, the BCBSTX Clinical Pharmacy Department team frequently reviews the preferred drug list. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.
The BCBSTX Clinical Pharmacy and Marketing Departments have finalized the preferred drug list for 2011.

For the 2011 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html.

Are utilization management decisions financially influenced?
BCBSTX is dedicated to serving its customers through the provision of health care coverage and related benefit services. Our mission calls for us to respond to our customers with promptness, sensitivity, respect and dignity.

In support of this mission, BCBSTX encourages appropriate utilization decisions; it does not allow or encourage decisions based on inappropriate compensation. Physicians, other professional providers or BCBSTX staff do not receive compensation or anything of value based on the amount of adverse determinations, reductions or limitations of length of stay, benefits, services or charges. Any person(s) making utilization decisions must be especially aware of possible underutilization of services and the associated risks.

This topic has been addressed in the Blue Review provider newsletter and in previous BCBSTX employee communications as a requirement of our Utilization Review Accreditation Commission accreditation. This serves as a reminder for all physicians and other professional providers in the BCBSTX provider network.

Contact us
Click here for a quick directory of contacts at BCBSTX.

Update your contact information online
To update your contact information, go to bcbstx.com/provider, click on the Network Participation tab and follow the directions under Update Your Contact Information. This process allows you to electronically submit a change to your name, office or payee address, email 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 or board certification is not correct on Blue Cross and Blue Shield of Texas Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the “Other” field or contact your local Professional Provider Network office.

Blue Review is published for BlueChoice®, ParPlan and HMO Blue® Texas contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; email 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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