You Hold the Key to an Enhanced Online Experience
Blue Cross and Blue Shield of Texas (BCBSTX) has made a commitment to investing in health information technology solutions to help increase administrative efficiencies and reduce health care costs while ultimately striving to improve patient outcomes. With this goal in mind, we are pleased to announce the launch of Blue Access® for Providers – a new, secure section of our provider website.

Blue Access for Providers will offer greater specificity, efficiency and security when utilizing online tools and resources. In the first release, scheduled to occur in the fourth quarter of 2010, you will be able to review your provider record online for accuracy and completeness.

- This means you will have access to view key demographic information currently on file with BCBSTX for your practice, such as provider/group name, address, phone, NPI, e-mail address and more.
- If corrections are needed, you’ll be able to enter changes online for faster results.
- Keeping your provider record up-to-date will help BCBSTX members locate you on our Provider Finder®.
- This information is also critical to claim payments, remittance and related information.

In its first phase, Blue Access for Providers will also allow you to gain direct access to BCBSTX’s Electronic Refund Management (eRM) system, look up National Drug Code (NDC) pricing information and receive targeted communications with important updates relevant to contracted providers. Later this year, the secure site will be expanded to include single sign-on with Availity® and more.

The Next Step is Up to You
To gain entry to the secure site, you will need to register.

- Individual providers or solo practitioners will self-register online to create a user name and password. After the registration process, you will gain immediate access to Blue Access for Providers. Required elements to have on hand when registering are provider name, SSN, State License Number, Tax ID, NPI and e-mail address.
- Large groups, medical groups, facilities and all others: Watch Blue Review for details.

Please view the What’s New section of our website at bcbtx.com/provider for up-to-the-minute launch status, details and instructions.

Availity is a registered trademark of Availity, L.L.C., an independent third party vendor that is solely responsible for its products and services.
HealthSelect participants now have access to a new tobacco cessation program

Smoking among Texas adults and youth has exacted an enormous toll, contributing to or causing many preventable illnesses and deaths.** In an effort to stem the tide of tobacco use, a state agency began a new tobacco cessation program in August.

State employees, retirees and their families — including HealthSelect participants — now have access to a free nicotine replacement therapy (NRT) through the ACS Quitline (1-877-YES QUIT). In addition to providing over-the-phone tobacco cessation counseling, ACS Quitline also provides up to eight weeks of free NRT such as the patch, gum or lozenges.

Access to ACS Quitline’s NRT service is being funded by the Texas Department of State Health Services (DSHS) Tobacco Prevention and Control Program using American Recovery and Reinvestment Act funds. The free NRT service will be available to state employees, retirees and their families through the end of December 2011. ACS Quitline phone-counseling services will remain available even after funding for NRT ends.

Smokers double their chance of quitting when they take advantage of counseling and nicotine replacement therapy services. According to the American Cancer Society, within 12 hours of quitting, the level of carbon monoxide in the blood drops to normal. Within nine months of quitting, shortness of breath and coughing decrease, and the lungs have repaired their ability to function. After just one year of not smoking, the risk of coronary heart disease decreases by half compared to a smoker. Based on an average of a pack a day, those who quit could save as much as $2,142 a year.

*HealthSelect of Texas is administered by BCBSTX for the Employees Retirement System of Texas (ERS) for state of Texas and certain higher education employees, retirees and their dependents.

**Source: Texas Department of State Health Services Tobacco Prevention and Control Program

Predetermination process for the Respiratory Syncytial Virus

The Respiratory Syncytial Virus (RSV) season is upon us. Blue Cross and Blue Shield of Texas (BCBSTX) would like to take this opportunity to review the predetermination process for the RSV Prophylaxis program.

STEP 1 – BCBSTX Health Plan Predetermination/Authorization Process

- Complete the BCBSTX Synagis Request Form in its entirety. Two types of forms are posted at bcbstx.com/provider/downloadable_forms.htm.
- Submit the online version of the form or fax the completed hard-copy version of the Synagis Request Form to Allan J. Chernov, M.D. (Medical Director, Health Care Quality & Policy) at 972-766-5559.
- If the form is submitted using the online option, BCBSTX will send notification of the review outcome by e-mail. If the mail or fax option is utilized, notification will be sent by mail, unless e-mail notification is specifically requested.

STEP 2 – Ordering Process for Triessent

- Fax the Synagis Request Form, along with written authorization from BCBSTX, to Triessent at 866-203-6010.
• If the request form is incomplete or does not have the BCBSTX written authorization attached, the order will not be processed, and it will be returned to the physician for completion.

• If approved, the predetermination will cover a maximum of five monthly injections for that patient for the 2010-2011 RSV season, which runs from Oct. 1, 2010, to March 15, 2011. No additional reviews will be needed.

• For out-of-state members, the member’s Home Plan will need to be contacted for eligibility and benefit information. The Home Plan’s phone number will be on the back of the member’s ID card.

‘Hospital Acquired Conditions’ and ‘Never Events’
Effective Dec. 1, 2010, Blue Cross and Blue Shield of Texas (BCBSTX) will apply the following principles and guidelines for review and determination of Hospital Acquired Conditions (identified by CMS) and Never Events (identified by National Quality Forum), to determine whether reimbursement to a physician or other professional provider should be reduced for the additional costs related to the event:

• The error or event must be preventable
• The error or event must be within control of the physician or other professional provider
• The error or event must be a result of a mistake by the physician or other professional provider
• The error or event must result in significant harm
• Identification of non-payable events will incorporate case-by-case review and determination by a BCBSTX medical director, except when self reported and without dispute

If medical records are required to complete a review of a Hospital Acquired Condition/Never Event, the minimum defined record set will include: Discharge Summary, Admission History and Physical, Operative Reports, Consultation Reports, Physician Progress Notes, Emergency Department records (if admitted via the ER), and other documentation as determined by the medical director.

If adjustment of claims is determined applicable, the physician or other professional provider will be notified. The physician or other professional provider may appeal a decision made by BCBSTX for the Hospital Acquired Condition/Never Event and appeal instructions will be included in the notification letter.

Hospital Acquired Conditions
As defined by CMS, Hospital Acquired Conditions are those conditions that are acquired by a patient while they are in the inpatient hospital setting and were not present upon admission to the hospital.

The following Hospital Acquired Condition represents a potential area of responsibility and will be reviewed by a BCBSTX medical director on a case-by-case basis:

1. Foreign Object Retained After Surgery

Never Events
As defined by the National Quality Forum (NQF), Never Events are adverse events that are serious, but largely preventable and of concern to both the public and health care
providers for public accounting purposes. Never Events earned that name because these events should never happen in medical practice.

The following Never Events represent potential areas of responsibility and will be reviewed by a BCBSTX medical director on a case by case basis:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- The wrong surgical procedure performed on a patient

Should you have any questions, contact your local Professional Provider Network office.

NOTICES AND ANNOUNCEMENTS

Useful information when billing for a Rapid Desensitization Procedure

Rapid desensitization procedures utilizing procedure code 95180 represent each hour of service. According to CPT® guidelines, allergen immunotherapy codes 95115-95199 include the necessary professional services. Evaluation and management codes may be submitted in addition to allergen immunotherapy, including code 95180, if other identifiable services are provided at that time. Modifier-25 may be appended to the evaluation and management code only if those services are considered significant, separately identifiable as indicated by the definition of Modifier-25 in the CPT Manual. The patient’s medical record documentation must support the use of Modifier-25.

Preauthorization and the Interactive Voice Response (IVR) phone system

The Interactive Voice Response (IVR) is the automated phone system that manages call flow to our Provider Customer Service area. The primary function of the IVR is to manage general inquiries such as claim status and eligibility and benefits. The IVR provides our Customer Advocates valuable time to address your more complex and critical inquiries.

Most HMO and PPO benefit contracts require the member or provider to contact Blue Cross and Blue Shield of Texas to receive preauthorization (also known as precertification) for inpatient hospital admissions, including acute care, inpatient rehab, skilled nursing, long-term acute care, inpatient hospice, and coordinated health care such as skilled nursing visits, IV medication, etc.

When calling the IVR to obtain eligibility and benefits, you will be advised by the system if preauthorization is or may be required. If the IVR does not mention preauthorization, then preauthorization is not required for the services. It is not necessary to opt out to speak to a Customer Advocate to verify preauthorization.

Electronic claims with NPI-related errors

In June 2008, we published a complete listing of electronic claim edits that were implemented in support of an NPI-only claims processing environment. This document provided the three-digit error code along with a defining message indicating the severity level of the error and the resulting impact on the claim – “W” for Warning and “R” for Rejection.
An updated NPI-only Electronic Claim Submission Edits listing has been posted under the Alerts link in the Electronic Commerce section of the BCBSTX website at bcbstx.com/provider. Please be advised that most of the edits/error listings that were formerly set at the Warning level were set to Reject as of Aug. 1, 2010. The only two error types that will continue to remain at the Warning level are as follows:

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Message</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>BA6</td>
<td>Rendering NPI is not on file (Claim Level Error Message)</td>
<td>W</td>
</tr>
<tr>
<td>CA6</td>
<td>Rendering NPI is not on file (Service Line Level Error Message)</td>
<td>W</td>
</tr>
</tbody>
</table>

It is important to ensure that you and/or all of your electronic trading partners (billing services, clearinghouses and software vendors) are aware of and responsive to these messages. If you have any questions on these edits, please contact our Electronic Commerce Center at 800-746-4614.

If your office refers to a printed copy of the 2008 NPI-only Electronic Claim Submission Edits listing, please replace it with the updated version posted under the Alerts link in the Electronic Commerce section of the BCBSTX website at bcbstx.com/provider.

**Supervision of Physician Assistant, Advanced Practice Nurse or Certified Registered Nurse First Assistant**

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.)

**80 modifier:** PAs, APNs and CRNFAs billing with their own National Provider Identifier (NPI) AND acting as an Assistant Surgeon, must use modifier 80 appended to the surgical code.

For additional information on modifiers for professional claims, visit the Blue Cross and Blue Shield of Texas provider website at bcbstx.com/provider in the General Reimbursement Information section under “All Product News.”

**Clotting factor management initiative**

Patients with bleeding disorders such as hemophilia need immediate access to clotting factor and related products to manage bleeding episodes. Therefore, it is important that physicians who prescribe clotting factors prescribe amounts appropriate to the patient’s clinical situation.
Blue Cross and Blue Shield of Texas (BCBSTX) recommends the Medical and Scientific Advisory Council Recommendation Concerning Prophylaxis as a helpful resource in managing these patients. In addition, BCBSTX has implemented a review of prescription data to identify high utilization of clotting factors and related products. If high utilization is identified, a form requesting key clinical information and medical rationale may be sent to the prescribing physician. Completed forms are reviewed by a medical director, who will contact the prescribing physician with any questions or concerns. For additional information, visit bcbstx.com/provider/clotting_factor.htm.

Clear Claim Connection™ available to BCBSTX physicians and other professional providers
Clear Claim Connection (C3)*, a web-based code auditing reference tool, is now available to all contracted Blue Cross and Blue Shield of Texas (BCBSTX) physicians and other professional providers. You may access this tool through the secure provider portal at bcbstx.com.

C3 mirrors the ClaimCheck®** auditing rules that BCBSTX has adopted as part of its claim adjudication process. It provides easy access to ClaimCheck payment policies and rules in addition to clinical rationales, clarifications and source information for ClaimCheck edits. Certain claims, such as Medicare Primary and BlueCard, are exempt from ClaimCheck auditing.

The BCBSTX ClaimCheck database is updated periodically and upgraded to a new version annually, which may result in certain edit combinations being modified. Appropriate notice of such modifications will be provided on our website and through this Blue Review newsletter.

BCBSTX-contracted physicians and other professional providers are able to access the C3 web link via Availity®***, in addition to RealMed. Registration with RealMed or Availity is required prior to the first time you access C3. Instructions for registering with RealMed or Availity are located with the link to the respective portal. Once your registration process is completed, you will have access to C3.

To use C3, log on to the BCBSTX website at bcbstx.com and click on the “Providers” tab. You will find Clear Claim Connection in the General Reimbursement Information section under Bundling Information.

ClaimCheck audit results obtained on the BCBSTX website are specific to BCBSTX. Another carrier who offers C3 may have different edits, which will produce different results. This information is confidential and proprietary, and it is not to be shared. If you need more information, please contact your local Professional Provider Network (PPN) office or Provider Customer Service at 800-451-0287.

* Clear Claim Connection™ is a trademark of McKesson Information Solutions Inc.

** ClaimCheck™ is a registered trademark of McKesson Information Solutions Inc.

*** Availity is a registered trademark of Availity, L.L.C., an independent, third-party vendor. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity. The vendor is solely responsible for the products or services offered
by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

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 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 office. Please note the physician 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 Blue Cross and Blue Shield of Texas (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](http://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 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 office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician’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.

*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.*
BlueChoice® Solutions Large Employer Groups List
For your reference, the following is an alphabetical list of large employer groups currently enrolled in BlueChoice Solutions. Note that the employer groups listed below include insured and self-funded health plans. These employer groups may have chosen the BlueChoice Solutions network as an optional network for their employees. In addition, BlueChoice Solutions is offered to individual members.

<table>
<thead>
<tr>
<th>BlueChoice Solutions Large Employer Group List</th>
<th>As of July 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.H. Beck Foundation Co., Inc.</td>
<td>Reef Industries, Inc.</td>
</tr>
<tr>
<td>Air Force Villages, Inc.</td>
<td>Research Analysis &amp; Maintenance, Inc.</td>
</tr>
<tr>
<td>Centaurus Property Management, L.L.C.</td>
<td>Southwest Ford, Inc.</td>
</tr>
<tr>
<td>City of Sanger</td>
<td>SXSW, Inc.</td>
</tr>
<tr>
<td>DCTA</td>
<td>The Care Group of Texas</td>
</tr>
<tr>
<td>Naegeli Transportation, Inc.</td>
<td>The City of Glenn Heights</td>
</tr>
<tr>
<td>Overland Mortgage Corporation</td>
<td>United Graphics</td>
</tr>
</tbody>
</table>

Fee schedule updates
Reimbursement changes and updates for BlueChoice® and HMO Blue® Texas (Independent Provider Network only) practitioners will be posted under "Reimbursement Changes/Updates" in the Professional Reimbursement Schedules section on the Blue Cross and Blue Shield of Texas 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: 9-1-2010, 12-1-2010, 3-1-2011 and 6-1-2011.

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
Blue Cross and Blue Shield of Texas (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.

**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 Blue Cross and Blue Shield of Texas (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 pending policies, go to the Medical Policy section at bcbstx.com/provider and click on “Active/Pending Medical Policies.” After reading the disclaimer, click on “I Agree” to advance to the medical policy page. The policies can be accessed by clicking the “View Pending Policies” tab.

**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 the Medical Policy section of the BCBSTX website at bcbstx.com/provider and click on “Draft Medical Policies.” After reading the disclaimer, click on “I Agree” to advance to the Medical Policy page.

**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 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 Blue Cross and Blue Shield of Texas (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. 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**

Blue Cross and Blue Shield of Texas 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 supplemental charges, 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 Blue Cross and Blue Shield of Texas 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 Blue Cross and Blue Shield of Texas (BCBSTX) Clinical Pharmacy Department is currently working on updating the QVT list for 2010. Visit bcbstx.com for an updated and detailed list under the Pharmacy section.
Preferred drug list
Throughout the year, the Blue Cross and Blue Shield of Texas (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.

For the 2010 drug updates, visit the BCBSTX provider website under the Pharmacy section, or follow this link: bcbstx.com/provider/quantity_time.htm

Are utilization management decisions financially influenced?
Blue Cross and Blue Shield of Texas (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.