July 2020

NOTICES & ANNOUNCEMENTS

COVID-19 Coverage Updates for Medicare Providers

As the COVID-19 crisis continues to evolve, Blue Cross and Blue Shield of Texas (BCBSTX) is making changes to serve our Medicare members. We are following Centers for Medicare & Medicaid Services (CMS) guidelines as appropriate. You can find updates in our COVID-19 FAQs for Medicare Providers, including on testing, treatment, telehealth and claims.

Unless otherwise noted, the FAQs refer to our members in these individual and group Medicare Advantage and Medicare Supplement plans:

- Blue Cross Group Medicare Advantage (PPO)℠
- Blue Cross Group Medicare Advantage Open Access (PPO)℠
- Blue Cross Medicare Advantage (HMO)℠
- Blue Cross Medicare Advantage (PPO)℠
- Blue Cross Medicare Advantage Dual Care (HMO SNP)℠
- Blue Cross Medicare Supplement℠
- BlueStages℠

The FAQs include details on:

Coverage for testing, testing-related visits and treatment

Medicare Advantage and Medicare Supplement members won't pay copays, deductibles or coinsurance for:

- Medically necessary lab tests to diagnose COVID-19 that are consistent with CDC guidance
- Testing-related visits related to COVID-19 with in-network* providers, including at a provider's office, urgent care clinic, emergency room and by telehealth
- Treatment for COVID-19 with providers or at facilities from April 1 through June 30, 2020. This change may be extended if needed. Members should confirm whether their benefit plan covers services received from out-of-network providers. For questions about benefits, members may call the number on their ID card.

Expanded access to telehealth at no cost-share

Medicare Advantage and Medicare Supplement members can access in-network telehealth services at no cost-share for medically necessary, covered services and treatments consistent with the terms of the member's benefit plan. Medicare Advantage PPO members have access to telehealth services with out-of-network providers but will be responsible for member cost-share for these services consistent with the terms of their plans. This cost-share waiver for telehealth services applies to claims beginning March 1, 2020.

Telehealth for annual health assessments

Initial and subsequent Annual Wellness Visits (G0438 and G0439) may be conducted by telehealth. Submit claims for wellness visits with Modifier 95 and Place of Service (POS) 11. BCBSTX covers one wellness visit every calendar year.

- Note: CMS has not approved Initial Preventive Physical Examinations (IPPE) (G0402) for telehealth. Members are eligible for the IPPE during their first 12 months of enrollment in Medicare.

To confirm Medicare members' coverage and benefits, you may use the Availity® Provider Portal or your preferred vendor. To verify telehealth coverage, please call Provider Services at

1-877-774-8592 for individual and **1-877-299-1008** for group members.

Resources

- CMS Current Emergencies and News Alerts
- CMS Covered Telehealth Services and Telehealth Codes

Donated Remdesivir Ineligible for Separate Reimbursement

Facilities receiving donated remdesivir should not separately bill for the product.

We continue to provide coverage for medically necessary care for the treatment of COVID-19. The federal government is currently donating remdesivir to facilities for COVID-19 treatment. Remdesivir has been granted emergency use authorization[1] from the U.S. Food and Drug Administration for the treatment of COVID-19. However, it is still considered investigational. If providers submit claims for reimbursement for donated remdesivir, we will deny it as not covered. Other medically necessary treatment associated with hospitalization for COVID-19 will be covered.

Remedsivir Donations

Gilead Sciences, Inc., the maker of remdesivir, donated the medication[2] for treatment of COVID-19. The federal government is distributing remdesivir to facilities at no charge. The donation is part of a unique federal program to assess the drug's effectiveness in treating hospitalized COVID-19 patients.

Medical Policy Related to Remdesivir

Our Off-Label Use of Drugs Without a Medical Policy indicates that use of a drug that is experimental, investigational and unproven for an indication is considered off-label and not covered. At this time, remdesivir is considered experimental, investigational and unproven for the treatment of COVID-19 and will not be reimbursable.

[1] Coronavirus (COVID-19) Update: FDA Issues Emergency Use Authorization for Potential COVID-19 Treatment
[2] HHS announces shipments of donated remdesivir for hospitalized patients with COVID-19, May 19, 2020

COVID-19 Initiatives Extended into July

Blue Cross and Blue Shield of Texas (BCBSTX) has taken steps to make access to the testing and treatment for our members easier and less expensive during this national health emergency. We have extended the duration of these measures to continue serving our members.

The chart below details those dates. We will continue to monitor the situation and update as needed. Check our provider site and our COVID-19 Related News for the latest information on each initiative.

Initiative	Start Date	End Date
Chest CT Scan without Prior Authorization	March 2, 2020	Open ended*
COVID-19 Testing Cost-Share Waiver	March 7, 2020	End of Health and Human Services (HHS) public health emergency
COVID-19 Testing-Related Visits Cost-Share Waiver	March 18, 2020	End of HHS public health emergency
COVID-19 Treatment Cost -Share Waiver	April 1, 2020	June 30, 2020*
Credentialing Simplified	April 3, 2020	End of HHS public health emergency
Interfacility Transfer without Prior Authorization	April 1, 2020	July 31, 2020**
Prior Authorization Extension	Services scheduled between Jan. 1 and June 30, 2020	Dec. 31, 2020
Telemedicine/Telehealth Expansion, Cost-Share Waiver	March 10, 2020	July 31, 2020* for commercial and retail members

		Dec. 31, 2020 for Medicare and Medicaid members

*Services that were originally scheduled to end May 31, 2020
**Service originally scheduled to end May 15, 2020

New Group – Teacher Retirement System (TRS) Effective Sept. 1, 2020

What's new? We are excited to announce that Blue Cross and Blue Shield of Texas (BCBSTX) was awarded the contract for the Teacher Retirement System (TRS) ActiveCare account, effective Sept. 1, 2020. TRS participants will be offered benefit plans using the statewide Blue Choice PPO℠ or Blue Essentials℠ provider networks.

What's Next? As additional details become available related to benefits, prior authorization requirements and ID cards, we will share them in News and Updates and our Blue Review newsletter. We look forward to providing health care services to our TRS-ActiveCare participants.

CLAIMS & ELIGIBILITY

CMS Payment Adjustments for Medicare Providers

During the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) has adjusted certain payments to Medicare providers. Blue Cross and Blue Shield of Texas (BCBSTX) is applying these temporary adjustments to claims reimbursements, as appropriate and where consistent with network contracts, for Medicare Advantage providers.

What has changed?
Diagnosis Related Group (DRG) add-on payment: For discharges of members diagnosed with COVID-19, the weight of the assigned DRG has temporarily increased 20 percent. Providers should use the appropriate diagnosis code and date of discharge to identify members:

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after Jan. 27, 2020, and on or before March 31, 2020.
- U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the emergency period.

Medicare sequestration suspended: The Medicare sequester has been suspended between May 1, 2020, and Dec. 31, 2020. During this time, BCBSTX is suspending the 2% sequestration reduction in Medicare claims payments. This applies to Medicare providers who service Medicare Advantage members.

Questions?
Please call the number on members' ID cards.

Resources
CMS Current Emergencies and News Alerts

Claims for Medications with Outer Packaging

Submitting claims with the appropriate National Drug Code (NDC) information can help with claims processing and help you spend less time troubleshooting a rejected claim line.

A common question is, "If a medication comes with additional outer packaging, like a box with multiple vials, which NDC information should be submitted on the claim? Is it the NDC number on the box (outer packaging) or the NDC number on the individual vial?"

In these cases, the best option is to use the NDC number on the box (outer packaging), along with the appropriate NDC unit of measure and NDC units. You should do this whenever possible to help improve claims processing and to have fewer unnecessary claim rejections. Not all NDC numbers on vials have manufacturer pricing to support an allowance, so outer packaging NDC numbers are the preferred method of NDC claim submission.

Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding policies on our website describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is a resource for our payment policies; it is not intended to address all reimbursement-related issues. We regularly add and modify clinical payment and coding policy positions as part of our ongoing policy review process. The following have been recently added or updated:

- Hernia Repair – Updated Effective 9/15/2020
- Neonatal Intensive Care Unit (NICU) Level of Care Authorization and Reimbursement Policy – Updated Effective 6/15/2020
- Observation Services Tool for Applying MCG Care Guidelines – Updated Effective 6/15/2020
- Point-of-Care Ultrasound Examination Guideline – Added Effective 9/15/2020

EDUCATION & REFERENCE

Resources for Providers/Members

Providers can refer to Resources for Providers/Members for information available to assist members in accessing care using the following resources:

- Telemedicine/Telehealth
- Language line
- Crisis line
- 24/7 Nurseline

For your convenience, this resource is located on the provider website under **Education & Reference** on the Provider Tools page then **Related Resources**.

NETWORK PARTICIPATION

Changes to Contacting Electronic Commerce Services

As of June 15, 2020, providers and/or clearinghouses calling **1-800-746-4614** for Electronic Commerce Services will be directed to email inquiries to Electronic Commerce Services instead of calling.

Electronic Commerce Services will quickly respond to your email requests to assist you with the following Electronic Data Interchange (EDI) transactions:

- Electronic professional and institutional claim submission (837P and 837I transactions)
- Claim payment via 835 Electronic Funds Transfer (835 EFT)
- 835 Electronic Remittance Advice (835 ERA) or delivery of claim payment information

For more information on EDI transactions and other online tools and resources, refer to the Electronic Commerce section of our Provider website.

PRIOR AUTHORIZATION INFORMATION

Procedure Code Updates for Prior Authorization

On Sept. 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) will update its list of Current Procedural Terminology (CPT®) codes to comply with changes from the American Medical Association (AMA). These changes are the result of new, replaced or removed codes implemented by the AMA

What Should You Do

Providers will need to utilize the new list of procedure codes under on the Prior Authorization & Predetermination page when determining if a service requires prior authorization Sept. 1, 2020, and after. You can also use Availity® or your preferred vendor for prior authorization requirements. Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

Plans Affected
The following plans are affected by these changes:

- Blue Choice PPO℠
- Blue Essentials℠ and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- Blue Advantage℠ and Blue Advantage HMO℠ Plus
- MyBlue Health℠

Check Eligibility and Benefits: Before rendering services, providers should check eligibility and benefits through Availity® or your preferred vendor to confirm membership, check coverage, determine if you are in-network for the member's policy and determine whether prior authorization is required. Availity allows prior authorization determination by procedure code. Locate **How to Submit Prior Authorizations** on the Prior Authorizations and Predeterminations page to determine how to submit requests when it is determined if BCBSTX Medical Management, eviCore Healthcare® or AIM Specialty Health® handles prior authorization or prenotification for your services or procedure codes.

More Information: Check the AMA website for more information on CPT code changes. If you have questions, contact your Network Management Office location.

Blue Cross Medicare Advantage℠ Prior Authorization Updates Effective Sept. 1, 2020

On Sept. 1, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) will update its list of Blue Cross Medicare Advantage Prior Authorization Procedure Codes to comply with the American Medical Association (AMA). These changes are the result of new, replaced or removed codes implemented by the AMA.

What's New: Providers will need to utilize the new list of procedure codes on the Prior Authorization & Predetermination page when determining if a service requires prior authorization **Sept. 1, 2020,** and after. Scroll to and open the Blue Cross Medicare Advantage PPO℠ and Blue Cross Medicare Advantage HMO℠ section. You can view the Blue Cross Medicare Advantage Prior Authorization Requirement List, Blue Cross Medicare Advantage Procedure Code List and Blue Cross Medicare Advantage Procedure Code List Change Summary. You can also use Availity® or your preferred vendor for prior authorization requirements.

Check Eligibility and Benefits: Prior to rendering services, providers should use Availity or your preferred vendor to check eligibility and benefits to confirm membership, check coverage, determine if you are in-network for the member's policy and determine whether prior authorization is required. Availity allows prior authorization determination by procedure code and providers can submit requests on Availity using the Authorization & Referral tool. Refer to the BCBSTX Eligibility and Benefits page for more information on Availity. Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

More Information: Check the AMA website for more information on CPT codes. If you have questions, contact your Network Management Office location.

AIM Specialty Health® (AIM) to Perform Utilization Management

What you need to know: On Sept. 1, 2020, we will be using AIM Specialty Health to process prior authorization and post review support for some members on our Blue Choice PPO℠ and Blue Essentials℠ networks.

You will be able to identify the impacted members by the three-character prefixes: (T2U and T2S) on the member's ID card.

Dig deeper: Currently, AIM handles a prenotification Radiology Quality Initiative Program for our Blue Choice PPO plans and has a high satisfaction rating with providers. The new agreement would expand AIM's capabilities by providing required prior authorization review and approvals for select outpatient services for some members using the Blue Choice PPO and Blue Essentials networks.

Select outpatient procedures that may require prior authorization through AIM include:

- Advanced Imaging
- Cardiology
- Sleep Medicine
- Pain Management
- Joint and Spine Surgery
- Radiation Therapy
- Genetic Testing

We'll share more information about prior authorization requirements with AIM as we get closer to Sept. 1. Additionally, please check News and Updates and our Blue Review newsletter for training opportunities with AIM and updated details.

As a reminder, it is important to check eligibility and benefits before rendering services. This step will help you determine if prior authorization is required for a member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on Blue Cross and Blue Shield of Texas (BCBSTX's) provider website.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been prior authorized or predetermined for benefits 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 questions, contact the number on the member's ID card

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eviCore® Prior Authorization Code Changes Effective April 20, 2020

What's new: We have updated the procedure code list for services prior authorized by eviCore healthcare (eviCore) for fully insured members effective April 20, 2020. These code changes were a result of new, replaced or removed codes implemented by the American Medical Association (AMA). The procedure code list is located on the Prior Authorizations & Predeterminations page under Prior Authorization Procedure Codes List for Fully-Insured Members Effective 1/1/2020. Refer to the Updates column for the changes.

What you need to do: You should use Availity® or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient and whether any prior authorization is required for your patient. Availity allows you to determine if prior authorization is required through BCBSTX medical management, or another vendor such as eviCore, based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity.

When the procedure, such as these new changes, requires you to prior authorize through eviCore, you can:

- Enter online using the eviCore Healthcare Web Portal which is available 24/7
- Call 1-855-252-1117 between 6 a.m. to 6 p.m. (CST) Monday through Friday and 9 a.m. - noon Saturday, Sunday and legal holidays.
- Refer to the eviCore implementation site for more information.

Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients. If you need assistance, view the list of our Network Management offices to contact.
As a reminder, it is important to check eligibility and benefits before rendering services. This step will help you determine if benefit prior authorization is required for a member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

CLINICAL RESOURCES

Importance of a Great Discharge Summary

Physicians and other practitioners need to know details about the care a patient receives during an inpatient hospital stay. Discharge summaries are an invaluable resource that may improve patient outcomes by providing for continuity and coordination of care and a safe transition to other care settings and providers.

Improving the Discharge Process: Researchers in the field of transitions of care look at approaches to improve the discharge process. They categorize interventions as:

- Pre-discharge interventions including patient education, discharge planning, medication reconciliation and scheduling a follow-up appointment;
- Post-discharge interventions involving a follow-up phone call, communication with the ambulatory provider or home visits;
- Bridging interventions including transition coaches, patient-centered discharge instructions and clinician continuity between inpatient and outpatient settings.

Important Elements: The primary mode of communication between the hospital care team and aftercare providers is often the discharge summary, raising the importance of successful transmission of this document in a timely manner. Important elements in the discharge summary, as mandated by the Centers for Medicare and Medicaid Services, are:

- The outcome of the hospitalization
- The disposition of the patient
- Provisions for follow-up care including appointments, statements of how care needs will be met, and plans for additional services (e.g., hospice, home health assistance, skilled nursing)

It is critical to include this information to the aftercare providers. An essential component is identifying those laboratory or other tests for which final results remain pending at the time of discharge[1].

Provider Survey Results: The Blue Cross and Blue Shield of Texas (BCBSTX) Provider Satisfaction Survey includes questions about PCPs' satisfaction with hospital discharge summaries. In 2019, we saw an increase in PCPs who received a hospital discharge summary compared to 2018. Of those received, the timeliness and content remained consistent and overall satisfaction with continuity of care remained the same. The results demonstrate opportunities for improvement, but most importantly making sure the PCP receives a discharge summary.

BCBSTX Provider Satisfaction Survey – Hospital Discharge Summary Feedback

Survey Questions	2017 (Goal 90%)	2018 (Goal 90%)	2019 (Goal 90%)
When your patients are admitted to a hospital, are you sent summary information after the discharge?	72%	59%	67%
When you receive hospital discharge information, does it reach your office within a timely manner?	83%	83%	83%
When you receive hospital discharge information, does it contain adequate information about medications at discharge?	87%	89%	86%
Overall satisfaction with continuity of care	74%	79%	79%

Communications via the discharge summary provides a smooth and long-lasting transition of the patient to the next level of care and avoid miscommunication or delays in care that may lead to poor outcomes.

We applaud practitioners that have adopted a structured approach to discharge summaries and strongly encourages those who have not, to consider adopting this practice.

1. ***Hospital discharge and readmission*** *[Online] / auth. Eric Alper MD, Terrence A O'Malley, MD, Jeffrey Greenwald, MD // UpToDate. - January 2019. - https://www.uptodate.com/contents/hospital-discharge-and-readmission#H11.*

HEALTH & WELLNESS

New Annual Wellness Visit Resources for Medicare Providers

We have two new resources to help you care for our Medicare Advantage members during their annual wellness visits: an Annual Wellness Visit guide and Annual Wellness Visit form. These resources can help you document our members' visits to more easily meet Medicare requirements.

The guide and form are for your use only and do not need to be returned to us.

What's New?
The **Annual Wellness Visit Guide** includes a wellness visit checklist and information on:

- Medicare coverage for wellness visits
- Correct coding for wellness visits
- Guidance to help ensure all member conditions are correctly coded each year
- Coding for other evaluation and management services, such as lab tests
- Preventive services and screenings
- Closing care gaps by performing Healthcare Effectiveness Data and Information Set (HEDIS®) measurements
- Coding tips to help minimize requests for medical records and help expedite claims processing

You may use the new **Annual Wellness Visit form** during wellness visits. It includes sections for members' medical history, risk factors, conditions, treatment options, coordination of care and advance care planning. It can be used as a digital fillable form or printed and completed by hand during the visit.

Annual Wellness Visits Help Our Members Stay Healthy
Wellness visits provide opportunities to screen for health conditions and manage chronic ones. To support our members' health, you can:

- Remind them to schedule their annual wellness visit for 2020.
- Discuss behavioral and physical health and preventive measures such as healthy weight, fall prevention, diet and exercise.

Members may be able to earn a reward for getting an annual wellness exam and other screenings. An initial preventive visit and subsequent annual wellness visits have no copay and are provided at no additional out-of-pocket cost for Medicare Advantage members. See our guide for more information. Additional services may result in member cost-sharing.

It is important that you use the Availity® Provider Portal or your preferred vendor to check eligibility and benefits before every scheduled appointment. Eligibility and benefit quotes include membership confirmation, coverage status and applicable copayment, coinsurance and deductible amounts. Ask to see the member's Blue Cross Medicare Advantage Member ID card and a driver's license or other photo ID to help guard against medical identity theft.

BEHAVIORAL HEALTH

Behavioral Health Program Changes Reminder

As of **June 1, 2020**, we are administering behavioral health benefits for Blue Essentials℠, Blue Essentials Access℠, Blue Premier℠ and Blue Premier Access℠ provider networks. Magellan Healthcare® is no longer administering behavioral health benefits for these members.

Also, behavioral health services for HealthSelect of Texas® and Consumer Directed HealthSelect℠ participants will be administered by us effective **Sept. 1, 2020**.

For more detail, refer to the April 15, 2020, article on News and Updates as well as the Behavioral Health page on our provider website. Also, watch for additional provider training sessions in the coming months.

If you have any other questions about these changes, please contact your local Network Management Office.

PHARMACY

- Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2020 — Part 2

Did You Know?

The following is information that Blue Cross and Blue Shield of Texas (BCBSTX) is required to provide in all published correspondence with health care providers. It includes a collection of articles to assist provider offices in servicing BCBSTX patients. For the latest updates, visit the News and Updates area of the BCBSTX provider website.

Topics:

- Authorizations and Referrals
- Benefits and Eligibility
- Claims
- Clinical Resources
- CMS Guidance Notifications
- Education & Reference
- Electronic Options
- eviCore®
- Pharmacy
- Provider General Information
- Rights and Responsibility

Authorizations and Referrals

Importance of Obtaining a Prior Authorization/Referral

A prior authorization/referral is required for certain types of care and services. Although BCBSTX participating health care providers are required to obtain prior authorizations/referrals, it is also the responsibility of the member to confirm that this action has been taken for services that require a prior authorization/referral.

To determine if a service requires a referral or prior authorization, it is imperative that providers check eligibility, benefits, and prior authorization requirements through Availity® or your preferred vendor and also reference Prior Authorizations & Predeterminations under Clinical Resources on bcbstx.com/provider. In addition, providers can submit needed prior authorizations managed by BCBSTX via Availity Authorizations & Referrals.

Prior authorizations/referrals may be required for any services provided by someone other than the member's primary care physician/provider (PCP) (i.e., specialist, ambulatory surgery centers, ancillary, etc.). A prior authorization/referral is also needed for an initial stay in a facility and any additional days or services added on.

Prior authorizations are required to allow for medical necessity review. If a member does not obtain a prior authorization/referral for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced. Retrospective reviews for medical necessity will not be performed for any HMO plans except in limited special circumstances.

A prior authorization/referral does not guarantee payment. All payments are subject to determination of a member'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.

If a prior authorization/referral request is received from an out-of-network (OON) provider and the member does not have an OON benefit, BCBSTX will contact the ordering provider to discuss network options. However, if a member has an OON benefit, OON benefits will apply, which could result in a higher cost sharing.

Reminder: Utilization Management Review

The Medical Management team, which includes physicians and nurses, evaluate hospital admissions (anticipated or unanticipated) and continued stays, as well as outpatient services. The team utilizes a variety of resources, including MCG criteria and BCBSTX medical policy to inform benefit determinations regarding the level of care, transition of care and the management of home care needs.

Medical management does not make determinations about whether services are medically appropriate, only if the services meet the definition of medically necessary under the terms of the applicable benefit plan. If a service does not meet the definition of medically necessary, initially the case is referred to a medical director for a review of the medical necessity determination. Board certified physicians are available to review referred cases, make medical necessity determinations and resolve appeals.

See the provider manual for guidance on provider requirements when requesting services. The final determination about what treatment or services should be received is between the patient and their health care provider.

Enrollee Notification Form Required for Out-of-Network Care for Blue Choice PPO℠ and Blue Advantage HMO℠ (for Blue Advantage Plus)

Prior to referring a Blue Choice PPO or Blue Advantage HMO (for Blue Advantage Plus point-of- service benefit plan) member to an out-of-network provider for non-emergency services – if such services are also available through an in- network provider – the referring participating network provider must complete the appropriate Out-of-Network Care – Enrollee Notification forms for Regulated Business (used when “TDI is on the member’s ID Card) or Non-Regulated Business (No “TDI on member’s ID card). Locate them under Forms on the provider website.

The referring network physician must provide a copy of the completed form to the enrollee and retain a copy in the enrollee’s medical record files.

It is essential that Blue Choice PPO and Blue Advantage Plus enrollees fully understand the financial impact of an out-of-network referral to a health care provider that does not participate in their BCBSTX provider network. They have out-of-network benefits and may choose to use out-of- network providers, however they will be responsible for an increased cost-share under their out-of-network benefits.

For additional information, refer to the Provider Manual section D Referral Notification Program on the bcbstx.com/provider website.

AIM RQI Reminder

Health care providers must contact AIM Specialty Health® (AIM) first to obtain a Radiology Quality Initiative (RQI) for most Blue Choice PPO℠ members. Providers should check eligibility, benefits, and prior authorization requirements through Availity® or your preferred vendor for applicable members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in health care 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 an RQI, log into AIM’s provider portal at aimspecialtyhealth.com, and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive an 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 Provider Portal℠ uses the term "Order" rather than "RQI."

Notes:

- Facilities cannot obtain a RQI from AIM on behalf of the ordering health care provider.
- The RQI program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX PPO coverage are included in the program.

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Benefits and Eligibility

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)℠

All Blue Cross and Blue Shield Medicare Advantage℠ (BCBS MA PPO) plans participate in reciprocal network sharing. This network sharing allows 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 if the member sees a contracted BCBS MA PPO provider.

For detailed information on BCBS MA PPO network sharing, refer to the Blue Cross Medicare Advantage (PPO) Provider Manual Supplement located under Standards and Requirements/Manuals on the BCBSTX provider website.

If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 1-877-774-8592.

Claims

Preventive Services Reminder: Zero Copay for Blue Cross Medicare Advantage℠

Are your patients up-to-date on preventive services benefits? BCBSTX would like to remind you that there are no copays for preventive services for Blue Cross Medicare Advantage (PPO)℠ or Blue Cross Medicare Advantage (HMO)℠. Blue Cross Medicare Advantage covers a full range of preventive services to help keep patients healthy, help find problems early and determine when treatment is most effective. You should let members know which of these services is right for them.

Access the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network® Medicare Preventive Services for detailed information on Medicare Preventive Services for detailed information on Medicare Preventive Services.

Additionally, you should check eligibility and benefits electronically through Availity®, or your preferred web vendor.

Annual Health Assessment Coding*

Code**	Service	Description
G0402	**Initial Preventive Physical Examination**	Code is limited to new beneficiary during the first 12 months of Medicare enrollment.
G0438	**Initial Annual Wellness Visit (AWV)**	The initial AWV, G0438, is performed on patients who have been enrolled with Medicare for more than one year, including new or established patients.
G0439	**Subsequent AWV**	The subsequent AWV occurs one year after a patient's initial visit.

**Codes for Annual Health Assessments are subject to change by Medicare Advantage Organization (MAO), without prior notice to Medical Group, for codes to be consistent with Medicare coding requirements for Annual Health Assessments.*

***Any updates, deletions and/or additions to coding shall be updated according to nationally recognized coding guidelines.*

Billing and Documentation Information and Requirements

BCBSTX has implemented changes to clarify existing policies related to billing and documentation requirements for the BlueChoice® PPO, Blue Advantage HMO℠, Blue Essentials℠, Blue Premier℠, MyBlue Health℠, Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO) ℠ plans. These updates are reflected in the Blue Choice PPO Provider Manual and the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Heath Provider Manual in Section F Filing Claims posted on bcbstx.com/provider under Standards and Requirements/Manuals.

ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and HCPCS codes are periodically added to or deleted from the ClaimsXten code auditing tool software on a quarterly basis and are not considered changes to the software version.

BCBSTX will normally load this additional data to the BCBSTX claim processing system within 60 to 90 days after receipt from the vendor and will confirm the effective date via the News and Updates section of the BCBSTX provider website. Advance notification of updates to the ClaimsXten software version also will be posted on the BCBSTX provider website.

To help determine how coding combinations on a 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 for additional information on gaining access to C3.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the C3 page under the Education and Reference then Provider Tools or Claims and Eligibility then Claims Filing Tips in the Bundling section on the BCBSTX website. Additional information may also be included in upcoming issues of *Blue Review*.

Cotiviti Code-Auditing Software

In addition to ClaimsXten℠, BCBSTX uses Cotiviti code-auditing software. This software further enhances the auditing of professional and outpatient facility claims for correct coding according to the Healthcare Common Procedure Coding System (HCPSC), Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services guidelines. Providers may use the Claim Research Tool (CRT), which is available on the Availity Provider Portal to research specific claim edits.

**The above notice does not apply to government program claims (Medicare Advantage and Texas Medicaid).*

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 health care 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.

Contracted Providers Must File Claims

As a reminder, health care 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 (Health Insurance Portability and Accountability Act of 1996) 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.

Hospitals, and Routine Services and Supplies

Routine services and supplies are generally already included by the provider in charges related to other procedures or services. As such, these items are considered non-billable for separate reimbursement. The following guidelines may assist hospital personnel in identifying items, supplies, and services that are not separately billable (this is not an all-inclusive list):

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over-the-counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

Clinical Resources

BCBSTX Lab Guidelines

Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for Blue Essentials℠, Blue Premier℠, Blue Advantage HMO℠ and MyBlue Health℠ members* and the preferred statewide outpatient clinical reference laboratory provider for Blue Choice PPO℠ 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:

- Online 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 195 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 health care providers located in the HMO Reimbursable 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 and professional provider's office for Blue Essentials members. All other lab services must be sent to Quest. You can access the county listing and the Reimbursable Lab Services list in the General Reimbursement Information section located under the Standards and Requirements tab.

**Note: Health care providers who are contracted/affiliated with a capitated IPA/medical group and health care 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.*

Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

Quest Diagnostics, Inc., Clinical Pathology Laboratory (CPL) and LabCorp, Inc. are the preferred outpatient clinical reference laboratory providers for Blue Cross Medicare Advantage (PPO) members.

Note: This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

For locations or questions contact:

- Quest Diagnostics at 888-277-8772 or questdiagnostics.com/patient
- Clinical Pathology Laboratory at 800-595-1275 or cpllabs.com
- LabCorp at 800-845-6167 or labcorp.com

As previously indicated, if lab services are performed at the participating physician's or other professional provider's office, the physician or professional provider may bill for the lab services. However, if the physician's or other professional provider's office sends the lab specimens to a contracted lab for completion, only the contracted lab can bill Blue Cross Medicare Advantage (PPO) for the lab services.

Medical Necessity Review of Observation Services

As a reminder, it is the policy of BCBSTX to provide coverage for observation services when it is determined to be medically necessary based on the medical criteria and guidelines as outlined in the MCG Care Guidelines. Claims for observation services are subject to post- service review, and BCBSTX may request medical records for the determination of medical necessity.

When medical records are requested, documentation should include the following information:

- Attending physician's order for observation care with clock time (or clock time can be noted in the nurse's observation admission note)
- Physician's admission and progress notes confirming the need for observation care
- Supporting diagnostic and/or ancillary testing reports
- Admission progress notes (with the clock time) outlining the patient's condition and treatment
- Discharge notes (with clock time) with discharge order and nurse's notes
- Itemized bill

CMS Guidance Notifications

CMS Notifications for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM

The Centers for Medicare and Medicaid Services (CMS) routinely publishes notifications that provide CMS guidance to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare and one of the Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO) plans. These CMS notifications are located in the Medicare Learning Network (MLN Matters) on CMS.gov and in the BCBSTX News and Updates section of the provider website under CMS Notifications Medicare Advantage Plans and may include informational regulatory updates and reminders, as well as required actions or changes by the provider rendering services. As such, it is important for providers to review these notifications and ensure your staff are aware of them.

Electronic Options

Multiple Online Enrollment Options Available in Availity®

BCBSTX offers you multiple enrollment opportunities for electronic options through the Availity Provider Portal. This is in addition to other electronic transactions available to you through Availity or your preferred web vendor portal. Instead of faxing or mailing paper enrollment forms, you can complete the online enrollment options listed below through Availity at no cost. Availity also provides single sign-on access to several online tools that offer greater convenience and security, without the need for another user ID and password. Refer to the Provider Tools and Electronic Commerce Solutions on the provider website for additional information on the following services:

- Availity transactions and single sign on
- Authorizations & Referrals
- Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA)
- Electronic Refund Management (eRM)
- Claim Inquiry Resolution (CIR)
- Clinical Quality Validation (CQV)
- Electronic Quality and Risk Adjustment Medical Record Requests

For assistance or customized training, contact a BCBSTX Provider Education Consultant at PECS@tx.com.

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eviCore®

Use eviCore Web Portal for Prior Authorization Requests

BCBSTX contracts with eviCore (eviCore), an independent specialty medical benefits management, for select specialty utilization management services.

After you use Availity®, or your preferred vendor, and determine the service for a member requires prior authorization through eviCore, you should submit prior authorization requests through eviCore's provider portal.
Using the eviCore provider portal to submit requests for prior authorization allows you to view and print information, review clinical to determine what is needed, and schedule consultations for questions.

To begin managing eviCore authorizations, go to eviCore.com and register. Training sessions are available through the eviCore training center. For provider portal help, portal.support@evicore.com or call 800-646-0418 and select option 2.

Pharmacy

Pharmacy Benefit Tips

For BCBSTX members with prescription drug benefits administered by Prime Therapeutics®, providers can ensure appropriate utilization of prescription drugs. BCBSTX providers can assist in this effort by:

1. Prescribing drugs listed on the drug list
   BCBSTX drug lists are provided as a guide to help in the selection of cost-effective drug therapy. Every major drug class is covered, although many of the drug lists cover most generics and fewer brand name drugs. The lists also provide members with criteria for how drugs are selected, coverage considerations and dispensing limits.
   While these drug lists are a tool, the final decision about what medications should be prescribed is between the health care provider and the patient.

   BCBSTX drug lists are regularly updated and can be found on the Pharmacy Program page on the BCBSTX provider website. For current drug updates, visit Pharmacy Program/Prescription Drug List and Prescribing Guidelines on the BCBSTX provider website.

   Note: For members with Medicare Part D or Medicaid coverage, the drug lists can be found on the plan's website:

   - Blue Cross MedicareRx (PDP) SM: getbluetx.com/pdp/druglist
   - Blue Cross Medicare Advantage SM: getbluetx.com/mapd/druglist
   - Blue Cross Medicare Advantage Dual Care (HMO SNP) SM: getbluetx.com/dsnp/druglist
   - Texas STAR: bcbstx.com/star/prescription-drugs/drug-coverage
   - Texas CHIP: bcbstx.com/chip/prescription-drugs/drug-coverage
   - Texas STAR KIDS: bcbstx.com/starkids/plan-details/drug-coverage.html

2. Reminding patients of covered preventive medications
   Many BCBSTX health plans include coverage at no cost to the member for certain prescription drugs, women's contraceptive products and over-the-counter medicines used for preventive care services.*

- ACA $0 Preventive Drug List
- Women's Contraceptive Coverage List

3. Submitting necessary prior authorization requests
   For some medications, the member's plan may require certain criteria to be met before prescription drug coverage may be approved. You will need to complete the necessary prior authorization request and submit it to BCBSTX. More information about these requirements can be found on the Pharmacy Program page on the BCBSTX provider website.

4. Assisting members with drug list exceptions
   If the medication you wish to prescribe is not on your patient's drug list or the preventive care lists, a drug list exception can be requested. You can call the customer service number on the member's ID card to start the process or complete the online form.

Visit the Pharmacy Program page for more information.

**Not available for all plans. Members should call the customer service number on their ID card to help determine what benefits may be available, including any requirements, limitations or exclusions that apply. Please refer to the member's certificate of coverage and prescription drug list as there may be coverage for additional products beyond these lists.*

Provider General Information

After-hours Access Is Required

BCBSTX requires that primary care,and specialty care health care providers provide urgent, and emergency coverage for care 24 hours a day, seven days a week. Providers 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/provider or on-call physician/provider,
- 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/provider or on-call physician/provider and the phone number is provided.

For more detail, please refer to the provider manuals for Blue Choice PPO SM Provider Manual (Section B) and Blue Essentials, Blue Advantage HMO, Blue Premier, MyBlue Health Provider Manual (Section B) available in the General Reference Information section of our provider website.

After-hours or weekend care is reimbursable, within limitations, for services provided by an individual physician or other health care professional who is required to provide office-based services outside of regular posted office hours to treat a patient's urgent illness or condition.

BCBSTX does not reimburse facility-based or non-office-based providers for CPT Codes 99053, 99056 and 99060. These codes will be considered inclusive of the primary procedure.

Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX provider website on the 1st or 15th 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 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

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 1st and the 15th of each month with a review period of approximately two weeks.

View draft medical policies. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

Rights and Responsibilities Notification

Thank you for choosing to be a participating practitioner with BCBSTX. Please review the information below for the latest information that could affect your practice.

Your Rights

As a participating practitioner of our network, you have the right to review information submitted to support your credentialing application and receive the status of your credentialing (or recredentialing) application, upon request.

Providers have the responsibility to work directly with the reporting entity(ies) to correct erroneous information and/or conflicting information within 30 calendar days. All corrections must be submitted in writing to our Enterprise Credentialing Department, your assigned Network Management Consultant or a Medical Director to avoid future delays in processing your information for consideration in BCBSTX networks.

Mail: 1001 E. Lookout Drive Richardson,
Texas 75082
Fax: 972-766-2137
Email: CredentialingCommittee@bcbstx.com

Note: Credentialing decisions will not be made until the applicant has responded or if the response has exceeded the 30 calendar days allocated.

Applicants who only see patients in an office setting and do not have hospital admitting privileges at a network hospital may attest to having coverage for hospital admissions by submitting a signed Hospital Coverage letter. You can find a copy of this letter by visiting the Forms section under Education and Reference on the BCBSTX provider website.

Care Management Programs: Case Management and Disease Management

BCBSTX Case Management (CM) and Disease Management (DM) staff work with enrolled members to increase their knowledge about their condition and help them better manage crisis events when they occur. CM and DM staff support the member and practitioner relationship, and aid communication between them. Members are encouraged to discuss issues and questions with their practitioner, develop a “shared decision making” partnership with their practitioner and take an active role in managing their own health.

Member compliance with physician treatment plans is monitored, including keeping appointments, compliance with medications and completing ordered tests. Program interventions are designed to coordinate with the activities of a member’s treating practitioners, specifically their primary care physician and/or appropriate specialist.

As a practitioner, you may refer a member for these care management programs at any time by calling the number on the back of the member’s identification (ID) card. A clinician will collaborate with you to provide our members with available resources and additional support.

Member Rights and Responsibilities

As a BCBSTX practitioner, it is important that you are aware of our members' Rights and Responsibilities. Our health plan members can find their Rights and Responsibilities in their benefit booklet or on our website.

Member Rights and Responsibilities include:

- A right to receive information about BCBSTX, our services, our providers and facilities, and member rights and responsibilities.
- A right to be treated with respect and recognition of the member's dignity and right to privacy.
- A right to participate with providers in making decisions about the member's health care.
- A right to have a candid discussion of appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about BCBSTX or the care we provide.
- A right to make recommendations regarding our members' Rights and Responsibilities policy.
- A responsibility to provide, to the extent possible, information that BCBSTX and the provider and facility need to provide care.
- A responsibility to follow the plans and instructions for care that the member has agreed to with their provider.
- A responsibility to understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

Utilization Management Decisions
BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. Utilization Management (UM) determinations are made by licensed clinical personnel based on the:

- benefits policy (coverage) of a member's health plan,
- evidence-based medical policies and medical necessity criteria, and the
- medical necessity of care and service.

All UM decisions are based on appropriateness of care and service, and existence of coverage. BCBSTX prohibits decisions based on financial incentives, nor does BCBSTX specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The criteria used for UM determinations are available upon request. Please call the Customer Service or Health Advocate number on the back of the member's ID card.

Pharmacy Benefits
As a participating practitioner, you are given a list of drugs that are reviewed and updated throughout the year.

For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for the drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines.

For more information regarding our Pharmacy programs, visit the Pharmacy Program section on the BCBSTX provider website. For Federal Employee Program (FEP) members, information can be found at fepblue.org/pharmacy. We encourage you to check the website regularly and watch for updates in this newsletter.

You can find the following information on our website:

- Formulary lists, including restrictions and preferences
- How to use our pharmacy procedures
- An explanation of limits or quotas
- How you can provide information to support an exception request
- The process for generic drug substitutions, therapeutic interchange and step-therapy protocols

BCBSTX distributes the Roles and Responsibilities Notification to our practitioners annually to keep you informed about important topics that impact you and your practice.

Contact Us
View our quick directory of contacts for BCBSTX.

Update Your Information
Do you need to update your location, phone number or other important details on file with BCBSTX? Do we have the most current email address for you and your staff? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local BCBSTX Network Management Representative to have up to 10 of your office email addresses added.

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

Checking eligibility, benefit information and/or if a service has been prior authorized 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.

eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.

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Aerial and Medecision® are trademarks of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity or Medecision. The vendors are solely responsible for the products or services

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits.

Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

bcbstx.com/provider

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association