JUNE 2021

NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

As the COVID-19 crisis evolves, we're continuing to update our COVID-19 Preparedness and our COVID-19 Related News pages. Be sure to check these pages frequently for updates including COVID-19: Texas Provider FAQs and COVID-19: FAQs for Medicare Providers.

SA Modifier and Midlevel Provider Contracting Update

***Note**: Refer to the SA Modifier Clarification below*

On January 19, 2021, Blue Cross and Blue Shield of Texas (BCBSTX) posted an article regarding contracting and credentialing midlevel providers and the upcoming implementation of the ClaimsXten™ edit of the SA modifier for non-payable services resulting in the SA modifier being non-reimbursable. **This edit has not been implemented and there are currently no plans for future implementation of this edit.**

SA Modifier Clarification

- Append modifier to supervising physician claim when billing on behalf of a Physician Assistant (PA), Advanced Practice Nurse (APN), or Certified Registered Nurse First Assistant (CRNFA) for **non-surgical** services
- Append modifier to PA's, APN's, or CRNFA's claim when billing with their own NPI number for assisting with any other **non-surgical** procedures.
- Claims will be processed based on the provider's contracting status.

This information can be found in the Clinical Payment and Coding Policies - **Modifier Reference Guideline** located on the provider website. Information about the reimbursement amount for the SA modifier is available in the **Reimbursement Schedules and Related Information (Secure Content)** area of the **General Reimbursement information page.** You will need a password to access this information which can be obtained from your local Network Management Office location.

Contracting and Credentialing Midlevel Providers

BCBSTX directly contracts and credentials with midlevel providers. Refer to the Network Participation page on the provider website for the process to directly contract and credential these providers. We appreciate your consideration to become a directly contracted provider.

Please contact your Network Management Office if you have further questions.

Update to Telemedicine Code List

We updated the Telemedicine Code List to include the codes below. These codes are effective Jan. 1, 2021.

Code	Short Description
93797	Cardiac rehab
93798	Cardiac rehab/monitor
G0422	Intens cardiac rehab w/exerc
G0423	Intens cardiac rehab no exer
G0424	Pulmonary rehab w exer
G0410	Grp psych partial hosp 45-50

More Info

Refer to the Telemedicine and Telehealth Services page for additional information related to telehealth coverage. To review the clinical payment and coding policy for Telemedicine and Telehealth Services, visit our Clinical Payment and Coding Policies page.

Newsletter Readership Survey: Your Feedback Is Important

Blue Review strives to deliver important information each month to our contracted providers. To provide the content that's most relevant, we need your feedback. You will soon receive a survey via email that will only take a few minutes to complete. As a thank you for your time, we're providing an opportunity to win one of three, $25 Amazon.com® gift certificates. (Note: Government employees are not eligible.)

BEHAVIORAL HEALTH

Free CME Webinar on Depression

Join our board-certified psychiatrists and behavioral health medical directors for a one-hour webinar, **Depression in a Primary Care Setting**. The webinar is **Wednesday, June 16, 2021**, at **8 a.m.** Central time. It is free to all providers. Those who attend will earn one continuing medical education credit (CME) or continuing education unit (CEU).

You'll gain a high-level overview of depression and measurement-based care in a primary care setting. This introductory training will focus on behavioral health in the primary care setting, with treatment options across settings.

How to Attend
Register here.

Future CME/CEU Offerings
Upcoming free webinars include:

- Opioid Use Disorder on Aug. 18, 2021
- Comorbid Behavioral Health and Physical Health Conditions on Oct. 27, 2021

Watch News and Updates and our Provider Training page for details on these and other trainings.

The New Mexico Osteopathic Medical Association (NMOMA) is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians. NMOMA designates this program for a maximum of 1 AOA Category 1-A credits and will report CME and specialty credits commensurate with the extent of the physician's participation.

Social Work CEUs Approved by NASW-NM. The Licensee must maintain proof of continuing education courses taken for the past four (4) years. The New Mexico Regulations and Licensing Department, Boards and Commissions, Social Work Licensing Board reserves the right to audit a licensee's continuing education records as it deems necessary. This event has been approved for a total of 1 CEU.

Physicians (MDs) and nurses can use AOA Cat 1-4 credit toward licensure. Psychologists, social workers and mental health counselors (LPC, LCPC, LPCC) can use the Social Work CEU credit toward licensure.

CLAIMS & ELIGIBILITY

Prepayment Reviews on BlueCard Inpatient DRG Claims

Beginning July 1, 2021, the Blue Cross and Blue Shield Association will require Blue Cross and Blue Shield of Texas (BCBSTX) to **review select inpatient, diagnosis-related group (DRG) claims before processing.** The review will check for compliance with ICD-10 procedure coding system guidelines. For those claims, providers must submit medical records for the claim to process.

Which claims: This is for inpatient, **DRG claims** for services rendered to any hosted **BlueCard member.** Hosted BlueCard members are members of any Blue Cross and Blue Shield plan outside Texas receiving health care services in Texas.

What's next: If we review your claim and find an error in how it's coded in relation to the diagnosis, you'll receive a letter that explains the review and the outcome.

How to submit medical records: When you are notified a claim is selected for review, you may be requested to submit medical records. You can submit them electronically using our Claim Inquiry Resolution tool. **Include** the corresponding **claim number** for quicker review and turnaround time.

More Information: If you have any questions, please contact your BCBSTX Provider Network Representative. For information about BlueCard, see our website under Claims & Eligibility.

Checking eligibility and benefits and/or obtaining benefit preauthorization/pre-notification or predetermination of benefits is not a guarantee that benefits will be paid. Payment is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations and exclusions set forth in your patient's policy certificate and/or benefits booklet and/or summary plan description. Regardless of any benefit determination, the final decision regarding any treatment or service is between you and your patient. If you have any questions, please call the number on the member's BCBSTX ID card.

Update: Professional Provider Fee Schedule via Availity®

The Fee Schedule tool will be available as of May 27, 2021 via Availity.

Fee schedules are a key component of your contractual relationship with Blue Cross and Blue Shield of Texas (BCBSTX). To ensure you have this information quickly, As of May 27, 2021, BCBSTX will be implementing a new online Fee Schedule viewer tool via the Availity Provider Portal for some **participating** professional providers. Once it's available professional providers may use this Availity tool to electronically request up to 20 procedure codes at a time and immediately receive the currently contracted price allowance for the patient services submitted.

How to Use the Availity Fee Schedule Listing Tool:
Note: Availity Administrators must assign the "Provider Fee Schedule" role for users to gain access to this tool.

- Log in to Availity
- Select Claims & Payments from the navigation menu
- Select Fee Schedule Listing
- Select BCBSTX as the payer
- Select your organization and Tax ID number

- Enter the Billing National Provider Identifier (NPI) and Rendering NPI (if applicable)
- Select the Network, Place of Service, and Provider
- Enter the procedure code(s) and modifier(s)

You must be registered with Availity to use the new Fee Schedule tool. You can sign up today at Availity, at no charge. For registration assistance, call Availity Client Services at **1-800-282-4548**. If you do not have online access, you may continue to submit your requests using the Professional Fee Schedule Request form located on our provider website.

For More Information

We will have an instructional **Fee Schedule Tool User Guide** that will be added to the Provider Tools section of our website. If you have further questions, please contact our Provider Education Consultants.

Medicare Advantage and Texas Medicaid

Links to these fee schedules are available by selecting the Claims & Payments menu, Fee Schedule Listing, and then choose the appropriate Additional Fee Schedules for Medicare and/or Medicaid. They can also be found via the Resources tab in the BCBSTX-branded Payer Spaces section in the Availity portal.

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:

- Increased Procedural Services (Modifier 22) – Effective 08/12/2021
- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Effective 08/15/2021

CERiS to Review Complex Claims

One of our post-payment **reviewers of complex claims is changing**. CERiS will continue to conduct post-payment reviews of complex claims from providers and facilities on behalf of Blue Cross and Blue Shield of Texas (BCBSTX). However, beginning July 2021, **EquiClaim, a Change Healthcare Solution, will no longer provide these reviews** and you will no longer be contacted by them if your claim was incorrectly paid.

CERiS will continue to review claims for:

- Compliance with the provider agreement

- Compliance with clinical payment and coding policies
- Accuracy of payment

If a claim is determined to be reimbursed incorrectly, CERiS will tell you how to repay the funds or appeal the decision. We may recoup payment for any claim that doesn't meet our policies. For more information, refer to our Provider Manuals.

Questions? Contact your BCBSTX Network Representative.

CorVel Healthcare Corporation, dba CERiS and EquiClaim, a Change Healthcare Solution, are independent companies that have contracted with BCBSTX to provide medical claim audits for members with coverage through BCBSTX.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Reminder: PEAQ Program

What is PEAQ

The PEAQ Program evaluates physician performance in a transparent and multidimensional way. A goal of PEAQ is to work with the physician community to maximize physician efficiency, appropriateness, and quality of care.

The guiding principles of the program include metrics, transparency, collaboration, continuous improvement, insights, and member focus to achieve more optimal outcomes and effective delivery. Providers can review the current methodology on our PEAQ Program page.

PEAQ Program Reports

Results of the PEAQ evaluation will show how a physician was scored and where their scores rank in comparison to peers within the same region and working specialty. These reports will be available soon and providers can access them via Availity® by using the Reporting On-Demand tool located in the Blue Cross and Blue Shield of Texas-branded Payer Spaces section. If you are not currently registered with Availity get ready now by signing up at Availity, **at no charge**. If you need registration assistance, contact Avility Client Services at **1-800-282-4548**.

Watch News and Updates and the Blue Review for more detailed information on accessing your PEAQ reports in the near future.

CLINICAL RESOURCES

Keys to Diabetes Management

Provider Survey Results

In late 2020, we asked Blue Cross and Blue Shield of Texas (BCBSTX) providers to tell us what works best to manage diabetes.

We asked providers **what methods are most important** in educating patients with diabetes. They recommend:

- One-on-one education
- Referral to a specialist educator

We also asked **which methods they most commonly recommend** for managing diabetes. They recommend:

- Diet, exercise and weight loss
- Frequent follow-up visits
- Keeping a diary of blood sugar levels

Also, half of survey responders said they **perform HbA1c testing in-office**, which can improve decision-making, patient compliance and outcomes. Most indicated they test their patients' HbA1c **every three months**.

Closing care gaps

Our provider survey is part of our effort to measure and improve the quality of care our members receive. Comprehensive diabetes care is a Health Effectiveness Data Information Set (HEDIS®) measure developed by the National Committee for Quality Assurance (NCQA).

Supporting members with diabetes

BCBSTX offers some members programs like the following to support your treatment options:

- **Livongo**®, focuses on diabetes management and offers supplemental, remote care in the member's home. Features include:
  - Real-time personalized messaging via a connected blood glucose meter
  - Certified diabetes educators available 24/7
  - Member-initiated reporting to a BCBSTX clinician, a PCP or specialist, with blood glucose readings and trends to enable more focused conversations. Members can also choose to send alerts to family or member of their personal support group.
  - Instant interventions when blood glucose readings are out of range.
- **Omada**®, focuses on diabetes prevention with supplemental remote care that members can do at home. Omada can help reduce the risk of type 2 diabetes and heart disease. Features include:
  - Health coach for ongoing digital support and guidance
  - Weekly lessons to empower healthier habits around food, activity, sleep and stress
  - Cellular-connected scale that automatically uploads readings to a member's account
  - Optional small online group for real-time motivation from a community of peers

More resources:

- Resources for delivering quality care
- Preventive Care Guidelines

Livongo is an independent company that provides diabetes management for BCBSTX. Livongo is solely responsible for the products and services it provides.

Omada is an independent company that provides diabetes prevention services for BCBSTX. Omada is solely responsible for the products and services it provides.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider. HEDIS is a registered trademark of the NCQA.

HEALTH & WELLNESS

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in News and Updates and our Wellness Can't Wait web page.

Catch Up Now on Child and Adolescent Vaccinations

Due to COVID-19, children and adolescents have fallen behind on receiving recommended vaccines. The Centers for Disease Control and Prevention (CDC) recommends that children get caught up now with vaccinations so that they're protected as they return to in-person learning. **We encourage providers to schedule catch-up vaccinations as soon as possible and prepare for COVID-19 vaccine protocols**.

What You Need to Know About COVID-19 Vaccine Protocols

The Pfizer COVID-19 vaccine has received emergency use authorization for children ages 12 and older. By fall, COVID-19 vaccines may be approved for younger children. The CDC recommends the COVID-19 vaccine for everyone ages 12 and older.

In updated clinical guidance, the CDC says that other vaccines may be given with the COVID-19 vaccine. It's no longer necessary to wait 14 days between the COVID-19 vaccine and other vaccines as a precaution. The American Academy of Pediatrics also supports this guidance.

To help children and adolescents catch up on all needed vaccines, the CDC recommends that providers:

- Identify members whose children have missed vaccinations and contact them to schedule appointments

- Check at each visit for any missing immunizations and deliver vaccines that are due
- Let members know what precautions are in place for safe delivery of in-person services

Why Catching Up on Vaccinations Is Crucial

Vaccines protect children from serious and potentially life-threatening diseases. According to the National Committee for Quality Assurance, as of Feb. 14, 2021:

- Overall adolescent vaccination rates are down as much as 22% due to the pandemic
- Overall provider orders (other than flu) from the federally funded Vaccines for Children Program are down by almost 10.9 million doses
- This decline includes MMR/MMRV vaccines for measles, mumps, rubella and varicella, which are down by 1.4 million doses

More Resources

- COVID-19 coverage
- Preventive care guidelines on immunization schedules

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

Treating Substance Abuse

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in News and Updates and our Wellness Can't Wait web page.

More than 20 million people ages 12 and older in the U.S. struggle with a substance use disorder each year. Fewer than 20% of them receive treatment, according to the Substance Abuse and Mental Health Services Administration.

We encourage providers to talk with our members about the signs of substance abuse disorders and how alcohol can affect them. Consider urging the member to seek help, if appropriate.

Treatment, including medication-assisted treatment (MAT) with counseling or other behavioral therapies, can help reduce substance abuse mortality, according to the National Committee for Quality Assurance (NCQA). Treatment may also help improve health, productivity and social outcomes.

Closing Care Gaps

As part of monitoring and improving quality of care, we track **two** Healthcare Effectiveness Data and Information Set (HEDIS®) **measures related to substance abuse**:

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
- Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

What IET Measures

IET applies to members ages 13 and older with a new episode of alcohol or other drug (AOD) abuse or dependence. The measure captures two stages of adequate and timely follow-up treatment:

- **Initiation of treatment,** one treatment within 14 days of the diagnosis
- **Engagement of treatment,** at least two additional treatment sessions within 34 days of the initiation appointment

Treatment may occur in an inpatient, residential, outpatient or telehealth setting or as MAT.

What FUA Measures

FUA applies to members ages 13 and older with a principal diagnosis of AOD abuse or dependence during an emergency department (ED) visit. The measure captures rates for AOD follow-up visits after an ED visit:

- **Within seven days** of the ED visit (eight total days)
- **Within 30 days** of the ED visit (31 total days)

If the first follow-up visit is within seven days after discharge, both rates are counted for this measure.

Tips to Consider

- Discuss the importance of timely follow-up visits.
- Use the same diagnosis for substance use at each follow-up.
- Coordinate care between behavioral health and primary care physicians. Share progress notes and include the diagnosis for substance use.
- Reach out to members who cancel appointments and help them reschedule as soon as possible.
- For FUA, ED providers can help members schedule an in-person or telehealth follow-up visit within seven days. Send ED discharge paperwork to the appropriate outpatient provider within 24 hours of discharge.

For more resources, see our Wellness Can't Wait web page.

Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

MEDICARE ADVANTAGE PLANS

Update to Prior Authorization Codes for Medicare and Medicaid Members

What's Changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Medicare and Medicaid members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

For Medicare: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website. The revised lists can be found on the Prior Authorization Lists for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ page.

For Medicaid: Refer to **Prior Authorization Lists and Reports** on the **Utilization Management** section of our Medicaid provider website.

Changes include:

- **July 1, 2021** - Removal of Advanced Imaging codes previously reviewed by eviCore
- **July 1, 2021** - Removal of Genetic Testing codes previously reviewed by eviCore
- **July 1, 2021** - Adding Genetic Testing codes to be reviewed by eviCore
- **July 1, 2021** - Adding Specialty Drug codes to be reviewed by eviCore

Check Eligibility and Benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® or your preferred vendor.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2021 – Part 1

This pharmacy update includes changes/updates to the drug list, dispensing limits, the Utilization Management program, benefit coverage for select high-cost claimants and HIV pe-exposure prophylaxis coverage. It also includes reminders about the Split Fill program and the HDHP/HAS Preventive Drug program.

PRIOR AUTHORIZATION

Update to Prior Authorization Codes for Commercial Members

What's New: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its lists of procedure codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA).

More Information: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website, Revised lists can be found on the **Prior Authorization Lists for Fully Insured and Administrative Services Only (ASO) Plans.** Changes include:

Effective April 16, 2021

- Removed review by AIM for **E1399* - Sleep Medicine Durable Medical Equipment** review by AIM

*Code E1399 may require prior authorization by BCBSTX medical management dependent on the description of the unlisted DME.

Effective July 1, 2021

- Added review by BCBSTX Medical Management for **E0764 - Functional Neuromuscular Stimulator**
- Removed review by AIM for:
  - **76975** from **Advanced Imaging**
  - **G9840** and **G9841** from **Molecular Genetic Testing**
  - **62324** and **64640** from **Pain Management**

Check Eligibility and Benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® or your preferred vendor.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

UTILIZATION MANAGEMENT

New Location for Utilization Management on Provider Website

Utilization Management information, which includes Prior Authorizations, is now located under **Claims and Eligibility** on the Blue Cross and Blue Shield of Texas (BCBSTX) provider website. This change was designed to enhance your experience for the entire claim cycle from the moment a member walks into your office, from reviewing prior authorization requirements to processing claims for covered services you provide.

Be sure to bookmark the new location for Utilization Management which includes:

- Explanations of utilization management reviews
- Links to tools to manage utilization management reviews
- Links to predetermination and prior authorization code lists

If you have questions, contact your Network Management Representative.

Utilization Management Decisions

We are 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 the appropriateness of care and service and the existence of coverage. We prohibit decisions based on financial incentives, nor do we 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 number on the back of the member's ID card.

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

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

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.

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

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

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.

The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

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.

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

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