# BLUE REVIEW℠

For Providers

**AUGUST 2024**

## BEHAVIORAL HEALTH

### Provider Depression Disorder Prescribing

**Screening and Treatment**

The National Institute of Health estimated 21 million American adults, or 8.4% of the adult population, have had at least one depressive episode.[1] Depression can create barriers to management of other chronic conditions but is remarkably responsive to antidepressant therapy when patients are treated in a timely manner, attend follow-up appointments, and are referred for behavioral health services when necessary. Proper treatment of depression has been proven to effectively reduce symptoms, decrease the risk of relapse, emergency department visits, and hospitalization rates.[2]

**Telemedicine Reduces Barriers to Follow up**

Telehealth use increased by 556% during the COVID-19 pandemic and usage specifically for mental health and substance use disorder increased 40% and declined only 4% after the pandemic[4]. Leveraging telemedicine for mental health may help a reluctant patient remain treatment compliant because it reduces health disparities, patient barriers and provides access to rural patients.[3]

**References**


[1] https://www.nimh.nih.gov/health/statistics/major-depression

[2] https://www.jmcp.org/doi/full/10.18553/jmcp.2021.27.2.223

[3] Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders published by SAMHSA in 2021.

[4] https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/


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## CLAIMS & ELIGIBILITY

### CPT® Category II Codes Can Help Close Care Gaps

Using the proper Current Procedural Terminology Category II codes when filing claims can help streamline your administrative processes and close gaps in care. Learn how CPT codes ease administrative burdens and how to submit them. Read more.

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## Proper Billing for Supplies for Transcutaneous Electrical Nerve Stimulation Units

Proper coding for Transcutaneous Electrical Nerve Stimulation Units and necessary supplies eliminates additional costs to you and our members. This article provides tips to ensure you and your patients get what you need. Read more.

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## Technical and Professional Components

**Modifier 26** denotes professional services for lab and radiological services. **Modifier TC** denotes technical components 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 services for a lab or radiological procedure, they must submit the total service, not each service individually.

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## Fighting Fraud, Waste and Abuse

Every year, analysts and investigators for BCBSTX review claims data, industry trends and investigative results to identify potential areas of fraud, waste and abuse. For more information refer to these BCBSTX informational resources:

- Provider Standards and Requirements
- Medical Policies
- Fraud and Abuse

If you encounter potential fraud, waste or abuse:

- Please file a report online
- Call our Fraud Hotline at 800-543-0867
    - All online reports and calls are confidential, and you may remain anonymous.

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## New Coupe Health Plan: Update Your Member Records

Starting in October 2024, providers in the commercial Blue Choice PPO℠ and Blue High Performance Network® may see members of our new Coupe Health benefit plan. This plan streamlines the payment process for your office and our Coupe Health members.

Coupe Health is a copay-only plan, and members pay no deductibles or coinsurance. **You won't collect any copay from Coupe Health plan members.** Instead, Blue Cross and Blue Shield of Texas will reimburse you directly for the full allowed amount, including the member share. For reimbursement, follow the billing instructions on the member's ID card.

### Check ID Cards to Identify Coupe Health Members

As with all our members, it's important to ask to see the member ID card before all appointments, and to check eligibility and benefits. **Update your records if member ID numbers have changed.** Use Availity® Essentials or a preferred vendor to check membership, coverage and prior authorization requirements, and to confirm that you are in-network for the member's policy. Emergency services are covered at the in-network benefit level.

If you have questions, call the customer service number on the member's ID card.

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## Claim Processing Enhancements for ERS Effective Sept. 1, 2024

Effective Sept. 1, the following updates will be made related to claim processing for **Employee Retirement System of Texas** participants:

- **Cotiviti**
  - **Diagnosis Code Guideline Policy** added to identify multiple scenarios where a diagnosis submitted for a procedure or service is reported in an inappropriate position on professional and/or facility claim line(s).
  - **Anatomical Modifiers** edit will focus on coding the appropriate modifier based on the area or part of the body the procedure is performed and will apply to professional claims and facility claims.
  - **Emergency Room Evaluation & Management** edits to identify miscoded facility and professional claims that were billed at high intensity levels (4 & 5).

- **MultiPlan out-of-area or out-of-network rate negotiations**
  - We will negotiate charges for covered health care services from out-of-network health care providers to reduce the amount a participant may be liable for and/or help protect participants from balance billing.

For additional information, contact your Blue Cross and Blue Shield of Texas Network Management office.

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## ClaimsXten™ Quarterly Update Effective Aug. 19, 2024

Blue Cross and Blue Shield of Texas will implement its third quarter code updates for the ClaimsXten auditing tool on or after Aug. 19, 2024.

These quarterly code updates aren't considered changes to the software version. Code updates may include additions, deletions and revisions to:

- Current Procedural Terminology (CPT®) codes
- Healthcare Common Procedure Coding System (HCPCS) codes

When applicable, BCBSTX may also post advance notice of significant changes, like implementation of new rules, in the News and Updates section of our Provider website and the Blue Review monthly newsletter.

Use **Clear Claim Connection™ (C3)** to determine how certain coding combinations may be adjudicated when we process your claim. C3 is a free, online reference tool that mirrors the logic behind our code-auditing software.

Please note that C3 doesn't contain all of our claim edits and processes. Its results don't guarantee the final claim decision.

**For more information,** refer to the Clear Claim Connection page in the Education and Reference/Provider Tools section of our provider website for more information on C3 and ClaimsXten. It includes a user guide, rule descriptions and other details.

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### Clinical Payment and Coding Policy Updates

Our website's Clinical Payment and Coding Policies 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 and does not address all reimbursement-related issues. We may add and modify clinical payment and coding policies. The following policy was added or updated:

- CPCP006 Preventive Services Policy Update, Effective 07/01/2024
- CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services Updated, Effective 07/01/2024
- Update to CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services, Effective 10/01/2024
- CPCP012 Hernia Repair Updated, Effective 10/10/2024
- Annual Review: CPCP034 Unbundling Policy; Professional Providers Updated, Effective 06/25/2024
- Annual Review: CPCP021 Laboratory Panel Billing Updated, Effective 07/11/2024
- Annual Review: CPCP039 Outpatient Facility Service(s) Overlapping During an Inpatient Stay Updated, Effective 07/15/2024

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## HEALTH & WELLNESS

### Breast Cancer Screening for Members Ages 40 to 74

In line with new U.S. Preventive Services Task Force recommendations, Blue Cross and Blue Shield of Texas recommends that breast cancer screening for **our members begin at age 40 rather than 50**. We are updating our Preventive Care Guidelines to reflect this change. Screening should continue every other year until age 74.

Routine screening for breast cancer is the best way to detect it early, according to the Centers for Disease Control and Prevention. Breast cancer is easier to treat when it's caught earlier.

**Tips to Close Gaps in Our Members' Care**

- Talk with our members about breast cancer risk factors and the importance of regular screening for women. We've created resources that may help.
- Breast cancer disproportionately affects Black women, according to the CDC. Talk with our members about the unique risks and barriers they may face, which can result in poorer outcomes than other women.
- Document screenings in members' electronic medical record. Indicate the specific date and result. This helps us track member progress on the quality measure Breast Cancer Screening from the National Committee for Quality Assurance.
- Document medical and surgical history in the medical record, including dates. Use correct diagnosis and procedure codes. Submit claims and encounter data in a timely manner.
- Offer telehealth services when available and appropriate for preventive care appointments.
- Follow up with members if they miss their appointment and help them reschedule.
- For members who need language assistance, let them know we offer help and information in their language at no cost. To speak to an interpreter, members may call the customer service number on their member ID card.
- For members who have transportation barriers, let them know that we provide Medicaid members with free non-emergency transportation services.
- See our Health Equity and Social Determinants of Health page for more information on health equity.

For men who are at high risk, the American Cancer Society recommends discussing with them how to manage risks.

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## MEDICARE ADVANTAGE PLANS

### Medicare Providers May Treat Blue Cross Group Medicare Advantage Open Access (PPO)℠ Members

If you're a Medicare provider, you may treat Blue Cross Group Medicare Advantage Open Access (PPO) members. This is an open access, non-differential national PPO plan without network restrictions. You may treat these members **regardless of your contract or network status with Blue Cross and Blue Shield of Texas**. That means you don't need to participate in our Medicare Advantage networks or in any of our networks to see these members.

The **only requirements** are that you agree to see the member as a patient, accept Medicare and submit claims to the member's Blue Cross and Blue Shield Plan.

Texas retiree groups with open access plans include University of Texas System, Texas A&M University System and City of Austin. Learn more.

**Check Member ID Cards**

As with all our members, it's important to ask to see the member's ID card before all appointments and to check eligibility and benefits. You can identify these members by the plan type listed on their ID card. Use the **entire member ID number**, including the alpha prefix, when verifying benefits and submitting claims. If you have questions, call the customer service number on the member's ID card.

**Open Access Advantages**

Blue Cross Group Medicare Advantage Open Access (PPO) is available to retirees of employer groups. It covers the same benefits as Medicare Advantage Parts A and B plus additional benefits depending on the plan. It includes medical coverage and may include prescription drug coverage.

Members' coverage levels are the same **inside and outside their plan service area nationwide** for covered benefits. Plan members may have to pay deductibles, copays and coinsurance, depending on their benefit plan.

Referrals aren't required for office visits. Prior authorization may be required for certain services from Medicare Advantage-contracted providers with BCBSTX.

**For Reimbursement**

Follow the billing instructions on the member's ID card. When you see these members, you'll submit the claims to BCBSTX and not Medicare.

- **If you're a Medicare Advantage-contracted provider with any BCBS Plan,** you'll be paid your contracted rate. You're required to follow utilization management review requirements and guidelines.
- **If you're a Medicare provider who isn't contracted for Medicare Advantage with any BCBS Plan,** you'll be paid the Medicare-allowed amount for covered services. You may not balance bill the member for any difference in your charge and the allowed amount.* You aren't required to follow utilization management guidelines. However, you may request a review to confirm medical necessity.

** Members may be responsible for cost share for supplemental dental services from non-contracted Medicare providers.*

*Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations.*

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## NETWORK PARTICIPATION

### Physician Performance Insights Reports Are Now Available

Physician Performance Insights reports are available for physicians who are eligible for our Physician Efficiency, Appropriateness and Quality℠ (PEAQ) program. The reports show how physicians compare to their peers and include information on how to improve performance. Read more.

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### Provider Finder® Ranks Providers to Help PPO Members Find Care

Later this year, Provider Finder will add a tiering feature that shows how providers rank against peers in their working specialties in some PPO products. The tier will display only for members in employer groups with a tiered benefit option. Members can use this information to take advantage of incentives such as lower copays and coinsurance for care from high performers.

Tiering is based on composite results of the Physician Efficiency, Appropriateness, and Quality℠ program. This evidence-based program evaluates primary care physicians and some specialists on components of cost efficiency, medical appropriateness, and quality of patient care. Tiering applies to providers in the following specialties:

| Medical | Surgical | Primary Care |
|---|---|---|
| Cardiology | Cardiothoracic Surgery | Family Medicine |
| Endocrinology | Ophthalmology | Internal Medicine |
| Gastroenterology | Orthopedic Surgery | Pediatrics |
| Nephrology | Urology | |
| Obstetrics and Gynecology | Vascular Surgery | |
| Pulmonary Medicine | | |
| Rheumatology | | |

- **Tier 1** has lower member out-of-pocket costs. It includes behavioral health providers and physicians who have above average composite scores as compared to their peers.
- **Tier 2** has standard member out-of-pocket costs. It includes unscored providers* and physicians who have average composite scores as compared to their peers.
- **Tier 3** has higher member out-of-pocket costs. It includes physicians who have below average composite scores as compared to their peers.

Tiering in 2024 is based on previous PEAQ results. Tiering in 2025 will be based on 2024 PEAQ results.

*Unscored providers include those practicing in specialties evaluated by PEAQ℠ who did not reach minimum criteria thresholds and those who practice in specialties that PEAQ does not currently evaluate. If you have questions, contact PEAQ Inquiries. The full PEAQ methodology is on our PEAQ page.

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### Has Your Information Changed? Update Us and the NPI Registry

Our members **rely on accurate provider information** to find care. When your **practice address**, **phone number** or other demographic information changes, take the following steps:

**Update your demographic information** for your NPI in the National Provider Identifier Registry:

- Update through the National Plan & Provider Enumeration System website, or
- Download and mail in the Centers for Medicare & Medicaid Services' NPI update form

Instructions are provided online in the NPPES FAQs. See the CMS website for more on NPIs.

**Update Blue Cross and Blue Shield of Texas**

- Update your demographic information via the Provider Data Management feature in Availity® Essentials.
- Or use our Demographic Change Form if you're unable to use Availity.
- You can also use these tools to verify that your directory information is accurate. Federal law requires that directory information be **verified every 90 days** even if it hasn't changed. Learn more.
- Availity administrators should also keep their organization's provider information current in **Availity** Manage My Organization to ensure the associated provider data is accurate in the various Availity self-service tools. Manage My Organization is a separate function from Provider Data Management, and data should be updated in both tools.

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### Hospitals, and Routine Services and Supplies

Providers usually include routine services and supplies in charges related to other procedures or services. As such, those services/supplies are considered non-billable for separate reimbursement. The following guidelines identify items, supplies and services that are not separately billable. (Note: 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.

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## PHARMACY

### Pharmacy Program Quarterly Update, Part 2: Changes Effective July 1, 2024

Review important pharmacy benefit reminders, drug list and dispensing limit changes, and Utilization Management program changes. Read more.

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## UTILIZATION MANAGEMENT

### Check Prior Authorization Requirements for Procedure Codes through Availity® Essentials or Our IVR System

Providers can check prior authorization requirements for procedure codes online by using Availity Essentials Eligibility and Benefits. If you aren't able to check online, our IVR phone system has a new menu option to **quickly confirm prior authorization requirements** for procedure codes for our commercial members.

With this option, you can proceed directly to checking prior authorization requirements without speaking to customer service.

**How to use it:** When you call the customer service number on our members' ID cards, follow the prompts to "Check Procedure Code Requirements." Refer to the updated Check Authorization by Procedure Code IVR Caller Guide for more details.

Learn more about prior authorization. Need IVR help? Email our Provider Education Consultants.

*This information does not apply to Blue Cross Medicare Advantage or Medicaid members.*

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### Prior Authorization Code Changes for Commercial Members Effective Oct. 1

**What's New:** Blue Cross and Blue Shield of Texas will be updating its lists of codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes. These changes are based on updates from Utilization Management prior authorization assessment, Current Procedural Terminology (CPT®) code changes released by the American Medical Association or Healthcare Common Procedure Coding System changes from the Centers for Medicaid & Medicare Services.

**Changes effective Oct. 1, 2024, include:**

- Addition of Genetic Testing codes **to be reviewed** by Carelon Medical Benefits Management
- Removal of Genetic Testing codes **previously reviewed** by Carelon
- Replacement of a Medical Oncology drug code **reviewed** by Carelon
- Addition of Medical Oncology codes **to be reviewed** by Carelon
- Removal of Specialty Drug codes **previously reviewed** by BCBSTX

**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 Plans.**

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

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## NICU Utilization Management Update Effective Sept. 1, 2024, for ERS Plans

**What's changing:** Effective Sept. 1, 2024, ProgenyHealth® is delegated for all neonatal intensive care unit (NICU) admissions and concurrent reviews for the Employees Retirement System of Texas (ERS) Plans. Providers have the option to notify ProgenyHealth pre-service to ensure medical necessity, level of care and other plan requirements are met prior to submitting claims.

**ProgenyHealth for NICU Key Points**

BCBSTX encourages providers to request Recommended Clinical Review (RCR) for all NICU admissions and concurrent reviews.

- ProgenyHealth's NICU UM program coordinates and monitors the appropriateness, cost-effectiveness and efficiency of the care being provided in the NICU while maximizing the quality of health care and services provided to the participant.
- Each family is matched with a ProgenyHealth case manager who provides support up to the first year of the newborn's life. Case managers connect with families to assess needs, optimize care and collaborate with hospital staff to support the baby's transition from the hospital to home.
- ProgenyHealth ensures continued care with the family's pediatrician by reducing unnecessary emergency department visits and unplanned readmissions and provides any additional mental or physical health needs.
- Providers are encouraged to notify ProgenyHealth directly of admissions via Sfax at **1 (855)732-8182**. ProgenyHealth's clinical staff will coordinate with providers to perform utilization management and discharge planning throughout the inpatient stay.

**More information:** Be sure to check eligibility and benefits through Availity® Essentials or your preferred vendor.

Watch for updates about ERS' RCR processes on the ERS Tools page and News and Updates on our provider website.

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## Changing Prior Authorization to Recommended Clinical Review Effective Sept. 1 for TRS Participants

**What's changing:** Effective Sept. 1, 2024, Blue Cross and Blue Shield of Texas will be moving prior authorization to **Recommended Clinical Review Option for outpatient services** for **Teacher Retirement System of Texas** participants as indicated below:

**Outpatient Services** previously requiring PA by **BCBSTX moving to RCR**: (As a reminder, inpatient services were changed to RCR effective 03/01/2024)

- Cardiology -Lipid Apheresis
- Ear, Nose and Throat
- Gastroenterology
- Neurology
- Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw)
- Pain Management
- Wound Care
- Home Health Services including but not limited to home private duty nursing (PDN), home infusion therapy (HIT)
- Home Hemodialysis
- Home Hospice
- Non-Emergent Air Ambulance
- Transplant Services, Transplant Evaluations and Transplants

- Durable Medical Equipment > $5000 applicable to medical necessity review per benefit language (less than $5000 medical necessity review not needed)
- Outpatient Physical Therapy/Occupational Therapy/Speech Therapy
- Mental Health and Substance Use Disorder Services
    - Applied Behavior Analysis
    - Electroconvulsive Therapy
    - Intensive Outpatient Treatment
    - Partial Hospitalization
    - Psychological Testing/Neuropsychological Testing
    - Repetitive Transcranial Magnetic Stimulation
- Specialty Pharmacy Medications that are covered by Medical Benefits
    - Infusion Site of Care
    - Medical Oncology & Supportive Care (through Carelon)
    - Provider Administered Drug Therapies

**Carelon Medical Benefits Management** will handle RCR for the following services:

- Advanced Imaging / Radiology
- Cardiology
- Molecular Genetic Lab Testing
- Musculoskeletal - Joint, Spine Surgery, Musculoskeletal - Pain
- Radiation Therapy / Radiation Oncology
- Sleep

Providers are encouraged to submit an RCR for services that previously required prior authorization to prevent post service medical necessity reviews. Refer to the RCR page for a list of applicable services.

**Recommended Clinical Review Key Points**

- RCR requests are optional medical necessity reviews conducted before services are provided. Submitting a request prior to rendering services informs you of situations where a service may not be covered based upon medical necessity.
- Submitting a recommended clinical review evaluates the medical necessity of a service but does not guarantee the service will be covered under the participant's benefit plans. The terms of the participant's plan control the available benefits.
- Claims for services for which the RCR option is available will be subject to retrospective review if a provider elects not to submit a request for RCR.

**For more information:** Refer to the RCR page for information on RCR services and how to submit requests for services managed by BCBSTX or Carelon.

Learn more about our utilization management process, including prior authorization and recommended clinical review in the Utilization Management section of our provider website. Follow our News and Updates page for future updates.

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### Utilization Management Update Including Change to Recommended Clinical Review Effective Sept. 1, 2024, for ERS Plans

**What's changing:** Blue Cross and Blue Shield of Texas will be making the following changes effective Sept. 1, 2024, for the Employee Retirement System of Texas (ERS) medical plans, including HealthSelect of Texas® and Consumer Directed HealthSelect℠:

- Moving all services previously requiring prior authorization, as well as other certain services needing medical necessity review, to **Recommended Clinical Review (RCR).**
    - RCR allows providers to submit requests for medical necessity review before the services are provided. RCR will replace post-service review for medical necessity when an RCR is completed. This includes concurrent reviews.
    - RCR is an optional medical necessity review conducted before services are provided. Submitting a request prior to rendering services informs you of situations where a service may not be covered based upon medical necessity or other plan rules.

- **Carelon Medical Benefits Management** will handle RCR for the following services:
    - Advanced Imaging (such as CT scan, nuclear stress test, MRI, PET scan with the exception of MRI of the breast)/cardiology imaging
    - Musculoskeletal (Joint/Spine), pain
    - Genetic/molecular testing
    - Radiation (oncology) therapy for cancer
    - Medical oncology specialty drugs and supportive care

**Important:** Medical necessity does not guarantee payment. Eligibility and other plan requirements must be met. You can access the HealthSelect of Texas and Consumer Directed HealthSelect documents at: healthselect.bcbstx.com/medical-benefits.

**Coming soon:** Refer to the updated ERS RCR Services List for the most current services applicable for an RCR and how to submit the requests.

Note: Providers may continue to request medical necessity review of additional services even when not included on the RCR Services List.

Effective Sept. 1, 2024, providers submitting RCR requests for services for ERS participants will have the option of submitting the request electronically via BlueApprovR℠ or the Availity® Authorization & Referrals tool.

**More information:** Be sure to check eligibility and benefits and confirm if a service is eligible for RCR through Availity® Essentials or your preferred vendor.

Learn more about ERS processes, including RCR on the Utilization Management section of our provider website. Follow our News and Updates page for future updates.

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### Contact Us

View our quick directory of contacts for BCBSTX.

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### Verify and Update Your Information

Verify your directory information every 90 days. Use the Provider Data Management feature on Availity® or our Demographic Change Form. You can also use this form to submit email addresses for you and your staff to receive the *Blue Review* each month.

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*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.*

*Material presented 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. The fact that a service or treatment is described 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.*

*Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through 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.CPT copyright 2021 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.*

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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.*

*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.*

*Change Healthcare is an independent third-party vendor that is solely responsible for the products or services they offer.*

*HealthSmart RX is an independent company that has been contracted by BCBSTX on behalf of TRS to provide TRS patient support services for certain covered drugs. HealthSmart RX does not offer Blue Products or Services.*

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*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.*

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