BLUE REVIEW℠

For Providers

FEBRUARY 2024

CLAIMS & ELIGIBILITY

NDC Billing Tool on Our Provider Website is Being Retired

Effective Mar 1, 2024, the National Drug Coding (NDC) Billing Tools for Contracted Providers under Resources on the BCBSTX provider website home page will be retired. Providers will continue to have access to the NDC Units Calculator via Availity® Essentials.

Accessing the NDC Units Calculator Via Availity

Log into Availity Essentials

1. Select Payer Spaces from the navigation menu and choose BCBSTX
2. Click on the Applications tab
3. Select NDC Units Calculator and users will be redirected to RC Claim Assist
4. If you have not registered for Availity, you can sign up at no charge today! For registration assistance, contact Availity Client Services at **1-800-282-4548**.

Contracted providers needing access to the BCBSTX **NDC fee schedules** can access the secure area of our General Reimbursement Information section on the provider website. This secure area requires a password you can obtain from your Network Management Representative. It is only available to participating providers.

Additional Resources

- Refer to the NDC Units Calculator Tool User Guide for instructions on using the NDC Units Calculator via Availity.
- If have additional questions or need customized training, email our Provider Education Consultants.

ClaimsXten™ Quarterly Update Effective April 15, 2024

Blue Cross and Blue Shield of Texas will implement its first quarter code updates for the ClaimsXten auditing tool on or after April 15, 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 BCBSTX's 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.

Update to Claim Editing Changes for Facility Emergency Department Services

As previously, disclosed in July 2024, BCBSTX is enhancing our claims editing and review process with Cotiviti for **emergency department evaluation and management** for some of our commercial members. These editing enhancements for facility and professional claims will help ensure accurate billing and proper reimbursement.

Originally, we indicated that edits for facility services would be effective with dates of service beginning Nov. 1, 2023. However, it was delayed. Beginning with dates of service on Mar. 1, 2024, we will edit applicable **facility claims** to help ensure accurate billing and proper reimbursement. As a reminder, we began to edit applicable **professional claims** to help ensure accurate billing and proper reimbursement for date of services beginning Nov. 1, 2023.

What's changing: when we review your claim your reimbursement may be processed at a lower level of service if we cannot validate the level of E&M services billed. We will follow the American Medical Association guidelines for level of service and medical decision making.

What happens next: if you agree with the level of service reimbursed, no further action is needed. If you do not agree with the level of service reimbursed, you may submit additional medical records to support your claim.

Learn More: For more information on revisions to our ED claims editing process, please review our Clinical Payment and Coding Policies web page – see our revised **CPCP003 Emergency Department Evaluation and Management (E/M) Services – for Facility Services** policy and our new **CPCP042 Emergency Department Evaluation and Management (E/M) Services Coding – for Professional Services** policy.

Notification of Annual Benefit Updates

We update our member files annually with benefit changes. As such, if you need to contact BCBSTX Provider Customer Service, please understand that hold times may be longer than usual at the beginning of the year. As always, we encourage you to obtain your eligibility and benefit information using Availity or your preferred electronic vendor. Deferring eligibility and benefit information requests to a later date is appreciated for patients not scheduled for appointments.

Three New ClaimsXten™ Rules to be Implemented March 2024

Note: See also Disclosure Notice page.

On or after March 1, 2024, we will update the ClaimsXten software database to better align coding with the reimbursement of claim submissions.

These are the changes:

Bundled Service	This rule identifies claim lines containing procedure codes indicated by the Centers for Medicare & Medicaid Services to be always bundled when billed with any other procedure. According to the CMS National Physician Fee Schedule Relative Value File, this procedure has a status code indicator of "B," which is defined as: "Payment for covered services is always bundled into payment for other services not specified." This rule is appropriate for professional claims only.
CMS Add-on Without Base Code Facility	This rule identifies claim lines containing a Current Procedural Terminology or Healthcare Common Procedure Coding System assigned add-on code when billed without acceptable supporting primary procedure/base code by the same practitioner for the same patient on the same date of service, per CMS. According to CMS, add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. An add-on code is eligible for payment if its related primary procedure/base code is also eligible for payment to the same practitioner for the same patient on the same date of service. This rule is appropriate for outpatient facility claims only.
Ancillary Procedures	This rule identifies claim lines billed by the same or a different provider either on the same day or different day (depending on the procedure code) after a non-covered service. This rule can consider both facility and non-facility claims. Before denying an ancillary service, the rule checks for other covered services that may have been performed on the same day as the non-covered procedure. If found, the rule will allow the ancillary service. This rule is appropriate for professional claims and outpatient facility claims only.

To determine how coding combinations may be evaluated during claim adjudication, use Clear Claim Connection™ (C3). Refer to our Clear Claim Connection page for more information on ClaimsXten and C3.

CLINICAL RESOURCES

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 policies were added or updated:

- CPCP006 Preventive Services Policy Update, Effective Jan. 1, 2024

EDUCATION & REFERENCE

Coding Webinars: Major Depressive Disorder and Annual Wellness Visits

Join our Coding Compliance Team for the following half-hour webinars on coding and guidelines. The webinars are free to providers and coding professionals. They include information from the Official ICD-10-CM Coding Guidelines, American Hospital Association Coding Clinic and Centers for Medicare & Medicaid Services.

Coding for Major Depressive Disorder

We will offer this webinar three times.

- Jan. 26, 2024, from 12 to 12:30 p.m. CT. Register here.
- Feb. 23, 2024, from 12 to 12:30 p.m. CT. Register here.
- March 29, 2024, from 12 to 12:30 p.m. CT. Register here.

Webinar topics include:

- ICD-10-CM guidelines and case studies
- CMS Version 28 risk adjustment updates
- Closing gaps in care for patients

Coding for Annual Health Assessments / Annual Wellness Visits for Medicare Advantage members

We will offer this webinar quarterly in 2024. The first two dates are:

- Feb. 16, 2024, 12 to 12:30 p.m. CT. Register here.
- April 12, 2024, 12 to 12:30 p.m. CT. Register here.

The webinar will include information on:

- Components and types of wellness visits
- Documentation standards and general coding requirements
- Coding for chronic conditions, screenings and Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Common coding errors

If you're unable to view the registration site, you may need to clear your web browser history. After you register, you'll receive an email with a calendar reminder and link to the webinar.
The webinars don't offer continuing education credits.

Provider Learning Opportunities

We offer free webinars to contracted providers who service our members. These trainings focus on electronic options and other helpful tools and resources. Review upcoming training sessions on our Provider Training and Continuing Education page. Also, if you are a new provider or have new staff, please refer to our Provider Orientation information.

HEALTH & WELLNESS

Annual HEDIS®/QRS Reports

Because we aim to improve the care our members receive, we're providing a chart that summarizes how we're performing on selected Healthcare Effectiveness Data and Information Set and Quality Rating System measures, along with key interventions and key accomplishments. Read more.

Supporting Healthy Hearts

You may care for our members who have risk factors for heart disease and stroke. These conditions are among the leading causes of death in the U.S. We encourage you to talk with our members about reducing and managing their risks. This may include taking medications as prescribed, smoking cessation, increasing physical activity and eating a low-sodium diet. We've created resources for members, including information on high blood pressure and cholesterol.

Closing Gaps in Members' Care

We track data from the quality measures Controlling High Blood Pressure and Statin Therapy for Patients with Cardiovascular Disease. These are Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance.

For **Controlling High Blood Pressure**, we measure the percentage of members ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled. NCQA defines controlling blood pressure as:

- Systolic blood pressure < 140 mmHg
- Diastolic blood pressure < 90 mmHg

Statin Therapy for Patients with Cardiovascular Disease tracks the percentage of men ages 21 to 75 and women ages 40 to 75 who:

- Have atherosclerotic cardiovascular disease, and
- Were dispensed at least one high- or moderate-intensity statin medication and remained on the medication for at least 80% of the treatment period

Tips to Consider

- The U.S. Preventive Services Task Force recommends blood pressure checks for adults age 18 and older at every visit. Ensure that screenings and results are documented in our members' electronic medical records.
- The American Heart Association recommends statin therapy to treat cardiovascular disease in adults with established clinical atherosclerotic cardiovascular disease. USPSTF recommends statin therapy to prevent cardiovascular disease in adults with certain risk factors. See our preventive care and clinical practice guidelines for more information.
- Heart disease, stroke and their risk factors disproportionately affect some populations, including Black adults. Social determinants of health can play a significant role in cardiovascular health, according to the Centers for Disease Control and Prevention. See our Health Equity and Social Determinants of Health webpage for information about addressing barriers to health.
- Offer **telehealth services** when available and appropriate for preventive care appointments.
- Encourage members to return for **follow-up visits**. Build care gap alerts in your electronic medical records as reminders. Reach out to those who cancel or miss appointments and help them reschedule as soon as possible.
- 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and QHP Enrollee Experience Survey (EES)

Blue Cross and Blue Shield of Texas (BCBSTX) conducts an annual CAPHS and QHP EES surveys. The aim of the surveys is to monitor the members' experience and their satisfaction with BCBSTX and its contracted providers.

Each year, the surveys are mailed in the month(s) of February/March to randomly selected members. It instructs the members to rate their experience with the care they received in the last six and twelve months, respectively.

Examples of topics and questions addressed in the survey are listed below, with an emphasis on domains where providers have the most impact.

Survey Category/Topic	Sample Questions
Getting Needed Care	• How often was it easy to get the care, tests or treatment you needed? • How often did you get an appointment to see a specialist as soon as you needed to?
Getting Care Quickly	• When you needed care right away, how often did you get care as soon as you needed it? • When you made an appointment for a check-up or routine care visit at a doctor's office or clinic, how often did you get an appointment as soon as you needed it?
How Well Doctor Communicates	• How often did your personal doctor explain things in a way that was easy to understand? • How often did your personal doctor listen carefully to you? • How often did your personal doctor spend enough time with you?
Smoking Cessation	• How often did your doctor advise you to quit smoking? • How often did your doctor recommend medications to help you quit smoking? • How often did your doctor recommend a strategy or other method other than medications to help you quit smoking?

What You Can Do to Help Improve CAHPS and EES Survey Results
We strongly encourage any efforts to improve results. Here are some recommendations that may help you and your staff to improve member satisfaction:

- Make walk-in appointments available in the morning/evening hours for urgent care.
- Spend time with the patients and explain things in a way they can understand easily. Encourage your office staff to assist the patients in scheduling appointments with specialists.
- Follow up with member's specialists to ensure continuity of care.
- Provide the patients with educational materials and resources as you empower patients' personal engagement and decision-making about their care.
- Consider performing a preventive health care visit during a sick visit if time and indications allow.
- Discuss available treatment and medication options with the patients.
- Educate patients about preventive care including wellness exams, immunizations including applicable to age RSV, Shingles, COVID and flu shots.
- At the end of each visit, review the treatment plan, discuss with your patient reasons why and why not to take medications, and list all available treatment options.

Encourage Your Patients to Participate
During the months of February and March, if your patients receive a survey, please encourage them to complete and return it using the BCBSTX enclosed pre-paid envelope provided.

Managing Antidepressant Medication
Major depressive disorder is one of the most common mental disorders in the U.S., affecting more than 17 million adults each year, according to the Substance Abuse and Mental Health Services Administration. About a third of those don't receive behavioral therapy or medication treatment, or a combination. Patients often rely on their primary care physicians for behavioral health care, according to the American Academy of Family Physicians.

We encourage you to talk with our members about getting help for depression, if needed. A depression screening tool can help clarify whether depressive symptoms indicate major depressive disorder.

We created a video about depression screening tools, procedure codes and following up on positive screening. You can watch the video here.

Supporting Quality Behavioral Health Care
We track Antidepressant Medication Management, a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance. By managing patients' antidepressant medication, providers can help increase medication compliance, monitor side effects and improve treatment outcomes, according to NCQA.

AMM applies to our members with major depression who are age 18 and older. It captures the percentage of members who are newly treated with antidepressant medication and remain on it. Providers who prescribe antidepressants should support members in reaching these two phases:

1. **Effective Acute Treatment Phase:** Adults who remained on antidepressant medication for at least 84 days (12 weeks)
2. **Effective Continuation Treatment Phase:** Adults who remained on antidepressant medication for at least 180 days (six months)

Each phase starts when the prescription is first filled.

Tips to Consider

- Document all the following:
  - Date of service
  - Diagnosis of major depression
  - Clear evidence that antidepressant medication was prescribed
- Help our members understand that most antidepressants take four to six weeks to work. How long treatment lasts depends on the episode severity and number of recurrences.
- Encourage members to continue any prescribed medication, even if they feel better. Discuss the danger of discontinuing suddenly. If they take medication for fewer than six months, they are at a higher risk of recurrence.
- Give members written instructions to reinforce the proper use of medication and what to do if they experience side effects.
- Discuss other factors that may improve symptoms, such as aerobic exercise and counseling or therapy.
- Assess members within 30 days from when the prescription is first filled for any side effects and their response to treatment.
- Coordinate care between behavioral health and primary care physicians by sharing progress notes and updates.
- Reach out to members who cancel appointments and help them reschedule as soon as possible.

Resources

- HEDIS tip sheets
- Documentation and coding resources for major depressive disorder

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MEDICARE ADVANTAGE PLANS

Prior Authorization Code Updates for Medicare Advantage Members Effective April 1, 2024

What's Changing: BCBSTX is changing prior authorization requirements for Medicare Advantage members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association effective April 1, 2024. A summary of changes is included below. 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.

Changes effective April 1 include:

- Addition of lab codes reviewed by eviCore healthcare

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.

NETWORK PARTICIPATION

Reminder: Update Your Demographic Information

Have you had a change in your location, phone number, email or other important details? As indicated in your provider agreement and as required by the Consolidated Appropriations Act (CAA) of 2021, make sure you verify and notify Blue Cross and Blue Shield of Texas (BCBSTX) of these changes **timely**. It's important that your demographic information is current so our members can locate you in our Provider Finder® tool. Be sure to review yourself on Provider Finder to verify the accuracy of your information.

CAA Requirement

As a reminder, the Consolidated Appropriations Act (CAA) of 2021 requires that certain directory information be verified every 90 days **even if your data hasn't changed since you last verified it.** Under the CAA, we're required to remove providers from Provider Finder® whose data we're unable to verify.

What to Verify

Verify every 90 days, your name, address, phone, specialty, and digital contact information (website) every 90 days and you must update your information when it changes. This includes if you join or leave a network. Refer to the Verify and Update Your Information page on our provider website.

Professional Providers Verification Process

- We recommend you use the **Availity® Essentials Provider Data Management feature** to quickly verify your information with us and other insurers every 90 days. See the Provider Data Management web page and User Guide for more details.
- If you're unable to use Availity, you may use our Demographic Change Form. See our User Guide on how to verify your data using this form.
- If you haven't verified your data, you may receive email or postcard reminders from us. The email has a unique link to verify information.

Facilities and Ancillary Providers Verification Process

Facilities and ancillary providers may only use the Demographic Change Form to verify information. See our User Guide for more details.

We appreciate the care you provide to our BCBSTX members and want to ensure that your current information is available to them.

PHARMACY

Pharmacy Program Quarterly Update, Part 2: Changes Effective Jan. 1, 2024

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

Introducing Smart RxAssist via HealthSmartRx®

Addition of Keytruda effective May 1, 2024, to the provider-administered specialty drug list.

Blue Cross Blue Shield of Texas (BCBSTX) is working with HealthSmartRx (HSRx), an independent company, to implement the Smart RxAssist program for certain eligible Teacher Retirement System of Texas (TRS) participants effective **Oct. 16, 2023**.

What Is Smart RxAssist?

Smart RxAssist offers assistance with enrolling in pharmaceutical manufacturer copay assistance programs to eligible participants who are prescribed specific provider-administered specialty drugs***.** The manufacturer copay assistance ensures continued access to these drugs with a significantly reduced copay, which can improve adherence and clinical outcomes. This copay assistance applies only to the cost of the provider administered drug(s) and does not apply to office visits or any other associated costs.

Enrollment is optional for eligible TRS participants and participation is voluntary for providers. The resulting payments from the copay assistance, TRS participant's cost sharing, and the health plan will equal the Allowable Amount that applies today. Participants who choose to participate are required to enroll in the Smart RxAssist program per their group benefits for in-scope provider-administered drugs.

HealthSmartRx Smart RxAssist Process

- If your patient has not yet enrolled in Smart RxAssist, an HSRx Patient Advocate will reach out to your patient by phone to facilitate enrollment and answer any questions they may have.
- Your office may be contacted by HSRx via phone or fax for enrollment and/or to provide documentation required by the manufacturer for the copay assistance program.
- Once your patient is enrolled, an HSRx Patient Advocate will contact your office to provide additional details on copay assistance claim submission and how you will receive copay assistance funds from the manufacturer.
- If required, initiate prior authorization and follow utilization review requirements in the Provider Manual. You will receive notification if the prior authorization is approved.
- Submit a medical claim to BCBSTX for primary payment.
- Follow applicable manufacturer program reimbursement procedures to obtain copay assistance funds.

More Information

- Review the TRS participant Smart RxAssist FAQs.
- If you have questions, call 1-833-798-6741 or visit SmartRxAssist.

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.

PRIOR AUTHORIZATION

Update to Prior Authorization Code Changes for Commercial Members Effective April 1, 2024

In addition to the changes effective April 1, 2024 to the Prior Authorization Codes announced on 12/15/2023, the following change is being added:

- Addition of Gene Therapy codes to be reviewed by BCBSTX for certain member plans

What's New: BCBCS is 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 (AMA) or Healthcare Common Procedure Coding System (HCPCS) changes from the Centers for Medicaid & Medicare Services.

Changes effective April 1, 2024, include:

- Addition of Genetic Testing codes reviewed by Carelon Medical Benefits Management
- Addition of Infusion Site of Care codes to be reviewed by BCBSTX
- Addition of Medical Oncology drug codes to be reviewed by Carelon
- Removal of Medical Oncology drug codes previously reviewed by Carelon
- Addition of Gene Therapy codes to be reviewed by BCBSTX for certain member plans (Added 01/08/2024)

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.

- **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.

STANDARDS & REQUIREMENTS

Federal Employee Program (FEP®) HEDIS® Medical Records Collection February - April 2024

Providers who care for our FEP members may receive medical record requests from BCBSTX as or our medical record retrieval vendor, from February through April 2024. BCBSTX collects data for Healthcare Effectiveness Data and Information Set (HEDIS) measures to help monitor FEP members' care.

How You Can Help

Either BCBSTX or our vendor will contact you by fax, phone or email to provide details about the medical records needed and how you can return them. When requested, please **provide complete and accurate records** within **5 business days** of the request.

Patient authorization isn't required to release these records, as their collection and review is considered a component of health care operations under HIPAA.

What Data We're Seeking

We collect data for HEDIS measures developed by the National Committee for Quality Assurance, including:

- High Blood Pressure Control
- Diabetes Care
  - Hemoglobin A1c Control
  - Blood Pressure Control
  - Eye Exam
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Childhood Immunizations
- Immunizations for Adolescents
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

This data helps us ensure compliance with Federal Employee Health Benefits Program requirements.

If you have questions, contact FEP Quality Improvement at 1-888-907-7918.

UTILIZATION MANAGEMENT

Utilization Management: Avoid Delays and Denied Claims

Our Utilization Management (UM) program provides BCBSTX information supporting the care you render our members**.** Our preservice review process, including required prior authorizations or optional recommended clinical reviews, use evidence-based clinical standards of care to help determine whether a benefit may be covered under the member's health plan, care and place of setting options.

Member benefits where to begin

Before rendering care or services, always check eligibility and benefits first**,** via Availity® Essentials or your preferred web vendor. In addition to verifying membership and coverage status, this step returns information on prior authorization requirements and utilization management, depending on the vendor.

Note: If you deliver care or services without a prior authorization when one is required, a post service medical necessity review will be conducted and you, not the member, would be responsible for any non-covered charges.

Reminders as you render care to BCBSTX members

- Leverage information on UM website explaining various review types needed or suggested that can help with timely payment, reduce delays and denials.
- Review member benefits for prior authorization requirements and recommended clinical reviews as they may vary based on services rendered and benefit plan
- Refer to code lists and details on how to submit.
- Reference review requirements and recommendations as they may vary based on services rendered and individual/group policy elections.

Contact Us

View our quick directory of contacts for BCBSTX.

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.

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 coverageapplicable 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, limitationsand 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 independentcompany 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 registeredtrademark of the AMA.

ClaimsXten and Clear Claim Connection are trademarks of Change Healthcare, an independent company providing coding software to BCBSTX. Change Healthcare is solely responsible for the software and all the contents.

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 Primeto 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 orservices 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.

BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors

HEDIS is a registered trademark of NCQA.

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 certificateof 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, limitationsand 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 LegalReserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

bcbstx.com/provider