BLUE REVIEW℠

For Providers

SEPTEMBER 2024

CLAIMS & ELIGIBILITY

Additional Claim Processing Enhancements for ERS Plans Effective October 21, 2024

Effective 10/21/2024, in addition to post pay audits already in place for the **Employee Retirement System of Texas** (ERS) participants, pre-payment reviews will be implemented for improved facility claim billing and payment accuracy.

CERIS, who currently performs post pay audits on behalf of Blue Cross and Blue Shield of Texas, will begin pre-payment claim reviews effective 10/21/2024 for ERS plan participants. This may help avoid refund requests handled post-pay.

As a part of the pre-pay review process, CERIS may request documentation such as an itemized bill in order to conduct the review. Documentation should be submitted to the address listed on the request letter from CERIS, not to BCBSTX.

For additional information regarding the pre-pay review performed by CERIS on behalf of BCBSTX, watch for a FAQ coming soon on the ERS Tools page.

CERIS, a CorVel Health Corporation, is an independent company contracted with Blue Cross and Blue Shield of Texas 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.

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

Before referring a Blue Choice PPO or Blue Advantage HMO (for the Blue Advantage Plus point-of-service benefit plan) member to an out-of-network provider for non-emergency services, when such services are available through an in-network provider, you must complete the appropriate Out-of-Network Care – Enrollee Notification form for **Regulated Business** (used when "TDI" is on the member's ID card) or **Non-Regulated Business** (used when "TDI" is not on the member's ID card). These are located under Forms on our provider website.

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

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

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:

- Annual Review: CPCP003 Emergency Department Services Evaluation and Management: E/M Coding – Facility Services, Effective 07/26/2024
- Annual Review: CPCP004 Neonatal Intensive Care Unit/NICU Level of Care Authorization and Reimbursement Policy Updated, Effective 07/31/2024
- Annual Review: CPCP031 - Trauma Activation- Facility Services Updated, Effective 08/01/2024
- Annual Review: CPCP001 Observation Services Policy, Effective 08/14/2024
- CPCP026 Therapeutic, Prophylactic, Diagnostic, Injection and Infusion Administration Coding Updated, Effective 11/21/2024
- Revised Coding for Consultation Services – See our Clinical Payment and Coding Policy CPCP024 Evaluation and Management Coding – Professional Services

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EDUCATION & REFERENCE

Medical Necessity Review of Observation Services

As a reminder, it's our policy to provide coverage for observation services when medically necessary based on the medical criteria outlined in the MCG Care Guidelines. Claims for observation services are subject to post-service review, and we might request medical records for the determination of medical necessity.

Language Line Supporting Cultural Competence

Language barriers between patient and providers may result in poor understanding of diagnosis, treatment, and medication instructions, which may increase the likelihood of a serious medical complication. In addition to health factors, a language barrier may cause poor patient experience [(4)]. The use of telephonic or video interpretation can improve quality of care simply by increasing access to professional interpreters to optimize communication. Refer to your local state or county agencies when providing care to patients whose primary language is not English [(3)].

Cultural Competence

- More than 67 million people in the United States speak a language other than English at home [(1)]. A third of Texans speak a language other than English at home, according to the U.S. Census Bureau. The American Academy of Family Physicians reported this population is least likely to access care or be satisfied with the care they receive. [(2)]
- Limited English proficiency complicates communication which increases the risk of adverse effects from medications and misunderstanding physician instructions or diagnosis information as noted in the American Family Physician Journal article Appropriate Use of Medical Interpreters [(2)].
- ·Results for the 2022 and 2023 BCBSTX Enrollee Experience Survey revealed a significant drop (5 percentage points) in member satisfaction with Cultural Competence directly related to translation services during a doctor or clinic appointment.

We encourage you:

- To use the language line that is available for your office as an additional resource for you and your office staff as you care for your patients.
- Attend ongoing essential language line training available to providers and your staff offered by your local and state resources when available.

(1) U.S. Census Bureau. American community survey. census.gov/programs-surveys/acs/
(2) U.S Census Bureau. data.census.gov/profile/Texas?g=040XX00US48
(3) aafp.org/afp/2014/1001/p476.html

(4) Use of Communication Technologies to Cost Effectively Increase the Availability of Interpretation Services in Healthcare Settings, ncbi.nlm.nih.gov/pmc/articles/PMC2992399/. Access August 30, 2023.

HEALTH & WELLNESS

Cancer Prevention Vaccine? The Sooner the Better

Current Centers for Disease Control and Prevention recommendations for the HPV vaccine should begin as early as 9 years of age[5], with the target of receiving two doses before age 13. The CDC recommends children ages 11–12 years get 2 doses, given 6 to 12 months apart, in most cases[4]. Only 2 doses are needed if the first dose was given before 13th birthday. Advocate for the HPV vaccination 'on the same day and in the same way' as other childhood vaccines[3].

Providers should share the following with parents to remind them how to protect their children with the HPV vaccine:

- Earlier vaccination means more opportunities to prevent cancer! It protects children long before they ever have contact with the virus. There is no way to predict which patients who have HPV will develop cancer.
- Since introduction of the HPV vaccine in 2006, the percentage of cervical pre-cancers caused by the HPV types most often linked to cervical cancer has dropped by 40% according to the Centers for Disease Control[2] .
- Cervical cancer is the fourth most common cancer in women and resulted in 350,000 deaths in 2022[1].
- With its incorporation into vaccine schedules in at least one hundred countries worldwide, along with high performance screening, the World Health Organization projects that by 2030, 90% of cancers will be treated in the pre-cancerous stage, and 90% of invasive cancers can be managed[6,7].

Parents may ask why does my child need the HPV vaccine?

- HPV can cause certain related cancers and diseases later in life including cancers of the cervix, back of the throat, anus, penis, vagina, or vulva that can potentially be avoided by vaccinating now[4]. The vaccine should be given prior to exposure to cancer-causing HPV types. There is no way to predict which patients who have HPV will develop cancer.
- It is important that both girls and boys receive the HPV vaccine. Penile cancer can occur in men. HPV has also been linked to anal, and head and neck cancers in both men and women[4].

Should I wait until my child is sexually active? Why is it important if my child isn't sexually active?
Because HPV infects about 13 million people, including teens, each year. Waiting until after exposure will not prevent transmission. Annually, about 36,000 men and women develop a cancer caused by HPV. The vaccination could prevent more than 90% of these cancers from ever developing[7].

Does HPV vaccination negatively affect fertility?
The HPV vaccine does not cause fertility problems. However, not getting the vaccine leaves people vulnerable to HPV cancers and precancers. People who develop a cancer caused by HPV will need treatment that can sometimes limit their ability to have children, such as a hysterectomy, chemotherapy, or radiation. Treatment for cervical precancer could also put women at risk for problems with their cervix, which can sometimes cause preterm delivery[7].

References:

1. World Health Organization, accessed 8/14/2024, https://www.who.int/news-room/fact-sheets/detail/cervical-cancer#:~:text=Key%20facts,350%20000%20deaths%20in%202022
2. Centers for Disease Control and Prevention, https://www.cdc.gov/hpv/vaccination-impact/index.html ; Date Accessed 8/14/2024 and Published 7/9/2024
3. Centers for Disease Control and Prevention, Date Accessed 8/14/2024 and Published November 16, 2021 ; specific website- https://www.cdc.gov/vaccines/vpd/hpv/hcp/index.html#:~:text=CDC%20encourages%20healthcare%20professionals%20to,recommend%20other%20vaccines%20for%20adolescents

4. Centers for Disease Control and Prevention, Date Accessed 8/14/2024 and Published JULY 9, 2024, https://www.cdc.gov/hpv/vaccines/index.html
5. Centers for Disease Control and Prevention, Date Accessed 8/14/2024 and Published November 16, 2021; https://www.cdc.gov/vaccines/vpd/hpv/hcp/vaccines.html#:~:text=HPV%20vaccines%20are%20highly%20immunogenic,titer%20determined%20to%20be%20protective
6. World Health Organization, (who.int). Date published 2020 & accessed 8/14/2024; https://www.who.int/publications/i/item/9789240014107
7. Centers for Disease Control and Prevention; HPV Vaccine Safety for Parents; Date Accessed 8/14/2024 and Published July 9, 2024 ; https://www.cdc.gov/hpv/vaccination-impact/index.html#:~:text=HPV%20Vaccine%20Safety%20for%20Parents

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Shared Decision-Making Aids Can Help Guide Care Choices

Shared decision-making is a communications process. It's a way for providers and patients to make informed health care decisions that align with what matters most to patients. Below are resources to help you involve your patients in shared decision-making.

These evidence-based aids provide information about treatment options, lifestyle changes and outcomes. They don't replace your guidance but can help your conversations with patients. When patients help make decisions about their health care, it can support improved patient experience, better outcomes and quality of life.

Mayo Clinic Knowledge and Evaluation Research Unit Care That Fits Tools

- Acute Myocardial Infarction Choice
- Anticoagulation Choice
- Cardiovascular Primary Prevention Choice
- Chest Pain Choice
- Depression Medication Choice
- Diabetes Medication Choice
- Graves Disease Treatment Choice
- Head CT Choice
- Osteoporosis Choice
- Percutaneous Coronary Intervention Choice
- Rheumatoid Arthritis Choice
- Smoking Cessation Around the Time of Surgery
- Statin Choice

See our Clinical Practice Guidelines page for these and other resources.

Speaking Out About the 'Silent Killer'

High blood pressure, or hypertension, is known as a "silent killer" because it usually has no warning signs. Nearly half of adults in the U.S. have hypertension, according to the Centers for Disease Control and Prevention, and only about 1 in 4 of them have the condition under control. Encourage our members to talk with you about their blood pressure and heart health.

Why Is Blood Pressure Control Important?

Controlling high blood pressure can prevent heart disease and stroke, which are among the leading causes of death in the U.S. According to the American Heart Association, blood pressure control can also reduce the risk of kidney disease, vision loss, peripheral artery disease and sexual dysfunction.

Closing Care Gaps

Controlling high blood pressure is recognized as a quality measure by the National Committee for Quality Assurance. The NCQA recommends controlling both the systolic blood pressure and diastolic blood pressure in adults as follows:

- SBP < 140 mmHg and DBP < 90 mmHg

View our clinical practice guidelines on hypertension.

Best Practices
Best practices include talking with members about:

- Taking medications as prescribed
- Smoking cessation
- Increased physical activity
- Maintaining a healthy weight
- Limiting alcohol intake
- Eating a low-sodium diet
- Returning for follow-up visits. Reach out to members who cancel or miss appointments and assist them with rescheduling as soon as possible.

Best practices also include using the proper codes when filing claims. Proper coding can help identify gaps in care, provide accurate data and streamline your administrative processes.

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.

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.

MEDICARE ADVANTAGE PLANS

Encourage Medicare Members to Respond to Health Outcomes Survey

The Centers for Medicare & Medicaid Services sends a Health Outcomes Survey to a sample of our members from August through November. The survey asks members in Blue Cross Medicare Advantage℠ and prescription drug plans to rate their last six months of care.

If you get questions from members who have received the survey, **please encourage them to respond**. The survey covers health care topics our members may discuss with you, such as:

- Maintaining or improving physical health, including managing pain and exercise habits
- Maintaining or improving mental health, including energy levels, mood swings and sleeping habits
- Preventing falls

HOS results identify opportunities to improve health care plans. Results also affect the CMS Star Ratings, which rate Medicare Advantage plans on a scale from one to five stars. Our goal is to achieve the highest possible Star rating for our plans.

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

What's changing: We are changing prior authorization requirements for Blue Cross Medicare Advantage members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association.

Changes, effective Oct. 1, 2024, include **addition of lab codes to be reviewed by eviCore healthcare**. Refer to our updated Prior Authorization Lists for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ available our provider website. You can also review how to submit requests on the Utilization Management page.

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.

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)℠

All Blue Cross Medicare Advantage plans participate in reciprocal network sharing, which allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO plan if the member sees a contracted BCBS MA PPO provider.

For more information, refer to this Blue Cross Medicare Advantage PPO Supplement.

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

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.

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.

PHARMACY

Pharmacy Program Quarterly Update Changes Effective Oct. 1, 2024 – Part 1

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

Pharmacy Benefits

As a participating practitioner, you are given a list of drugs that we review and update throughout the year. For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for the drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines. For more information, visit the Pharmacy Program page on our provider website. For Federal Employee Program® members, information can be found at fepblue.org/pharmacy. We encourage you to check our provider website regularly and watch for updates in this newsletter.

The following information is available on our website:

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

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UTILIZATION MANAGEMENT

Medical Policy Updates

When policies are posted: New or revised medical policies, when approved, may be posted on our provider website (under Standards and Requirements) on the 1st or 15th of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted. To streamline the review process, you can view medical policy drafts and provide your feedback online. If there are any draft medical policies to review, they will be made available around the 1st and 15th of each month with a review period of approximately two weeks.

Related information: Refer to the Recommended Clinical Review Option page for information on submitting a request for review of your services before rendering the service. Also, other policies and information regarding payment can be found on the Clinical Payment and Coding Policies page.

Recommended Clinical Review Services and Code List Changes for Certain Members

Periodically, as often as monthly, we update our lists of services and procedure codes that are available for Recommended Clinical Review (for some commercial members) to reflect new, replaced or removed codes. These changes are based on updates from our Utilization Management team's 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 Medicare & Medicaid Services.

Accessing RCR lists: To avoid post-service medical necessity reviews and minimize delays in claim processing, providers should refer to the RCR inpatient services and outpatient code lists on our Recommended Clinical Review Option webpage prior to rendering services. If services are performed that do not meet medical necessity criteria, they may be denied for payment and the rendering provider may not seek reimbursement from the member.

Check eligibility and benefits: Providers should check eligibility and benefits through Availity® Essentials or their preferred vendor. The site may also indicate if a service requires prior authorization or an RCR.

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.

Reminder: Update to Recommended Clinical Review Effective Sept. 1, 2024, for ERS Plans
As announced on May 31, effective for dates of services on or after Sept. 1, 2024, Blue Cross and Blue Shield of Texas (BCBSTX) is removing all prior authorization requirements for the Employee Retirement System of Texas (ERS) medical plans, including HealthSelect of Texas® and Consumer Directed HealthSelect℠.

Recommended Clinical Reviews
Services previously requiring prior authorization, as well as other certain services needing medical necessity review, can be submitted as a **Recommended Clinical Review (RCR)** prior to rendering services.

Submitting an RCR request prior to rendering services informs you of situations where a service may not be covered based upon medical necessity or other plan rules. RCR will replace post-service review for medical necessity when an RCR is completed.

Refer to the ERS RCR List for services that are available for RCR as well as determining whether you should submit the request to medical management at BCBSTX or Carelon Medical Benefits Management. Providers submitting RCR requests for services managed by BCBSTX for ERS participants will have the option of submitting the request electronically via Availity® Authorization & Referrals tool or effective Sept. 3, 2024, via BlueApprovR℠.

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

NICU Notification Change
ProgenyHealth will be delegated for all neonatal intensive care unit (NICU) admissions and concurrent reviews as of Sept. 1, 2024. 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.

Providers can notify ProgenyHealth for NICU admissions and concurrent care via fax at **(855) 732-8182**. ProgenyHealth will perform utilization management and discharge planning throughout the inpatient stay. **ProgenyHealth is hosting a webinar on Aug. 29, 2024 at 12:00 PM.** Register here**.**

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.

Reminder: Recommended Clinical Review for Outpatient Services Effective Sept. 1 for TRS Participants

As announced on May 31, 2024, Blue Cross and Blue Shield of Texas is moving prior authorization to **Recommended Clinical Review Option for outpatient services** for **Teacher Retirement System of Texas Administrative Services Only participants.** Inpatient services were previously moved to RCR. Outpatient prior authorization for **fully insured TRS** plans is not changing**.** Fully Insured plans will indicate "TDI" on their ID card.

Providers can refer to the Teacher Retirement System of Texas Recommended Clinical Review list on the provider website for the services applicable to RCR.

Providers are encouraged to submit an RCR for services that previously required prior authorization to prevent post service medical necessity reviews.

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.

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 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.

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

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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 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