

Physician and other Professional Provider Roles and Responsibilities

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Note:

Physicians and other Professional Providers who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group for instructions regarding referral and precertification process, contracting and claims related questions. Additionally, Physicians or other Professional Providers who are not part of a capitated IPA/Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated IPA/Medical Group must also contact the applicable IPA/Medical Group for instructions. Physicians or other Professional Providers who are contracted/affiliated with a capitated IPA/Medical Group are subject to that entity's procedures and requirements for Physician or other Professional Provider complaint resolution.

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Physician and other Professional Provider Roles and Responsibilities, continued

HMO Blue Texas ID Card

The member's identification card (ID card) provides information concerning eligibility and contract benefits, and is essential for successful claims filing. The alpha prefix is a critical part of the ID number and identifies what group benefits apply. When submitting a claim the alpha prefix should always be entered as it appears on the ID card. If the correct alpha prefix is not provided, the claim may be unnecessarily delayed or denied.

Using the ID Card

Each member receives an identification card (ID card) upon enrollment. Refer to the samples shown on the following page. This card is issued for identification purposes only and does not constitute proof of eligibility. Physicians or other Professional Providers should check to make sure the current group number is included in the member's records. A copy of the front and back of the ID card is also suggested.

The ID card should be presented by the member each time services are rendered. The ID card displays:

- The member's unique identification number
- The employer group number through which coverage is obtained
- The current coverage date
- Plan number
- The name, provider record, and telephone number of the Primary Care Physician selected by the member
- The PORG of the Primary Care Physician's Provider Network, if applicable
- Some (most common) applicable copayments.

The member is required to report immediately to HMO Blue Texas Customer Service any loss or theft of his/her ID card. A new ID card will be issued. The member is also required to notify HMO Blue Texas within 30 days of any change in name or address. HMO Blue Texas members are also required to notify HMO Blue Texas Customer Service regarding changes in marital status or eligible dependents.

The member is not allowed to let any other person use his/her HMO Blue Texas ID card for any purpose.

Department of Insurance (DOI) Requirements

TDI requires carriers to identify members who are subject to the requirements of prompt pay legislation. ID cards that reflect an indicator "TDI" signify members who are subject to the requirements of prompt pay legislation.

Other Information


Much of the information you will need is printed on the face and reverse side of your patient's ID card. Please note the copay amount is on the face of the card. Please call Provider Customer Service at **1-877-299-2377** if you have questions.


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Physician and other Professional Provider Roles and Responsibilities, continued

HMO Blue Texas ID Card

Pictured below is a sample of the HMO Blue Texas Member ID card.

		BlueCross BlueShield		HMO Blue[®] Texas	
www.bcbstx.com					
Subscriber	FirstName M. Lastname				
Member Name	Joe Doe				
Identification No.	ABC111223333-00				
Effective Date	01-01-01	Group No.	38158A		
			BC Plan 400 BS Plan 900		
PCP	PCP Name		Dental Rider		
\$15	Specialist Copay		POrg (972) 287-7287		
\$15	PCP OFFICE VISIT	\$5	GENERIC DRUG		
\$5	URGENT CARE CENTER	\$7	PREFERRED DRUG		
\$50	EMERGENCY ROOM	TDI \$20	NON-PREFERRED DRUG		



PROVIDERS: To precertify medical services, call 1-800-441-9188. For referral and precertification of mental health care and chemical dependency treatment, call 1-800-729-2422.

If Rx copays are shown on reverse side, use:

Prime Therapeutics: RxBIN 011552 RxBIN BCTX

For Customer Service information, call the claims or customer service telephone listed below.

For claims or customer service information, call 1-877-299-2377.

Claims should be mailed to:
HMO Blue Texas, P.O. Box 680044, Dallas, Texas 75268-0044.

For Dental Customer Service Call: 1-877-854-2583

For Guest Membership: 1-888-522-2396

For BlueCard Access: 1-800-810-BLUE

BlueCard Provider Eligibility: 1-800-678-BLUE
www.bcbstx.com

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

Fully Insured FMT 056

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Physician and other Professional Provider Roles and Responsibilities, continued

Member Eligibility Questions

To confirm eligibility and benefits, the HMO Blue Texas participating Physician or other Professional Provider may contact HMO Blue Texas Customer Service by calling the appropriate number listed below. When the member does not present an ID card, a copy of the enrollment application or a temporary card may be accepted. HMO Blue Texas also recommends that the member's identification be verified with a photo ID and that a copy be retained for his/her file. Capitated Primary Care Physicians may reference their member PCP eligibility list distributed by HMO Blue Texas.

HMO Blue Texas
1-877-299-2377

Employees of BCBSTX and dependents
1-888-662-2395

Eligibility Statement

HMO Blue Texas complies with the Eligibility Statement Legislation. For additional information on this legislation, please refer to the Texas Department of Insurance (TDI) Web site at www.tdi.state.tx.us.

Newborns

Newborns of HMO Blue Texas members are covered for an initial period of 31 days. Coverage continues beyond the 31 days only if the member notifies HMO Blue Texas within 31 days of the birth and pays any additional premium owed. The effective date of coverage will be the date of birth. Newborns of HMO Blue Texas dependents are subject to eligibility requirements established by each employer group and may not be automatically covered for the first 31 days.

Covered Services

HMO Blue Texas has multiple benefit plan options and riders available to employer groups. Members of HMO Blue Texas are entitled to receive an array of benefits as part of the basic benefit plan, which includes preventive care. Different types of services can have different levels of coverage and copayments can vary by plan.

The member is required to pay a copayment, if applicable, at the time services are rendered.

Note: HMO copayment(s) for basic services shall not exceed fifty percent (50%) of the cost (contract allowable) for covered services.

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Physician and other Professional Provider Roles and Responsibilities, continued

Verification

Under the Prompt Pay Legislation, providers of service have the right to request verification that a particular service will be paid by the insurance carrier.

Verification as defined by the Texas Department of Insurance (TDI) is a guarantee of payment for health care or medical care services if the services are rendered within the required timeframe to the patient for whom the services are proposed.

Verification Procedure

To initiate a request for verification, please contact HMO Blue Texas Provider Customer Service Department at **1-800-299-2377** and select the prompt for verification.

Note: Please be advised that verification is not applicable for all enrollees or providers. Routine eligibility check and benefit information may still be obtained when verification is not applicable.

The verification process includes researching eligibility, benefits, and authorizations. HMO Blue Texas will respond to the Physician's or other Professional Provider's request with one of the following letters within the required timeframes:

- Request for Additional Information
 - Verification Notice
 - Declination Notice
-

Delegated Entity Responsible for Claim Payment

Requests for verification of HMO services will be issued by HMO Blue Texas only if the claim processing will be performed by HMO Blue Texas. If your request is for a service covered under a capitated independent physician association (IPA), medical group, or other delegated entity responsible for claim payment, please make your request for verification directly to the appropriate IPA or entity.

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Physician and other Professional Provider Roles and Responsibilities, continued

Required Elements to Initiate a Verification

The 13 required elements a Physician or other Professional Provider needs to supply in order to initiate a verification are as follows:

- 1) patient name
- 2) patient ID number
- 3) patient date of birth
- 4) name of enrollee or member
- 5) patient relationship to enrollee or member
- 6) presumptive diagnosis, if known, otherwise presenting symptoms
- 7) description of proposed procedure(s) or procedure code(s)
- 8) place of service code where services will be provided and if place of service is other than Physician's or other Professional Provider's office or Physician's or other Professional Provider's location need name of hospital or facility where proposed service will be provided
- 9) proposed date of service
- 10) group number
- 11) if known to the Physician or other Professional Provider, name and contact information of any other carrier, including
 - a) other carrier's name
 - b) address
 - c) telephone number
 - d) name of enrollee
 - e) plan or ID number
 - f) group number (if applicable)
 - g) group name (if applicable)
- 12) name of the Physician or other Professional Provider providing the proposed services
- 13) Physician's or other Professional Provider's National Provider Identifier (NPI) number

Note: In addition to the required elements, please be prepared to provide a referral or precertification number for those services which require an authorization. Please also provide your office fax number for your written confirmation. This will expedite HMO Blue Texas' response.

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Physician and other Professional Provider Roles and Responsibilities, continued

Declination

Insurance carriers have the right to decline verification to a provider of service. Declination as defined by the Texas Department of Insurance (TDI) is a response to a request for verification in which an HMO or preferred provider carrier does not issue a verification for proposed medical care or health care services. A declination is not a determination that a claim resulting from the proposed services will not ultimately be paid.

Some examples of reasons for declination may include, but are not limited to:

1. Policy or contract limitations:
 - a. premium payment timeframes that prevent verifying eligibility for 30-day period
 - b. policy deductible, specific benefit limitations or annual benefit maximum
 - c. benefit exclusions
 - d. no coverage or change in membership eligibility, including individuals not eligible, not yet effective or membership cancelled.

A declination is simply a decision that a guarantee cannot be issued in advance, not a determination that a claim will not be paid. If a declination is given, Physicians and other Professional Providers cannot bill the member at the time of service except for the applicable copayments, deductible or coinsurance amounts.

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Physician and other Professional Provider Roles and Responsibilities, continued

Additional Fees Charged By Participating Physicians and other Participating Professional Providers Beyond Copayments and Coinsurance

- HMO Blue Texas does **not** support the practice of participating physicians and other participating professional providers charging members additional fees beyond required copayments and coinsurance.
- HMO Blue Texas physician and other professional provider agreements support the concept of physicians and other professional providers treating members in the same manner as all other patients. HMO Blue Texas members should be treated in accordance with the same standards, and within the same time availability as such services are provided to other patients, and without regard to the degree or frequency of utilization of such services.
- Notwithstanding the above, if a participating physician or other participating professional provider charges additional fees to its entire population of patients in the same manner for **non-covered services**, and the HMO Blue Texas member agrees in writing to accept payment responsibility for **the non-covered service** prior to receiving that service, then it would be appropriate to charge the member for the service. The member must acknowledge this agreement in writing and agree to accept payment responsibility for the specific service to be rendered.
- A participating physician and other participating professional provider cannot require HMO Blue Texas members to pay any type of "access fee" as a prerequisite to receiving services that are covered under member benefit plans.

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Physician and other Professional Provider Roles and Responsibilities, continued

Introduction Physician and other Professional Provider roles and responsibilities will differ among the various specialties; however, certain responsibilities will be shared by all HMO Blue Texas Physicians or other Professional Providers.

Role of the Primary Care Physician The member must contact his/her Primary Care Physician (family practice, general physician, internal medicine or pediatrician) for all of his/her health care needs, other than obstetrics and gynecology. For information on behavioral health services, refer to Section I, Behavioral Health Services of the HMO Blue Texas Provider Manual, for more detail.

Each Primary Care Physician is responsible for making his/her own arrangements for patient coverage when out of town or unavailable.

A Physician who has contracted with HMO Blue Texas as a Primary Care Physician will agree to render to the HMO Blue Texas member primary, preventive, acute and chronic health care management and:

- Provide the same level of care to HMO Blue Texas patients as provided to all other patients.
 - Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. PCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
 - Be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to members. Such requests must be responded to within one hour.
 - Keep a central record of the member's health and health care that is complete and accurate.
 - Refer the member to Specialty Care Physicians or other Professional Providers within the same Provider Network.
 - Complete referrals and precertifications through the iEXCHANGE System at <http://www.bcbstx.com/provider> or by calling **1-800-413-0869** unless otherwise instructed to call the Utilization Management Department. Department phone numbers and addresses are listed in Section C of this guide. Refer to the detailed information and instructions in Sections C & E for more information on the iEXCHANGE System for referrals and precertifications.
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Physician and other Professional Provider Roles and Responsibilities, continued

Role of the Primary Care Physician, continued

- Provide copies of X-ray and laboratory results and other health records to Specialty Care Physicians or other Professional Providers to enhance continuity of care and to preclude duplication of diagnostic procedures.
- Provide copies of medical records when requested by HMO Blue Texas for the purpose of claims review, quality improvement or auditing.
- Enter into the member's health record all reports received from Specialty Care Physicians or other Professional Providers.
- Assume the responsibility for arranging and preauthorizing hospital admissions in which he/she is the admitting Physician or delegate this responsibility to the admitting Specialty Care Physician or other Professional Provider.
- Assume the responsibility for care management as soon as possible after receiving information that a member on his/her Primary Care Physician list has been hospitalized in the local area on an emergency basis.
- Coordinate inpatient care with the Specialty Care Physician or other Professional Provider so that unnecessary visits by both Physicians are avoided.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the HMO Blue Texas patient in accordance with Texas Department of Health standards.
- Cooperate with HMO Blue Texas for the proper coordination of benefits involving covered services and in the collection of third party payments including workers' compensation, third party liens and other third party liability. HMO Blue Texas contracted Physicians or other Professional Providers agree to file claims and encounter information with HMO Blue Texas even if the Physician or other Professional Provider believes or knows there is a third party liability.
- Only bill HMO Blue Texas members for copayments, cost share (coinsurance) and deductibles, where applicable. Primary Care Physician will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member's insurance coverage.
Note: HMO copayment(s) for basic services shall not exceed fifty percent (50%) of the cost (contract allowable) for covered services.

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Physician and other Professional Provider Roles and Responsibilities, continued

**Role of the
Primary
Care
Physician,**
continued

- Agrees to use his/her best efforts to participate with BCBSTX's Plan's Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.
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Physician and other Professional Provider Roles and Responsibilities, continued

Back up PCPs The Primary Care Physician designates backup (covering) Primary Care Physicians during the network application process.

Note: If the Primary Care Physician is capitated, then the backup Physician should seek reimbursement directly from that PCP. The covering Physician is responsible for filing a claim for any member seen on behalf of the PCP. **The Primary Care Physician's staff must report any upcoming changes in covering Primary Care Physicians to their local Professional Provider Network office.**

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Physician and other Professional Provider Roles and Responsibilities, continued

Referrals to Specialty Care Physicians or other Professional Providers

Referrals to Specialty Care Physicians or other Professional Providers, except OBGyns, must be initiated by the Primary Care Physician. It is essential that the Primary Care Physician refer HMO Blue Texas members requiring specialty care to HMO Blue Texas participating Physicians or other Professional Providers within the same Provider Network, if applicable.

A Primary Care Physician may not refer to himself/herself as a Specialty Care Physician or other Professional Provider when treating the member who is already on his/her Primary Care Physician list.

Refer to the detailed information and instructions in Section D of this Provider Manual that discusses the iEXCHANGE system for referrals.

Once the iEXCHANGE system issues a confirmation number to the Primary Care Physician for the referral to the Specialty Care Physician or other Professional Provider, the system will automatically generate notification letters to the Specialty Care Physician or other Professional Provider and to the HMO Blue Texas member.

The Primary Care Physician may provide the HMO Blue Texas member with the iEXCHANGE referral confirmation number to take to appointments with the Specialty Care Physician or other Professional Provider or the Specialty Care Physician or other Professional Provider can access the iEXCHANGE system to obtain the referral confirmation number.

If the Specialty Care Physician or other Professional Provider determines that an HMO Blue Texas member needs to be seen by another Specialty Care Physician or other Professional Provider, the HMO Blue Texas member must be referred back to the member's Primary Care Physician.

Note: The Specialty Care Physician or other Professional Provider cannot refer to other Specialty Care Physicians or other Professional Providers.

(EXCEPTION: OBGyn Physicians have the ability to directly manage and coordinate a woman's care for obstetrical and gynecological conditions, including obtaining referrals through iEXCHANGE for obstetrical/gynecological related specialty care and testing to other HMO Blue Texas participating Physicians that participate in the same Provider Network as the member's Primary Care Physician, if applicable.)

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Physician and other Professional Provider Roles and Responsibilities, continued

Role of the Specialty Care Physician or other Professional Provider

An HMO Blue Texas participating Physician or other Professional Provider who provides services as a Specialty Care Physician (SCP) or other Professional Provider is expected to:

- Provide the same level of care to HMO Blue Texas patients as provided to all other patients.
- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. SCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Keep a central record of the member's health and health care that is complete and accurate.
- Accept referrals for HMO Blue Texas members in accordance with the services and number of visits requested by the Primary Care Physician in the same Provider Network, if applicable.
- Report back to the Primary Care Physician upon completion of the consultation/treatment.
- Provide copies of X-ray and laboratory results and other health record information to the member's Primary Care Physician as appropriate.

Additionally,

- If additional services and/or visits are needed, beyond those authorized by the Primary Care Physician through the IEXCHANGE System or the Utilization Management Department, a new referral authorization must be obtained from the Primary Care Physician.
- If authorized by the Primary Care Physician, arrange for hospital admission of the HMO Blue Texas member into a participating Facility through the Utilization Management Department and assume responsibility for completion of steps required by HMO Blue Texas to precertify the admission.

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Physician and other Professional Provider Roles and Responsibilities, continued

Role of the Specialty Care Physician or other Professional Provider, continued

- Coordinate inpatient care with the Primary Care Physician so that unnecessary visits by other Physicians or other Professional Providers are avoided.
- Provide inpatient consultation within 24 hours of receipt of request. Emergency consultation to be provided as soon as possible.
- Provide copies of medical records when requested by HMO Blue Texas for the purpose of claims review or auditing.
- Return the member to the care of the referring HMO Blue Texas Primary Care Physician as soon as medically feasible.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the HMO Blue Texas patient in accordance with Texas Department of Health standards.
- Cooperate with BCBSTX for the proper coordination of benefits involving covered services and in the collection of third party payments including workers' compensation, third party liens and other third party liability. BCBSTX contracted Physicians agree to file claims and encounter information with BCBSTX even if the Physician believes or knows there is a third party liability.
- Only bill HMO Blue Texas members for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty Care Physician or other Professional Provider will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member's insurance coverage.
Note: HMO copayment(s) for basic services shall not exceed fifty percent (50%) of the cost (contract allowable) for covered services.
- Agrees to use his/her best efforts to participate with BCBSTX's Plan's Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.

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Physician and other Professional Provider Roles and Responsibilities, continued

Specialist as a Primary Care Physician

Any HMO Blue Texas member with chronic, disabling or life-threatening illnesses may apply to the HMO Blue Texas Medical Director to utilize a Specialty Care Physician or other Professional Provider as a Primary Care Physician (PCP), provided that:

- The request for the Specialty Care Physician or other Professional Provider includes certification of medical need, along with all applicable supporting documentation, and is signed by the HMO Blue Texas member and the Specialty Care Physician or other Professional Provider interested in serving as the Primary Care Physician.
- The Specialty Care Physician or other Professional Provider must meet HMO Blue Texas requirements for Primary Care Physician participation. Refer to Section B, pages 10-14, Role of the Primary Care Physician. The Specialty Care Physician or other Professional Provider is willing to coordinate all the HMO Blue Texas member's health care needs and accept HMO Blue Texas reimbursement.
- All Physicians or other Professional Providers participating in HMO Blue Texas must have a current Texas license, be in good standing with the licensing board, the Provider Network and its hospital affiliates and Blue Cross and Blue Shield of Texas, plus meet other credentialing criteria established by HMO Blue Texas.
- If the request for special consideration is approved by HMO Blue Texas, the local Professional Provider Network Representative contacts the specialist within 30 days of receiving the request to educate them on the role and responsibilities of the PCP, preventive care guidelines, claim filing instructions and discuss reimbursement. They will also provide a current directory of participating specialists and professional providers.
- The Medical Care Management IQMP staff will send written notification of the approval, to include the effective date [first (1st) day of the month following the approved decision] to the member within 30 calendar days of receiving the request for special consideration.
- If the request for special consideration is denied by HMO Blue Texas, the HMO Blue Texas medical director sends a denial letter within 30 days of receiving the request explaining the denial and the member's right to appeal the decision through the HMO Blue Texas Complaint Process.
- The effective date of the new designation of the non-primary care specialist will not be retroactive and may not reduce the amount of the compensation owed to the original Primary Care Physician for services provided before the date of the new designation.

For further details, contact HMO Blue Texas Customer Service at:

1-877-299-2377

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Physician and other Professional Provider Roles and Responsibilities, continued

Role of OBGyn

A female HMO Blue Texas member has direct access to an HMO Blue Texas participating OBGyn *participating in the same Provider Network as her Primary Care Physician*. The access to health care services of an obstetrician or gynecologist, includes, but is not limited to:

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions
- Diagnosis, treatment and referral to a specialist who participates in the same Provider Network as the member's Primary Care Physician, for any disease or condition within the scope of the designated professional practice of a credentialed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts.

Any female HMO Blue Texas member may access an HMO Blue Texas participating OBGyn Physician *participating in the same Provider Network as her Primary Care Physician* without obtaining a referral from her Primary Care Physician **or** calling HMO Blue Texas.

When abnormalities are discovered, the HMO Blue Texas participating OBGyn has the ability to directly manage and coordinate a woman's care for obstetrical and gynecological conditions including issuing referrals for obstetrical/gynecological related specialty care and testing to other HMO Blue Texas participating Physicians or other Providers *who participate in the same Provider Network as the member's Primary Care Physician*.

If the OBGyn Physician has issued a referral to another Specialty Care Physician or other Professional Provider and additional follow-up visits are necessary for the subscriber to see the Specialty Care Physician or other Professional Provider, the OBGyn Physician is responsible for issuing a new referral or extending the original referral and obtaining referral authorization through the iEXCHANGE System.

Services for all other conditions must be coordinated through the HMO Blue Texas member's Primary Care Physician. Also, any services rendered outside of the OBGyn's office, such as ultrasound and mammograms, must be performed by Facilities contracted in the same Provider Network as the member's Primary Care Physician.

Note: Non-prescription contraceptives and associated care vary by employer benefit program. To check coverage for this type of service, call HMO Blue Texas Customer Service.

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Physician and other Professional Provider Roles and Responsibilities, continued

Notification of Obstetrical and Newborn Care

After the first prenatal visit, the HMO Blue Texas network participating Physician's office should provide notification of the HMO Blue Texas member's obstetrical care through the iEXCHANGE System. OB ultrasounds may be performed in the Physician's office and do not require precertification.

Extensions beyond the normal length of stay (48 hours for a vaginal delivery and 96 hours for a C-Section) require precertification through the IEXCHANGE System.

Note:

- Maternity care is subject to a one-time office visit copayment. This copayment should be collected at the time of the initial OB office visit.
- Physicians will be reimbursed for the initial OB visit separately from the "global maternity care" and should submit a claim for this service at the time of the initial OB visit.
- All subsequent office visits for maternity care and delivery are considered as part of the "global maternity care" reimbursement. Submit claim upon delivery.

FIRST OBSTETRIC VISIT

Please refer to the current edition of the Current Procedural Terminology in the Maternity Care and Delivery section for guidelines for billing. If a Physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy by abortion or referral to another Physician for delivery, see the antepartum and postpartum care codes 59425-59426 and 59430. For one to three care visits see the appropriate Evaluation and Management code(s).

Predetermination Requests

The Predetermination Request Form and instructions can be accessed online at the following address:

http://www.bcbstx.com/provider/downloadable_forms.htm

Mail completed form to:

Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044
Attn: Predetermination Department

For Status Call:

1-800-451-0287 for PPO/POS
1-877-299-2377 for HMO Blue Texas

For Urgent Requests Only Fax to: 1-888-579-7935

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Physician and other Professional Provider Roles and Responsibilities, continued

Physician or other Professional Provider Complaint Procedure

HMO Blue Texas participating Physicians and other Professional Providers are urged to contact Customer Service when there is an administrative question, problem, complaint or claims issue. To appeal a Utilization Management medical necessity determination, contact the Utilization Management Department.

Utilization Management decisions may be formally appealed by phone, fax, or in writing. For appeals of denied claims, refer to the Filing Claims section in this Provider Manual.

An HMO Blue Texas participating Physician or other Professional Provider may contact the Texas Department of Insurance (TDI) to obtain information on companies, coverage, rights or complaints at **1-800-252-3439** or the Physician or other Professional Provider may write the Texas Department of Insurance (TDI) at the following address:

Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091
FAX : (512) 475-1771
www.tdi.state.tx.us

For all other inquiries, please contact your local Professional Provider Network Representative.

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Physician and other Professional Provider Roles and Responsibilities, continued

Provider Record Information, Changes in Your Status or Changes Affecting Your Provider Record

You may submit changes to BCBSTX by clicking on the “Change Your Information” icon at www.bcbstx.com/provider, calling Provider Administration at **1-972-996-9610, press 3**, or contacting your local Professional Provider Network office. Please notify us of changes to the following information:

- Name
- Physical address (primary, secondary, tertiary)
- Billing address
- E-mail address
- Telephone number
- Tax ID or other information
- Specialty or sub-specialty
- Practice information/status
- Board certification
- NPI Number change
- TIN/SS number change
- Moving from Group to Solo practice
- Moving from Solo to Group practice
- Moving from Group to Group practice
- Back up/covering Physicians or other Professional Providers

Note: If requesting termination from a Network, please contact your local Professional Provider Network office.

You should submit all changes at least 30 days in advance of the effective date of the change. Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new provider record.

Reminders:

- BCBSTX will not change, add or delete information related to your provider record on a retroactive basis. All changes to your provider record will be effective with a future date.
- All provider record effective dates will be established as of the date that complete applications are received in the corporate BCBSTX office. This will apply to all additions, changes and cancellations.
- Retroactive provider record effective dates will not be established.
- Retroactive network participation effective dates will not be established.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Provider Record Information, Changes in Your Status or Changes Affecting Your Provider Record,
continued

- Provider record questions or to obtain a provider record application, please contact Provider Administration at **1-972-996-9610, press 3.**
- An application for a provider record **does not** constitute a request for participation in the HMO Blue Texas network. Submission (by fax or mail) of a fully completed Texas Standardized Credentialing Application packet, which includes the following information, is required:
 1. Texas Standardized Credentialing Application* and all applicable attachments,
 2. Hospital Referral Letter*,
 3. Signed HMO Blue Texas agreement

Fax to: Provider Administration (*preferred method*)
972-996-8230

or

Mail to: Blue Cross and Blue Shield of Texas
Attn: Provider Administration
P.O. Box 650267
Dallas, TX 75265-0267

*Located on the BCBSTX Provider Web site at www.bcbstx.com/provider, under Credentialing/Contracting, click on the Provider Record/Credentialing bullet.

Keeping BCBSTX informed of any changes you make allows for appropriate claims processing, as well as maintaining the HMO Blue Texas Provider Directory with current and accurate information.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Failure to Establish Physician or other Professional Provider Patient Relationship – Performance Standard

Reasons a Physician or other Professional Provider may terminate his/her professional relationship with a member include, but are not limited to, the following:

- Fraudulent use of services or benefits;
- Threats of physical harm to a Physician or other Professional Provider or office staff;
- Non-payment of required copayment for services rendered or applicable coinsurance and/or deductible;
- Evidence of receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or necessary;
- Refusal to accept a treatment or procedure recommended by the Physician or other Professional Provider, if such refusal is incompatible with the continuation of the Physician or other Professional Provider and member relationship (Physician or other Professional Provider should also indicate if he/she believes that no professionally acceptable alternative treatment or procedure exists);
- Repeated refusal to comply with office procedure in accordance with acceptable community standards;
- Other behavior resulting in serious disruption of the Physician or other Professional Provider/patient relationship.

Reasons a Physician or other Professional Provider may not terminate his/her professional relationship with a member include, but are not limited to, the following:

- Member's medical condition (i.e., catastrophic disease or disabilities);
- Amount, variety, or cost of covered health services required by the member; patterns of overutilization, either known or experienced;
- Patterns of high utilization, either known or experienced.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Procedures

When BCBSTX Professional Provider Network Department, receives preliminary information indicating a contracted Physician or other Professional Provider has deemed it necessary to terminate a relationship with a member, the BCBSTX Professional Provider Network Department will:

1. Review with the Physician or other Professional Provider, the following important points:
 - a. Refer to the Performance Standard section above – and if necessary explain why he/she may not terminate his/her relationship with a member.
 - b. Determine the effective date of termination based on the following: The effective date must be no less than 30 calendar days from the date of the provider's notification letter to the member. Exceptions: 1) If the provider is an HMO Blue Texas PCP, the term date must be the last day of the month following the initial 30 calendar days timeframe (due to monthly capitation arrangement with some PCPs); 2) Immediate termination may be considered if a safety issue or gross misconduct is involved – must be reviewed and approved by BCBSTX.
 - c. A notification letter from the Physician to the member is required and must include:
 - Name of member(s) – if it involves a family, list all members affected;
 - Member identification number(s);
 - Group number; and
 - Effective date of termination (as determined based on the above).
 - d. A copy of the letter to the member must be sent simultaneously to the applicable HMO Blue Texas Professional Provider Network Representative (or Director), via e-mail, or by fax or regular mail to the appropriate BCBSTX Professional Provider Network area office.

A list of the BCBSTX "Professional & Facility Provider Network Offices" including fax numbers and addresses is available by accessing the BCBSTX Provider Web site (link below) and clicking on "Contact Us" in the screen/page header to the far right.

<http://www.bcbstx.com/provider/>

Note: A sample Physician or other Professional Provider letter is available on page B-26.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Procedures, continued

- e. The Physician or other Professional Provider must continue to provide medical services for the member until the termination date stated in the provider's letter. If the Physician or other Professional Provider is a PCP, he/she may refer the member to another Network Physician or other Professional Provider. If the PCP is affiliated with an IPA/Medical Group, he/she may refer the member to a Physician within the IPA/Medical Group. Having a referral on file, if required, will assure the member continues to receive covered benefits until a new PCP is selected and effective.

When BCBSTX Professional Provider Network Department, receives a copy of the Physician's or other Professional Provider's letter to the member, the BCBSTX Professional Provider Network Department will:

1. Contact the Physician to confirm receipt of the letter, review important points outlined above, and address any outstanding issues if applicable.
2. Forward the Physician's or other Professional Provider's letter to the applicable BCBSTX Customer Service area and they will:
 - Send a letter to the member, 30 days prior to the termination date, which will include a new designated PCP or outline steps for the member to select a new PCP (or SCP if applicable).
 - Send a follow-up resolution letter to the Physician or other Professional Provider (or IPA/Medical Group if applicable).

If the Physician or other Professional Provider Agrees to Continue to See the Member:

If the member appeals the termination directly with the Physician or other Professional Provider and the Physician or other Professional Provider agrees to continue to see the member, the Physician or other Professional Provider must immediately:

- Notify HMO Blue Texas in writing of his/her approval to reinstate the member to his/her panel (so that BCBSTX Customer Service can re-assign the PCP to the member if the member requests such, and/or to prevent any future miscommunication).

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Sample of Letter from Physician or other Professional Provider to Member

Current Date

Patient Name*

Address

City/State/Zip

Phone Number

HMO Blue Texas Member Number

Group Number

Dear Patient:

I will no longer be providing services to you as a ____ (*insert Primary Care Physician or Specialty Care Physician*). I will continue to be available to you for your health care until ____ (*date*). (**Note:** *end date must be no less than 30 calendar days from the date of this letter, and if the physician is an HMO Blue Texas PCP the end date must be the last day of the month following the initial 30 days*). After this date, I will no longer be responsible for your medical care.

Upon proper authorization I will promptly forward a copy of your medical record to your new Physician or other Professional Provider. The BCBSTX Customer Service Department is available to assist you in selecting another physician to provide your care. Please call the customer service phone number listed on the back of your member identification card.

Sincerely,

John Doe, M.D.

cc: BCBSTX Professional Provider Network Department

*If the Physician or other Professional Provider is terminating the relationship with a family, all member names should be listed in this area.

Physician and other Professional Provider Roles and Responsibilities, continued

Panel Closure

Each HMO Blue Texas member shall select a Primary Care Physician (PCP) in accordance with the procedures set forth in the Membership Agreement. Individual PCP, Medical Group or Medical Group PCP agrees to accept HMO Blue Texas members who have selected or who have been assigned to the PCP unless Individual PCP, Medical Group or Medical Group PCP notifies HMO Blue Texas that the Individual PCP's or Medical Group PCP's entire practice is closed to new patients of HMO Blue Texas as well as new patients of all other health plans or unless the Individual PCP's or Medical Group PCP's practice contains 300 or more HMO Blue Texas members. Individual PCP, Medical Group or Medical Group PCP must give HMO Blue Texas not less than ninety (90) days prior written notice of closing their practice to new HMO Blue Texas members. Notwithstanding practice closure, Individual PCP, Medical Group or Medical Group PCP agrees to accept all existing patients who are or become HMO Blue Texas members. Individual PCP, Medical Group or Medical Group PCP agrees that HMO Blue Texas shall have no obligation to guarantee any minimum number of HMO Blue Texas members to Individual PCP, Medical Group or Medical Group PCP and that Individual PCP, Medical Group or Medical Group PCP shall accept all patients enrolling as HMO Blue Texas members.

Key Points:

- 90 days prior written notice to close practice is required.
 - PCP may only close his/her practice to HMO Blue Texas members if he/she closes his/her practice to all other patients, or if he/she has at least 300 or more HMO Blue Texas members. Thus, if the PCP has less than 300 HMO Blue Texas members, he/she can only close his/her practice to those HMO Blue Texas members if he/she closes his/her practice to BCBSTX PPO/POS subscribers AND patients from all other health plans.
 - If an HMO Blue Texas PCP has at least 300 HMO Blue Texas members, he/she can close his/her practice for HMO Blue Texas members and leave his/her practice open for all other patients.
-

Physician and other Professional Provider Roles and Responsibilities, continued

Implementation of Factor Drug Program for Hemophilia Members

Effective January 15, 2008, Accredo Health Group, Inc ("Accredo") has been designated as the **exclusive** home infusion therapy provider of these Factor products for HMO Blue Texas members*.

HCPCS Billing Code	
J7187	J7193
J7189	J7194
J7190	J7195
J7192	J7198

*Factor products may be provided by an HMO member's treating physician or by other specific providers identified by BCBSTX.

To refer your HMO Blue Texas patients to Accredo, please contact Accredo at **(800) 800-6606** and ask to speak with a pharmacist. Referral information can also be sent to Accredo via fax at (800) 330-0756.

Referring your HMO Blue Texas patients to Accredo allows the physician's office to avoid buying these Factor products from a supplier and billing BCBSTX for the Factor products. If you obtain these Factor products from a source other than Accredo, file the claim directly to BCBSTX. You will be reimbursed in accordance with your BCBSTX fee schedule.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Exclusive Lab Provider & County Listing

Laboratory Corporation of America (LabCorp) is the **exclusive** provider for HMO Blue Texas for all outpatient clinical reference laboratory services. **Exception:** Members whose PCP is associated with a capitated IPA/Medical Group must receive outpatient laboratory services from their applicable IPA's/Medical Group's designated outpatient laboratory. Contact the IPA/Medical Group for direction, if necessary.

For Physicians and other Professional Providers located in the following counties, the services that will be reimbursed on a fee-for-service basis ***if performed in the Physician's or other Professional Provider's office*** for HMO Blue Texas members are included on the Reimbursable Lab Services list that follows below. *All other lab services must be referred to HMO Blue Texas' exclusive provider LabCorp.*

County Listing:

Austin, Bell, Bexar, Brazoria, Brazos, Calhoun, Chambers, Collin, Comal, Cooke, Dallas, Denton, Ellis, Fannin, Fort Bend, Galveston, Gonzales, Grayson, Grimes, Guadalupe, Hardin, Harris, Hood, Houston, Hunt, Jackson, Jefferson, Johnson, Kaufman, Lavaca, Leon, Liberty, Madison, Matagorda, McLennan, Montague, Montgomery, Orange, Parker, Polk, Robertson, Rockwall, San Jacinto, Somervell, Tarrant, Trinity, Victoria, Walker, Waller, Washington, Wharton & Wise.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Reimbursable Lab Services

Note: For the County Listing and Reimbursable Lab Services **prior to 11/01/2009**, visit the BCBSTX Web site @ www.bcbstx.com/provider (under General Reimbursement Information, select ...and more, enter password – manual, under HMO Blue Texas, refer to the applicable bullet offerings).

Reimbursable Lab Services-Effective 11/01/2009	CPT Code
Collection of venous blood by venipuncture	36415
Collection of capillary blood specimen	36416
Venipuncture, cutdown; under age 1 year	36420
Basic metabolic panel	80048
Electrolyte panel	80051
Tacrolimos <i>New - Effective 11/01/09</i>	80197
Urinalysis, dipstick	81000
Urinalysis, with microscopy, automated	81001
Urinalysis, without microscopy, non-automated	81002
Urinalysis, without microscopy, automated	81003
Urinalysis, bacteriuria screen, except by culture or dipstick	81007
Pregnancy test, urine	81025
Stool for occult blood (Hemoccult)	82270
Stool for occult blood (Hemoccult single)	82272
Stool for occult blood	82274
Glucose, blood, quantitative	82947
Glucose, blood, reagent strip	82948
Glucose, blood, monitoring device	82962
H. pylori; breath test analysis for urease activity, drug administration	83014
Bleeding time	85002
Blood count, differential WBC, automated	85004
Blood count, smear, WBC differential, manual	85007
Blood count, smear, no WBC differential	85008
Blood count, spun microhematocrit	85013
Blood count, hematocrit	85014
Blood count, hemoglobin	85018
Blood count, complete CBC & WBC differential, automated	85025
Blood count, complete CBC, automated	85027
Blood count, manual, each	85032
Blood count, platelet, automated	85049

Note: All other outpatient clinical reference lab services not listed above must be referred to HMO Blue Texas' exclusive provider - Laboratory Corporation of America (LabCorp).

Continued on next page



Physician and other Professional Provider Roles and Responsibilities, continued

Reimbursable Lab Services – Effective 11/01/2009	CPT Code
Coagulation time, Lee and White	85345
Coagulation time, Lee and White, activated	85347
Coagulation time, Lee and White, other methods	85348
Prothrombin time	85610
Heterophile antibody screen for mononucleosis	86308
Skin test, coccidioidmycosis	86490
Skin test, histoplasmosis	86510
Skin test, tuberculosis, intradermal	86580
Wet mount for infectious agents	87210
Tissue exam by KOH slide	87220
Influenza	87400
Strep screening, qualitative	87430
Influenza, rapid	87804
RV, rapid	87807
Strep screening, rapid	87880
Culture of oocyte(s)/embryo(s), less than 4 days	89250
Assisted embryo hatching, microtechniques (any method)	89253
Oocyte identification from follicular fluid	89254
Preparation of embryo for transfer (any method)	89255
Sperm identification from aspiration (other than seminal fluid)	89257
Sperm isolation, complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnostic with semen analysis	89261
Sperm identification from testis tissue, fresh or cryopreserved	89264
Insemination of oocytes	89268
Extended culture of oocyte(s)/embryo(s), 4-7 days	89272
Assisted oocyte fertilization, microtechnique: less than or equal to 10 oocytes	89280
Assisted oocyte fertilization, microtechnique: greater than 10 oocytes	89281
Sperm evaluation, cervical mucus penetration test	89330
Thawing of cryopreserved; embryo(s)	89352

Note: All other outpatient clinical reference lab services not listed above must be referred to HMO Blue Texas' exclusive provider - Laboratory Corporation of America (LabCorp).

Additional information regarding LabCorp is included on the following pages.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

How to Access LabCorp Services

- **Supply Orders** – To order supply order forms or place your order, please call LabCorp at:

**Houston/San Antonio/
Austin/ South Texas**

(800) 800-2387, option 7
(713) 856-8288, option 7
FAX: (713) 856-4348

**Dallas/Ft. Worth/
El Paso/West Texas**

(800) 788-9892, option 7
(972) 566-7500, option 7
FAX: (800) 788-9338
FAX: (972) 661-5762

- **Patient Service Center Locations** - To find the closest LabCorp Patient Service Center, please access LabCorp's phone system at 1-888-LABCORP, or their Web site at www.labcorp.com. Both of these systems will prompt you for your zip code and will provide those service centers nearest the zip code location.
- **Specimen Pick-up** – For pick-up of specimens, please contact LabCorp's Logistics Department:

**Houston/San Antonio/
Austin/ South Texas**

(800) 326-8478, option 4
(713) 856-4327, option 4

**Dallas/Ft. Worth/
El Paso/West Texas**

(800) 788-9980, option 4
(972) 566-3251, option 4

- **Billing Guidelines** – Please complete the following information on the lab requisition:
 - a) Patient's Full Name
 - b) Patient Address
 - c) Sex
 - d) Patient Date of Birth
 - e) Diagnosis Code (ICD-9)
 - f) Patient/Insured ID Number

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

How to Access LabCorp Services, continued

Receiving Test Results – to provide your practice the flexibility and time saving convenience in ordering and receiving test results in an electronic manner, LabCorp offers a number of multiple result delivery systems including the Laboratory Communication Manager Computer (LCM) and high-speed remote report teleprinters. Interfaces with Practice Management Systems are an option as well. Laboratory test results are also available from LabCorp via e-Results over the internet and through various portals. Please contact LabCorp for more information on their internet portal solutions.

- **Questions** – If you have any specific questions regarding your LabCorp account or need to set-up an account with LabCorp, please contact LabCorp's Client Services Department:

**Houston/San Antonio/
Austin/ South Texas**

**Dallas/Ft. Worth/
El Paso/West Texas**

(800) 800-2387, dial 1 then ext.
3999

(713) 856-8288, dial 1 then ext.
3999

(800) 788-9892, dial 1 then ext.
6202

(972) 566-7500, dial 1 then ext.
6202

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Outpatient Diagnostic Imaging

- **Precertification Required** – High tech outpatient diagnostic radiology procedures - CT/CTA scans, MRI/MRA scans, SPECT/Nuclear Cardiology studies and PET scans (*excludes radiology services provided during emergency room visits, in-patient admissions, out-patient surgeries and 23 hour observation*) for members living in the following counties: Bastrop, Bexar, Collin, Comal, Dallas, Denton, Ellis, Grayson, Hays, Johnson, Kaufman, Parker, Rockwall, Tarrant, Travis, Williamson and Wise.

Please note: Physicians or other Professional Providers participating in capitated Limited Provider Networks should contact the Limited Provider Network for any additional certification requirements.

- **For Precertification**, contact American Imaging Management (AIM) at 1-800-859-5299. Requests for these procedures cannot be processed in the iEXCHANGE System.
- **Clinical Criteria** – Precertification requests are reviewed using American Imaging Management's (AIM) proprietary criteria. The criteria are based upon the literature and policies from major medical specialty organizations and are consistent with the American College of Radiology's appropriateness criteria for imaging.
- **Notification** – Notification of the determination is provided to the Referring Physician or other Professional Providers within the sooner of, 2 working days after receipt of necessary information to complete the review or 3 calendar days of receipt of the request.

Physician Review – A case will be referred to an AIM Physician Reviewer if the information received does not meet established criteria. In any instance where there is a question as to medical necessity or appropriateness of health care services, the network Physician or other Professional Provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment with the Physician Reviewer *prior* to the issuance of an adverse determination. The Physician Reviewer will attempt to contact the servicing Physician or other Professional Provider by telephone *prior* to issuance of an adverse determination. Physician Reviewers can be contacted by calling **1-800-859-5299** and select option 2.

Continued on next page



Physician and other Professional Provider Roles and Responsibilities, continued

Outpatient Diagnostic Imaging, continued

Note: For Outpatient Radiology Services **Not** Requiring Referral/Precertification:

- If not performed in the Physician's or other Professional Provider's office, the Physician or other Professional Provider **must** send the member to a contracted imaging location within the member's Provider Network.
 - Refer to the HMO Blue Texas Provider Directory for contracted imaging locations for each Provider Network. Physicians or other Professional Providers who are contracted/affiliated with an IPA/Medical Group may need to use a specified imaging location depending on the requirements of the IPA/Medical Group.
-

Accessibility of Outpatient Diagnostic Imaging Utilization Management Criteria

Outpatient Diagnostic Imaging Utilization Management review criteria is available to HMO Blue Texas network Physicians or other Professional Providers upon request. To receive criteria on a specific condition please contact the AIM Utilization Management Department at **1-800-859-5299**. A listing of the most common indications is displayed on the AIM web site at www.americanimaging.net under Physician Education.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

To Request a BCBSTX Provider Record

Requesting a Provider Record from BCBSTX does not mean you are a network participating provider.

- If you do not already have a Provider Record set-up with BCBSTX, please complete one of the following forms:
 - **Solo Provider Record Information Form*** should be completed by:
 - A provider who will not be employing another professional provider
 - A provider who will be using his/her social security number for tax purposes
 - A provider whose Tax Identification Number (TIN) is legally in the provider's name
 - A provider who is not incorporated
 - **Group Provider Record Information Form*** should be completed by:
 - A provider who has a practice with more than one professional provider
 - A provider whose Federal Tax ID has a corporate legal name
 - If the billing entity is incorporated
 - To add a provider to an existing group, use the Group Member Information Form on page 4 of the Group Provider Record Information Form

*Located on the BCBSTX Provider Web site at www.bcbstx.com/provider, under Credentialing/Contracting, click on the Provider Record/Credentialing bullet.

Forward completed Provider Record Forms to BCBSTX by:

Fax: Provider Administration 972-996-8445 (*preferred method*)

or

Mail: Blue Cross and Blue Shield of Texas
Attn: Provider Administration
P.O. Box 650267
Dallas, TX 75265-0267

- If you need the status of a previously submitted Provider Record Information Form or have questions regarding the completion of the Provider Record Information Form, please contact Provider Administration at **1-972-996-9610, press 3**.
- Once you have received notice of your established Provider Record and would like to be a participating provider, refer to information on page B-37.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Credentialing for Network Participation

To become a participating physician or other professional provider, you will need to complete a two-step process.

Step 1: Establish a BCBSTX provider record (*refer to information on page B-36*)

Step 2: Submit a fully completed TDI Standardized Credentialing Application Packet and all applicable attachments.

BCBSTX requires full credentialing of all physicians and other professional providers for their managed care networks. BCBSTX will provide an expedited credentialing process which allows for a "provisional network participation" status if the provider applicant

- 1) has a valid license in the state by, and in good standing with, the Texas Licensing Boards,
- 2) submits all documentation required to make an application complete, and
- 3) submits a current signed contract/agreement.

If BCBSTX is unable to verify license information, the applicant will be fully credentialed and made effective after credentialing approval.

If you are one of the following provider types that BCBSTX contracts with and would like to become a participating physician or other professional provider, submission of a fully completed Texas Standardized Credentialing Application packet is required.

- MDs and DOs
- DDSs (oral and maxillofacial surgery)
- Licensed Physical Therapists, Occupational Therapists
- Optometrists, Audiologists, Speech and Language Pathologists
- Physician Assistants, Surgical Assistants, Advanced Practice Nurses, Certified Midwives, Registered Nurse First Assistants
- Podiatrists
- Chiropractors
- Acupuncturists
- Certified Registered Nurse Anesthetists

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Credentialing for Network Participation, continued

All applicants should utilize the **TDI Credentialing Application Completion Guide*** to verify that they are submitting a fully completed application packet. **Incomplete application packets will be returned.**

- **Texas Standardized Credentialing Application**** (pages 1-20) and all applicable attachments. *(CAQH Users, please contact CAQH for instructions in downloading your information to the TDI Credentialing application)*
- **Hospital Referral Letter**** – required to be submitted in conjunction with the credentialing application for those providers who do not have admitting privileges at a network hospital.
- **Contract/Agreement** - To request for a contract/agreement to be sent to you from BCBSTX, complete the online request form located on the BCBSTX Provider Web site at www.bcbstx.com/provider/contract_request.htm or contact your local Professional Provider Network office.

Forward fully completed application packet to BCBSTX by:

Fax: Provider Administration 972-996-8230 *(preferred method)*
or

Mail: Blue Cross and Blue Shield of Texas
Attn: Provider Administration
P.O. Box 650267
Dallas, TX 75265-0267

**Located on the BCBSTX Provider Web site at www.bcbstx.com/provider, under Credentialing/Contracting, click on the Provider Record/Credentialing bullet.



Physician and other Professional Provider Roles and Responsibilities, continued

Recredentialing

To continue participation with BCBSTX's managed care networks, a fully completed Texas Standardized Credentialing Application packet is required. Use the **Texas Credentialing Application Completion Guide*** to verify that you are submitting a fully completed application packet. **Incomplete application packets will be returned.**

- **Texas Standardized Credentialing Application*** (pages 1-20) and all applicable attachments. *(CAQH Users, please contact CAQH for instructions in downloading your information to the TDI Credentialing application)*
- **Hospital Referral Letter*** – required to be submitted in conjunction with the credentialing application for those providers who do not have admitting privileges at a network hospital.

*Located on the BCBSTX Provider Web site at www.bcbstx.com/provider, under Credentialing/Contracting, click on the Provider Record/Credentialing bullet.

Forward fully completed application packet to BCBSTX by :

Fax: Provider Administration 972-996-8230 *(preferred method)*
or

Mail: Blue Cross and Blue Shield of Texas
Attn: Provider Administration
P.O. Box 650267
Dallas, TX 75265-0267

Physician and other Professional Provider Roles and Responsibilities, continued

Credentialing & Recredentialing

The Medical Advisory Committee conducts regularly scheduled meetings, or as needed, to review the Physician or other Professional Provider applicants for credentialing and recredentialing.

The Committee provides peer recommendations for approval or denial of Physician or other Professional Provider applicant files, reviews regular reports of HMO Blue Texas credentialing activities, and reviews/recommends action to resolve Physician or other Professional Provider appeals. The Committee also reviews and resolves quality of care issues.

The HMO Blue Texas credentialing process includes a review of each Physician or other Professional Provider applicant's file. Training, experience and the ability to deliver care that meets the medical standards of the community are an integral part of the process.

To participate in HMO Blue Texas, Physicians or other Professional Providers must have a current Texas license, be in good standing with the licensing board, the Provider Network and its hospital affiliates, and Blue Cross and Blue Shield of Texas, plus meet other credentialing criteria established by HMO Blue Texas.

The standard procedure used in processing a completed Physician or other Professional Provider application includes, but is not limited to, the verification of information regarding education and training, hospital privileges at the primary admitting network facility as indicated by the Physician or other Professional Provider on his/her application or recredentialing package, licensure and malpractice history.

All documentation and signatures must meet time frame criteria (i.e., current dates on DEA, DPS, practitioners license, liability insurance face sheet, attestation signature, etc.) that is required by all regulatory and/or accreditation agencies. Physicians or other Professional Providers who have submitted an application for credentialing/recredentialing have the right to review the information submitted in support of these applications to HMO Blue Texas. The right to review does not include references, recommendations, information that is peer review protected or which the health plan is otherwise prohibited from releasing. Physicians or other Professional Providers also have the right to be notified of any information obtained during the credentialing process that varies substantially from the information provided on the physician or other professional provider applications. Physicians or other Professional Providers also have the right to correct erroneous information submitted by another party. Physicians or other Professional Providers, upon request, have the right to be informed of the status of their credentialing or recredentialing application.

Continued on next page

Physician and other Professional Provider Roles and Responsibilities, continued

Credentialing Review Requests

Who can Request Review?	Any Physician or other Professional Provider may seek a review of a decision related to initial credentialing or continued participation in the HMO Blue Texas Network.
When to Request Review	Requests for review must be submitted in writing within 60 calendar days from the date of the denial/termination letter.
Addressing the Request	Written requests should be addressed to the Medical Director for your area. See addresses at the front of this manual.
What to Include	Requests should include any supporting documentation or facts the Physician or other Professional Provider feels would be beneficial for review.
Process	The following table describes the review process:

Stage	Description
1	The Physician or other Professional Provider submits an appeal request to the Medical Director.
2	The Medical Director reviews appeal request
3	<p>The Medical Director presents the Physician's or other Professional Provider's file, appeal request and supporting documentation for a recommendation to the Medical Advisory Committee.</p> <p>If the Medical Advisory Committee review panel is not able to make a recommendation based on the information provided, then the plan will seek the Physician's or other Professional Provider's consent to extend the review period. The extension will include the time necessary for the Medical Advisory Committee to receive additional information from the Physician or other Professional Provider, and will provide the required 30 days notification to members.</p> <p>Note: The committee recommendation is intended to assist the Medical Director. The committee's role is advisory only, and, as such, the recommendation of the committee is not binding.</p>
4	The Medical Director forwards the final determination in writing to the Physician or other Professional Provider within 60 days of initial notification to the Physician or other Professional Provider or the date of request for additional information for review.

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Physician and other Professional Provider Roles and Responsibilities, continued

Physician and other Professional Provider Termination Process

- If a Physician or other Professional Provider is being considered for BCBSTX network termination for any of the following reasons, BCBSTX will present the proposal for termination to a BCBSTX Advisory Peer Review Panel (Texas Medical Advisory Committee [TMAC] or Texas Peer Review Committee [TPRC]) along with all available supporting documentation:
 - Non-compliance with credentialing criteria; or
 - Loss, restriction or probation of license; or
 - Government action such as debarment from Medicare and Medicaid; or
 - Cost and utilization issues; or
 - Quality of care issues.
- A BCBSTX medical director may immediately terminate a Physician or other Professional Provider's network participation if he/she determines that:
 - Continued network participation by the Physician or other Professional Provider poses imminent harm to patient health; or
 - An action by a state licensing board effectively impairs the Physician or other Professional Provider of the reason(s) for termination. Physician's or other Professional Provider's ability to provide services; or
 - There has been fraud or malfeasance.
- If network termination is initiated based on advice from TMAC or TPRC, a written explanation shall be provided to the Physician or other Professional Provider of the reason(s) for termination.
- A Physician or other Professional Provider may, within thirty (30) days of the written termination notice, request in writing that a review of the termination decision be conducted by a different Advisory Peer Review Panel to consider whether the termination action was correct under the terms of the Provider Contract/Agreement.
- BCBSTX will not notify Subscribers of the provider's termination until thirty (30) days prior to the effective date of such termination or the time the Advisory Peer Review Panel makes a formal recommendation. However, if a provider is terminated for reasons related to imminent harm, BCBSTX may notify Subscribers immediately.
- Within sixty (60) days following receipt of Physician's or other Professional Provider's written request for review, BCBSTX will notify provider of its review decision.
- Upon request, BCBSTX will provide Physician or other Professional Provider with a copy of the recommendation of the Advisory Peer Review Panel. The Panel's recommendation must be considered by BCBSTX but is non-binding.

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Physician and other Professional Provider Roles and Responsibilities, continued

Urgent Care Center (UCC) Criteria

An Urgent Care Center must meet the following requirements:

1. Extended hours – UCC must be open weekday evenings until at least 7:00 p.m. Weekend hours preferred but not required.
 2. Defibrillator - If not physically adjacent to an Emergency Room, UCC must have a defibrillator in their office.
 3. Tax ID Number - UCC must have its own provider record and Tax ID number.
 4. UCC Summary – UCC must complete the Urgent Care Center Summary (included in the application packet) and return it along with their application.
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Urgent Care Center Services Billed Using CPT Code S9088

Effective March 1, 2009, BCBSTX will consider CPT[®] Code S9088 as a non-covered procedure; therefore no reimbursement will be allowed.

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