BlueCross BlueShield of Texas

Blue Advantage HMO℠ Quick Reference Guide

MAIN CHARACTERISTICS

- **Blue Advantage HMO** members must select a **Blue Advantage HMO** Primary Care Physician.
- **Blue Advantage HMO** providers may only bill for copayments, cost share (coinsurance) and deductibles, where applicable.
- Some services may be self-referred to a **Blue Advantage HMO** physician or professional provider (i.e., annual well woman exam, annual routine eye exam) as indicated by the member's benefit plan.
- To receive benefits, all medical care must be directed by the selected **Blue Advantage HMO** PCP. A PCP referral is required to all **Blue Advantage HMO** specialist providers.
- To receive benefits, referrals to out-of-network providers must be authorized by **Utilization Management.**
- **Blue Advantage HMO** members 19 and younger will receive their annual eye exam and eye wear from **EyeMed Vision Care** providers. **Blue Advantage HMO** members will continue to use **Blue Advantage HMO** contracted providers for medical eye care. Please include all appropriate diagnosis codes on your claims to accurately represent the services provided. To request network participation with **EyeMed Vision Care**, please call **888- 581-3648**. For all other **Blue Advantage HMO** members, providers for vision care could vary. Contact the customer service number on the member's ID card to verify the member's vision benefits.
- **Blue Advantage HMO** members under age 20 have an included dental benefit. For more information, refer to the member's **Blue Advantage HMO** ID card or call **Dental Network of America** at **800-820-9994**.

BENEFITS AND ELIGIBILITY

- Eligibility and benefit information may be obtained through Availity® Essentials or an electronic web vendor of your choice or call **Blue Advantage HMO Provider Customer Service** at **800-451-0287**. Note: *To access eligibility and benefits, you must have member's full information, i.e., member's ID, patient date of birth, etc.*
- Verification of benefits does not apply to administrative services only plans.

CLAIM SUBMISSIONS

- All claims should be submitted electronically. **Blue Advantage HMO Electronic Payor ID: 84980**
- If the provider must submit a paper claim, mail claim to:

  Blue Advantage HMO, PO Box 660044 Dallas, TX 75266-0044

- Claims must be submitted within 180 days of the date of service. Claims that are not submitted within 180 days from the date of service are not eligible for reimbursement. Providers must submit a complete claim for any services provided to a member. **Blue Advantage HMO** providers may not seek payment from the member for claims submitted after the 180 day filing deadline.

CLAIMS STATUS AND PROCESSING

- Claim Status may be obtained through the Availity Claim Status Tool or a web vendor of your choice.
- To submit claim reconsideration, you must have a document control number (claim number) then submit:
  - Electronically via the Claim Reconsiderations when available
  - Mail the **Claim Review** form which is located on the BCBSTX provider website. Select **Education & Reference** then select **Forms.**
  - Call **Blue Advantage HMO Provider Customer Service** at **800-451-0287**
- Claim Reviews and Correspondence should be sent to:

  Blue Advantage HMO PO Box 660044 Dallas, TX 75266-0044

UTILIZATION MANAGEMENT - Prior Authorization, Recommended Clinical Review and Referrals

- Providers should verify through Availity® or their preferred vendor if prior authorization or referrals are required or a recommended clinical review is available for select outpatient or inpatient services and determine if they are managed by Medical Care Management with BCBSTX , Carelon Medical Benefit Management or Alacura Transportation Management, LLC.
- Some services may be subject to a Prior Authorization Exemption.
- Refer to Utilization Management on the provider website for additional information.
- For case management or to contact the Utilization Management Dept., call **800-441-9188.**
- For Behavioral Health services managed by **Magellan** - see **Behavioral Health** section below.
- To submit referrals for specialty care and prior authorizations requests for inpatient and outpatient services managed by:

BCBSTX Medical Management:

1) Submit electronically using:

(a) BlueApprovR℠

- Log into Availity
- Select Payer Spaces from the navigation menu and choose BCBSTX within Payer Spaces, select the Applications tab and Blue ApprovR
- For more information, refer to BlueApprovR under Provider Tools on the provider website.

(b) Availity Authorizations & Referrals Tool

- Log into Availity
- Select **Patient Registration** menu option, choose **Authorizations & Referrals**, then **Authorizations** (choose **Referrals** instead of **Authorizations** if you are submitting a referral request
- Select **Payer BCBSTX**, then choose your organization
- Select **Inpatient Authorization** or **Outpatient Authorization**
- Review and submit your authorization
- For more information, refer to **Availity Authorizations & Referrals** under **Provider Tools** on the provider website.

2) By Phone: **855-896-2701**

Carelon Medical Benefit Management:

BlueHPN services authorized by **Carelon** may include advanced imaging, cardiology, sleep medicine, pain management, joint and spine surgery, radiation therapy, medical oncology support and genetic testing.

1) Submit electronically using Carelon Provider Portal
2) By Phone: **800-859-5299**
3) Fax: **800-610-0050** Note: Fax option is available only for physicians or professional providers who are submitting clinical information for existing requests.

Alacura:

(1) By Phone: **866-671-4834**

(2) By Fax: **866-671-4995**

(3) Online: https://alacura.my.site.com/preauth/s/

LABORATORY AND RADIOLOGY SERVICES

- Providers should refer outpatient lab and radiology services to in-network participating **Blue Advantage HMO** providers. To locate participating providers in the **Blue Advantage HMO** network, visit the Provider Finder®.
- Lab and radiology services may require prior authorization or referrals through **Medical Management with BCBSTX** or **Carelon**. See **Utilization Management** section above for more information.
- Advanced Imaging services may require site of care review
- Some ASO members may be applicable to the Clinical Payment and Coding Policies for Lab Management
- Refer to Section B (d) of the Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual for more information.

BEHAVIORAL HEALTH (Mental Health and Chemical Dependence)

- **Magellan Behavioral Health Providers of Texas, Inc.** coordinates all behavioral health (mental health and chemical dependency) services for **Blue Advantage HMO** members.
- Call **Magellan** at **800-729-2422** to obtain prior authorization, check benefits, eligibility, claims status/problems or verification.
- Provider or behavioral health professional must contact **Magellan** to prior authorize required inpatient, partial hospitalization and outpatient behavioral health services.
- Prior authorization must be obtained when required before the delivery of care for behavioral health services.
- The physician or professional provider is responsible for filing claims. Claims should be submitted electronically as indicated in your **Magellan** contract agreement. if you are unable to submit electronically, contact the number on the back of the member's ID card for appropriate paper filing instructions.

ADDITIONAL INFORMATION

For all Blue Advantage HMO networks, BCBSTX encourages provider's to:

- Ask for the member's ID card at the time of a visit;
- Copy both sides of the member's ID card and keep the copy with the patient's file;
- Check eligibility and benefits, prior authorization requirements and recommended clinical review option, via availity.com/essentials or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.
- Request prior authorization or referrals when required.

Claims Submission:

- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is **84980**.
- For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at **800-282-4548**.
- For information on electronic filing, access the Availity website at availity.com.
- If you must submit paper claims, submit on the Standard CMS-1500 (02/12) or UB-04 claim form.
- All claims must be filed with the insured's complete unique ID number including any letter or 3-character prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. Note: This does not apply to services provided by an employee of a physician or professional provider, e.g., Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing physician or professional provider.

Provider Record and Network Effective Dates:

- The Consolidated Appropriations Act requires name, address, phone, specialty and digital contact information in the provider directory be verified every 90 days. Refer to Verify and Update Your Information on how to submit.
- A minimum of 30 days advance notice is required when making changes affecting the provider's BCBSTX status, especially in the following areas:
  Physical address (primary, secondary, tertiary); Billing address; NPI and Provider Record ID changes; Moving from Group to Solo practice or vice versa; and moving from Group to Group practice. Utilize the Demographic Change Form to submit these requests.
- New Provider Record ID effective dates will be established when the request is received in the BCBSTX corporate office. This applies to all additions, changes and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files claims electronically and their Provider Record ID changes, the provider must contact Availity at 1-800-282-4548. to obtain a new EDI Agreement.
- Submit a Provider Onboarding form to obtain a Provider Record ID. Review Network Participation on our website for more information.

BlueCard® (Out-of-State Claims):

- To check benefits or eligibility, call **800-676-(2583)***;
- File all that include a 3-character prefix on the member's ID card to BCBSTX (Note: The member's unique ID number may contain alpha characters which may or may not directly follow the 3-character prefix);
- File all other claims directly to the Home Plan's address as it appears on the back of the member's ID card;
- For status of claims filed to BCBSTX, contact availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card or as listed on the previous pages for the appropriate plan type.
- Refer to BlueCard Program for more information.

*Interactive Voice Response (IVR) system. To access, you must have member's full information, i.e., member's ID, patient date of birth, etc.)

ADDITIONAL INFORMATION

The **Affordable Care Act** includes a provision that gives Health Insurance Marketplace members who receive advanced premium tax credits also known as subsidies, a three-month grace period to pay their premium.

- **Grace Period Overview:**
  - The three-month grace period is only required for enrollees who have made one full premium payment during the benefit year and who are receiving the APTC.
  - The health plan is responsible for adjudicating claims during the first month after a member enters the grace period. The claims adjudicated are for dates of service rendered within the first month of this grace period.
  - During the second and third months of the grace period, issuers have the choice of either pending the claims or adjudicating the claims and seeking a refund if the member doesn't pay all outstanding premium payments.
  - If a member fails to pay all outstanding premiums by the end of the three-month grace period, the health plan must terminate the member's coverage.
  - For additional details, go to www.Healthcare.gov.
- **How will BCBSTX make providers aware?**
  - Eligibility and Benefits Determination will include a paid through date and be provided by:
    - > Electronic and/or clearinghouse compliant with the HIPAA 270/271
    - > Interactive Voice Response / automated telephone system
    - > Provider Customer Service
  - Reminders to check for grace period status will be included on correspondence related to prior authorizations and referrals

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the **Blue Essentials®, Blue Advantage HMO℠, Blue Premier® and MyBlue Health® Provider Manual** online https://www.bcbstx.com/provider/standards/standards-requirements/manuals/hmo-manual.