BlueCross BlueShield of Texas

Blue Advantage HMO℠ Quick Reference Guide

Major Characteristics	Benefits, Eligibility, Claims Status or Verification	Claim Reviews, All Correspondence	Prior Authorizations and Referrals	Laboratory Services	Behavioral Health Services (Mental Health and Chemical Dependency)
• **Blue Advantage HMO** members must select a **Blue Advantage HMO** Primary Care Physician (PCP). • Blue Advantage 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 the Utilization Management Dept. •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 in order to accurately represent the services provided. To request network participation with **EyeMed Vision Care**, please call **1(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 **1-800-820-9994.**	• Eligibility and benefit information may be obtained through availity.com or a web vendor of your choice or call **Blue Advantage HMO** Provider Customer Service: **1-800-451-0287*** • Claim Status may be obtained through the Availity Claim Status Tool or a web vendor of your choice. • To adjust a claim, call **Blue Advantage HMO** Provider Customer Service: **1-800-451-0287**** • **Verification does not apply to administrative services only (ASO) plans.** • **All claims should be submitted electronically. Blue Advantage HMO** Electronic Payor ID: **84980** • If the provider must file a paper claim, mail claim to: **Blue Advantage HMO** P.O. 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. ** To access eligibility and benefits, you must have full member's information, i.e. member's ID, patient date of birth, etc.* *** To adjust a claim, you must have a document control number (claim number).*	• Claim Reviews and Correspondence should be sent to: **Blue Advantage HMO** P.O. Box 660044 Dallas, TX 75266-0044 • The Claim Review form with instructions is located on the BCBSTX provider website at: bcbstx.com/ provider Select **Education & Reference** tab then select **Forms.**	• Providers should verify through Availity® or their preferred vendor if prior authorization or referrals are required for select outpatient or inpatient services and determine if they are managed by BCBSTX Medical Care Management or AIM Specialty Health® (AIM). Some services may be subject to a Prior Authorization Exemption. Refer to Utilization Management on the provider website for additional information. • Submit requests managed by BCBSTX Medical Management: (1) Online using Authorizations & Referrals Tool on Availity. ✓Log in to availity.com ✓Select **Patient Registration** menu option**,** choose **Authorizations & Referrals,** then **Authorizations*** ✓Select **Payer BCBSTX,** then choose your organization ✓ Select I**npatient Authorization** or **Outpatient Authorization** ✓Review and submit your authorization ✓For more information, refer to Availity Authorizations & Referrals under Provider Tools on the provider website. * Choose **Referrals** instead of Authorizations if you are submitting a referral request. (2) By Phone: **1-855-896-2701** • Submit requests managed by AIM Specialty Health: (1) Online at aimspecialtyhealth.com (2) Phone - **1-800-859-5299** • Current listings of providers and their NPI numbers are available online through Provider Finder. • For case management or to contact the Utilization Management Dept., call **1-800-441-9188.**	**Laboratory Services** • Providers should refer outpatient lab services to in-network participating **Blue Advantage HMO** lab providers. • To locate participating labs in the Blue Advantage HMO network, visit the Provider Finder.	• Magellan Behavioral Health Providers of Texas, Inc. (Magellan) coordinates all behavioral health (mental health and chemical dependency) services for **Blue Advantage HMO** members. To obtain prior authorization, check benefits, eligibility, claims status/ problems or verification, call Magellan at 1-**800-729-2422.** Provider (PCP) or behavioral health professional must contact Magellan to prior authorize all inpatient, partial hospitalization and outpatient behavioral health services. • Prior authorization must be obtained ***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.

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 at https://www.bcbstx.com/provider/standards/standards-requirements/manuals/hmo-manual.

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or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.

Utilize Availity Authorizations & Referrals at http://www.availity.com to obtain approval of BCBSTX managed referrals, select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. Utiiize aimspecialtyhealth.com for AIM managed authorizations. For case management, call the Medical Care Management Department at 1-800-441-9188.

Claims Submission:

All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is 84980.

- For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at 1-800-282-4548.
- 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 1-800-282-4548.
- For information on electronic filing, access the Availity website at availity.com.

Paper claims must be submitted 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 ID and Network Effective Dates:

A minimum of 30 days advance notice is required when making changes affecting the provider's BCBSTX status, especially in the following areas:
(1) Physical address (primary, secondary, tertiary) (2) Billing address (3) NPI and Provider Record ID changes (4) Moving from Group to Solo practice (5) Moving from Solo to Group practice (6) Moving from Group to Group practice and (7) Backup/covering providers.

***New** [illegible] ... **Network** [illegible]*

[illegible]

(Note [illegible] -character prefix);

[illegible] **for in-network providers**

The Affordable Care Act (ACA) includes a provision that gives Health Insurance Marketplace members who receive advanced premium tax credits (APTC) 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 (IVR) / automated telephone system
  - Provider Customer Service
- Reminders to check for grace period status will be included on correspondence related to predeterminations, prior authorizations and referrals

** [illegible] member's information, i.e., member's I[illegible], patient date of birth, etc.*
*** To adjust a claim, you must have a document control number (claim number).*