BlueCross BlueShield of Texas

BlueEdge℠ Quick Reference Guide

MAIN CHARACTERISTICS

Blue Cross and Blue Shield of Texas offers two Consumer Driven Health Plans (CDHP) to choose from – **BlueEdge HCA** (Health Care Account) and **BlueEdge HSA** (Health Savings Account).

Both of these options include:

- A PPO plan utilizing the **Blue Choice PPO℠** network of health care providers.
- A high deductible – which is offset by the HCA/HSA.
- An account (HCA or HSA) established from which the first of any services incurred may be paid on a 100% basis.
- No copayments for office visits – office visits are subject to the deductible and coinsurance.
- Preventive/Wellness services from in-network providers paid at 100% of the allowable fee, separate from the HCA/HSA (services may include: physicals, diagnostic tests including lab, radiology and mammograms, and well child care and immunizations).
- **With BlueEdge, providers do not need to collect deductible amounts from the member at the time of service.**
- After HCA or HSA funds are depleted, the member is responsible for any remaining deductible or coinsurance.
- The Provider Claim Summary will notify you of any patient responsibility – following receipt of the PCS, the member may be billed for any deductible and coinsurance amount.

To receive network benefits, **BlueEdge** members must receive medical care from a health care provider within their applicable network.

Network providers may only bill **BlueEdge** members for deductibles, coinsurance and non-covered services.

If the member has **BlueEdge HCA** (Health Care Account), here are some important features:

- HCA is employer funded
- Amounts paid from the HCA may be applied to meeting the deductible
- Claims are paid by BCBSTX from the HCA account until the account is depleted
- After HCA funds are depleted, the member is responsible for any remaining deductible or coinsurance

If the member has **BlueEdge HSA** (Health Savings Account), here are some important features:

- HSA can be funded from employer, member or both
- Amounts for PPO-eligible expenses are applied to meeting the deductible
- If member elects, claims are paid by BCBSTX using available HSA account balance until the account is depleted
- The member may also access their available funds by use of a debit card or checkbook issued by the HSA administrator

BENEFITS AND ELIGIBILITY

- Eligibility and benefit information may be obtained through Availity®Essentials or an electronic web vendor of your choice or call our **Provider Customer Service** at **1-800-451-0287**.
  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 or out-of-state plans; however, verification will apply to fully insured groups. Contact our **Provider Customer Service at 800-451-0287.**

CLAIM SUBMISSIONS

- All claims should be submitted electronically. **BlueEdge Electronic Payor ID: 84980**
- If the provider must submit a paper claim, mail claim to: BlueEdge, PO Box 660044 Dallas, TX 75266-0044
- Claims must be submitted within 365 days of the date of service. Claims that are not submitted within 365 days from the date of service are not eligible for reimbursement. Providers must submit a complete claim for any services provided to a member. BlueEdge providers may not seek payment from the member for claims submitted after the 365 day filing deadline.

CLAIMS STATUS AND PROCESSING

- Claim status may be obtained through the Availity Essentials Claim Status Tool or a web vendor of your choice.
- To request a claim reconsideration, you must have a document control number (claim number) then submit:
  - Electronically via the Claim Reconsideration Requests when available.
  - Mail the **Claim Review** form which is located on the BCBSTX provider website. Select **Education & Reference** then select **Forms.**
  - Call **Provider Customer Service** at **800-451-0287**.
- Claim Reviews and Correspondence should be sent to: BlueEdge 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, recommended clinical review or referrals are required for select outpatient or inpatient services and determine if they are managed by BCBSTX Medical Care Management or Carelon Medical Benefit Management.
- Some services may be subject to a Prior Authorization Exemption.
- Refer to Utilization Management on the provider website for additional information.
- To submit prior authorization, RCRC or referral requests for inpatient and outpatients services managed by:
  - **BCBSTX Medical Management:**

    (1) Submit online using

    a)Availity Authorizations & Referrals Tool

    ✓ Log in to 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 the **Applications** tab and **Blue ApprovR**
    ✓ 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.

    b)BlueApprovR℠

    ✓ Log in to Availity
    ✓ Select **Payer BCBSTX**, then choose your organization and select the **Applications** tab and **BlueApprovR**
    ✓ For more information, refer to **Blue ApprovR** under **Provider Tools** on the provider website.

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

  - **Carelon Medical Benefit Management:**
    (1) Submit online using Carelon Provider Portal
    (2) By Phone: **800-859-5299**

  Alacura:

    (1) By Phone: **866-671-4834**
    (2) By Fax: **866-671-4995**
    (3) Online: https://alacura.my.site.com/preauth/s/

- 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 AND RADIOLOGY SERVICES

- Providers should refer outpatient lab or radiology to in-network participating **Blue Choice PPO** providers. To locate participating providers in the **Blue Choice PPO** network, visit Provider Finder.
- Services services may require prior authorization or be applicable to RCR through **Medical Management** at 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
- For routine services not requiring prior authorization, refer to the Blue Choice PPO and Blue High Performance Network Provider Manual **section B (d) - Outpatient Lab and Radiology**).

BEHAVIORAL HEALTH (Mental Health and Substance Use Disorder)

Important: Not all plans include Behavioral Health Benefits through BCBSTX.

- For BCBSTX Plans that include behavioral health, BCBSTX manages the behavioral health services.
- Members are responsible for requesting prior authorization when required, although behavioral health professionals and physicians or a family member may request prior authorization on behalf of the patient. All services must be medically necessary. Prior authorization may be required or recommended clinical review available for inpatient, partial hospitalization and outpatient behavioral health services.
- To obtain prior authorization or RCR, call BCBSTX: **1-800-528-7264**
- Prior authorization when required must be obtained prior to the delivery of behavioral health services.
- Refer to the online Blue Choice PPO and BlueHPN - Provider Manual (Section I).
- All claims should be submitted electronically using BCBSTX Electronic Payor ID: **84980**.
- If the provider must file a paper claim, mail claim to: **BCBSTX** PO Box 660044 Dallas, TX 75266-0044
- Claim status may be obtained through the Availity Claim Status Tool or a web vendor of your choice or call Provider Customer Service at 1-800-451-0287. (To access the Interactive Voice Response system, you must have member's full information, i.e., member's ID, patient date of birth, etc.).

ADDITIONAL INFORMATION

For all BlueEdge plans, BCBSTX encourages the provider's office to:

- Ask for the member's ID card at the time of a visit;
- Copy the member ID card and keep the copy with the patient's file;
- Eligibility, benefits, and/or verification requests, contact availity.com or web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.
- Claim Status may be obtained through the Availity Claim Status tool or a web vendor of your choice.
- For Claim Adjustments, call BCBSTX Provider Customer Service at 1-800-451-0287. To adjust a claim, you must have a document control number.

ParPlan is a BCBSTX payment plan under which health care professionals agree to:

- File all claims electronically for BCBSTX patients;
- Accept the BCBSTX allowable amount;
- Bill members only for deductibles, cost-share (coinsurance) and medically necessary services which are limited or not covered; either at the time of service or after BCBSTX has reimbursed the provider;
- Not bill BCBSTX for experimental, investigative or otherwise unproven or excluded services; and
- Not bill either BCBSTX or members for covered services which are not medically necessary.

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 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.

ADDITIONAL INFORMATION, cont.

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 the Network Participation on our website for more information.

BlueCard® (Out-of-State Claims):

- To check benefits or eligibility, call **-800-676-BLUE (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.
- Refer to BlueCard Program for more information.

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