BlueCross BlueShield of Texas

Blue High Performance Network® (BlueHPN®) - an Exclusive Provider Organization (EPO) Quick Reference Guide

MAIN CHARACTERISTICS

- **Blue High Performance Network** Benefits vary by plan type**.**
- Refer to the **BlueHPN** service areas listed on the BlueHPN page on the provider website.
- **BlueHPN** follows the current processes and requirements of our **Blue Choice® PPO** network
- **BlueHPN/EPO** physicians and professional providers may only bill for co payments, cost share (coinsurance) and
- deductibles, where applicable
- To receive benefits, **BlueHPN/EPO** members must receive medical care from within their **BlueHPN/EPO** network. No referrals or PCP selection are required.
- In **BlueHPN** service areas, members have access to emergent care with non-BlueHPN providers
- In non-**BlueHPN** service areas, members have access to urgent and emergent care.
- To receive benefits, referrals to out-of-network providers must be authorized by the Medical Care Management Dept. Unless an out-of-network physician or professional provider is authorized by the Medical Care Management Dept., there are no benefits available for the **BlueHPN/EPO** member.

BENEFITS AND ELIGIBILITY

- Eligibility and benefit information may be obtained through Availity® Essentials or an electronic web vendor of your choice or call **BlueHPN 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.*

CLAIM SUBMISSIONS

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

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

  BlueHPN
  PO Box 660044 Dallas, TX
  75266-0044

UTILIZATION MANAGEMENT - Prior Authorization and Recommended Clinical Review

- Providers should verify through Availity or their preferred vendor if prior authorization is required or recommended clinical review is applicable for select outpatient or inpatient services and determine if they are managed by Medical Care Management with BCBSTX, Carelon Medical Benefit Management or Alacura Medical 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 Medical Management Dept., call **800-441-9188**.
- To submit prior authorization, RCR 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 Request Type** -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:**

      (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 **800-441-9188.**

LABORATORY AND RADIOLOGY SERVICES

- Providers should refer outpatient lab or radiology services to in-network participating BlueHPN providers. To locate participating providers in the BlueHPN network, visit Provider Finder.
- Services may require prior authorization or be applicable to RCR through Medical Management with BCBSTX or Carelon. Refer to the 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 Disorders)

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 required or RCR available from BCBSTX for inpatient, partial hospitalization and outpatient behavioral health services.
- To obtain prior authorization or RCR, call BCBSTX: **1-800-528-7264**
- Prior authorization 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: **BlueHPN** 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**.

ADDITIONAL INFORMATION

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

- Ask for the member's ID card at the time of a visit;
- Copy both sides of 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 **1-800-282-4548**.
- 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 the Network Participation on our website for more information.

ADDITIONAL INFORMATION, cont.

BlueCard® (Out-of-State Claims):

- To check benefits or eligibility, call **1-800-676-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.

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 (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

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 Choice PPO and Blue High Performance Network–Provider Manual** online at https://www.bcbstx.com/provider/standards/standards-requirements/manuals/bluechoice-manual.