Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠, and MyBlue Health℠ Provider Manual - Roles and Responsibilities - Eligibility and Benefits

Important Note:

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health**. These plan/network specific requirements will be noted with the plan/network name.
If a plan/network name is not specifically listed or plan/network is referenced, the information will apply to all HMO products.

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Eligibility And Benefits Overview

This section of the manual provides an insight into importance of a Blue Cross and Blue Shield of Texas (BCBSTX) member's eligibility and benefits and how to make sure the services you are providing are covered.

Capitated Medical Groups Important Note

Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and preauthorization processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/ affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

Checking Eligibility and Benefits

Providers are responsible for checking eligibility and benefits prior to rendering services. Eligibility and benefit quotes include membership and coverage status, prior authorization requirements and determination that the provider is in-network for the patient's policy. It also includes other important information, such as applicable copayment, coinsurance and deductible amounts. Providers can check eligibility and benefits:

- Online via Availity®
- By phone contacting BCBSTX Provider Customer Services at the numbers listed on the following page or on the back of the member's ID card.

BCBSTX members are provided an identification card when they become eligible for our plans. If the member does not have a card prior to needing services, information can be obtained by:

- The Patient ID Finder tool via Availity
- Accepting a copy of the enrollment confirmation letter
- Contacting BCBSTX Provider Customer Services at the numbers listed below.

BCBSTX also recommends that the member's identification is verified with a photo ID and that a copy is retained for his/her file.

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Checking Eligibility and Benefits, cont.

BCBSTX Provider Customer Service*:

- **1-877-299-2377 - Blue Essentials and Blue Premier**
- **1-800-451-0287 - Blue Advantage HMO** and **MyBlue Health**
- **1-888-662-2395 - Employees of BCBSTX** and **their dependents**

*Be sure to have the member's full information, i.e., ID number, date of birth, etc.

Eligibility Statement

These Plans comply with the Eligibility Statement Legislation. For additional information on this legislation, please refer to the Texas Department of Insurance (TDI) website at tdi.texas.gov.

Newborns

Newborns of Plan members are covered for an initial period of 31 days. Coverage continues beyond the 31 days only if the member notifies the Plan within 31 days of the birth and pays any additional premium owed. The effective date of coverage will be the date of birth.

Note: Newborns of **Blue Essentials** members are subject to eligibility requirements established by each employer group and may not be automatically covered for the first 31 days.

Note: Newborns of **Blue Advantage HMO** members are subject to eligibility requirements established by each small employer group or individual plan and may not be automatically covered for the first 31 days.

Premium Payments for Individual Plan

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan members. In compliance with Federal guidance, BCBSTX will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal Government programs.

BCBSTX may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSTX directly for any or all of an enrollee's premium.

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Covered Services

Each of these **Plans** may have multiple benefit plan options and riders available to employer groups. Members of these **Plans** 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 **Plan** members are required to pay a copayment, if applicable, at the time services are rendered.

***Note**: For **Blue Essentials** members, the copayment(s) for basic services shall not exceed fifty percent (50%) of the cost (contract allowable) for covered services.*

Verification

Under the Texas Prompt Pay Legislation, health care providers 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 Provider Customer Service:

Blue Essentials and **Blue Premier** - Call **1-877-299-2377** and select the prompt for verification

Blue Advantage HMO and **MyBlue Health -** Call **1-800-451-0287**

***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. The **Plan** will respond to the physician's or professional provider's request with one of the following letters within the required timeframes:

- Request for Additional Information
- Verification Notice
- Declination Notice

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Blue Essentials Only - Delegated Entity Responsible for Claim Payment

Requests for verification of services will be issued by **Blue Essentials only** if the claim processing will be performed by **Blue Essentials**.

Required Elements to Initiate a Verification

The 13 required elements a participating health care provider need to supply to initiate a verification for a **Plan** member 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 the health care provider's office or 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 participating health care provider, name and contact information of any other carrier, including
    a) 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 participating health care provider providing the proposed services
13) Health care provider's National Provider Identifier (NPI) number

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

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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:

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

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, health care providers cannot bill the member at the time of service except for the applicable copayments, deductible or coinsurance amounts.

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Additional Fees Charged by Health Care Providers Beyond Copayments and Coinsurance

- The **Plan** discourages the practice of participating health care providers charging members additional fees beyond required copayments and coinsurance.
- **Plan** participating health care providers will treat members in the same manner as all other patients. These 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 health care provider charges additional fees to its entire population of patients in the same manner for **non-covered services** and the **Plan** member agrees in advance and in writing indicating the **specific non-covered service(s)** they are accepting payment responsibility for before receiving that service, then it would be acceptable to charge the member for the service. Non-covered services include personal choice services such as cosmetic surgery for which the member agrees in advance and in writing to pay. **Any such additional fee must be voluntary for members**. ***Note:*** *Services for which the **Plan** denies payment based on bundling or other claim edits **cannot** be billed to the member even if the member has agreed in writing to be responsible for non-covered services. The services referenced in this note are Covered Services but are not payable under **Plan** claims edits*.
- A participating health care provider cannot require **Plan** members to pay any type of "access fee" as a prerequisite to receiving services that are covered under member benefit plans.
- **Plan** members who do not pay the 'access fee" must not be treated differently from patients who pay the 'access fee' with regard to quality, comprehensiveness of care services, reasonable access to appointments, or after-hours coverage.

Notification of Obstetrical and Newborn Care

FIRST OBSTETRIC VISIT

Please refer to the current edition of the Current Procedural Terminology (CPT®) Codebook 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, refer to the antepartum and postpartum care codes 59400-59426 and 59430. For one to three care visits, refer to the appropriate Evaluation and Management code(s).

Recommended Clinical Review (formerly Predetermination) Requests

A recommended clinical review (formerly predeterminations) are optional reviews for medical necessity submitted before services are completed for a Covered Service that does not require prior authorization and helps limit the situations where a service may be denied based upon medical necessity retrospectively. Prior to submitting a recommended clinical review request, you should always check eligibility and benefits first to determine any pre-service requirements. A recommended clinical review is not a substitute for the prior authorization process.

Recommended clinical review requests, can be submitted via:

- Availity Attachments tool
- Recommended Clinical Review Request Form, available in the Education and Reference Center/Forms section of the BCBSTX provider website.

  Mail completed form to:

  Blue Cross and Blue Shield of Texas

  Attn: Recommended Clinical Review Department

  P.O. Box 660044

  Dallas, TX 75266-0044

  Fax to: 1-888-579-7935

Note: *The fact that a guideline is available for any given treatment, or that a service or treatment has an approved prior authorization or recommended clinical review is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.*

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Blue Advantage HMO Only Routine Vision Benefits	**Blue Advantage HMO** members 19 and younger will have routine vision care coverage through EyeMed Vision Care. 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 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 **EyeMed Vision Care** at **888-581-3648** or contact **EyeMed** at www.eyemedvisioncare.com.
Blue Advantage HMO Only Dental Coverage and Services	**Blue Advantage HMO** members **under the age of 20** have an included dental benefit. For more information, refer to the member's **Blue Advantage HMO** ID card.
Room Rate Updates Notification	Numerous plan group and member benefits only provide for a semi-private room. The room rate on file and loaded in the claims payment system is used to determine the patient's liability for claims when the difference between the private room and the semi-private room is the patient's responsibility. Therefore, the accurate information that you provide, assists in adjudicating the claim with the correct patient liability. For updates, please notify BCBSTX at least 30 days prior to the planned effective date. The **Room Rates Notification Form** is located on the BCBSTX Provider website under Education & Reference then Forms. The completed form can be faxed to the applicable fax number listed on the form or mail to your Network Management Representative.

Room Rate Updates Notification, cont.

It is also important to notify BCBSTX if your facility becomes private room only or a wing of the hospital is private room only. Once the information is received, BCBSTX will update their records with the effective date being later of:

- The actual effective date of the new rate, or
- Date it was received by BCBSTX

Contact your local Network Management Office with any questions.