BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network®

Provider Manual

Updated September 2026

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Contents

INTRODUCTION

The Blue Choice PPO℠ and Blue High Performance Network® Provider Manual for Blue Cross and Blue Shield of Texas is updated and reviewed periodically and contains information to assist your office with day-to-day business operations involving us and our members.

Throughout this manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge℠, EPO and the Federal Employee Program®. These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "Plan" is referenced, the information will apply to all products.

In the event of a conflict between the terms of a provider agreement and the terms of the provider manual, the terms of the Agreement will govern.

This manual provides links to information posted on our provider site.

A covered person is any person entitled to receive covered services pursuant to the terms of a coverage agreement at the time health care services are furnished. Covered persons are referred to as members for the purposes of this manual.

The following commercial or retail products and benefit plans for fully insured and/or Administrative Services Only members are included in this manual:

- Blue Choice PPO℠
- Blue Edge℠
- Blue High Performance Network® (BlueHPN®)
- Exclusive Provider Organization (EPO)
- Federal Employee Program (FEP®)
- Indemnity Traditional (ParPlan)

We also administer the Blue Cross Medicare Advantage PPO plan. In addition to referring to this manual, providers should reference the Blue Cross Medicare Advantage PPO℠ Supplement.

COMMITMENT

Our mission calls for us to respond to our customers with promptness, sensitivity, respect, and dignity. In support of this mission, we encourage appropriate utilization decisions; it does not sanction or encourage decisions based on inappropriate compensation. Providers or our staff do not receive compensation or anything of value based on the number of adverse determinations, reductions, or limitations of length of stay, benefits, services or charges. Any person making utilization decisions must be especially aware of possible under-utilization of services and the associated risks.

SUPPORT AREAS

We provide support to its providers through:

- Provider customer service
- Network management
- Health care management
- Medical directors and peer review committees (Texas Medical Advisory Committee and Texas Peer Review Committee)

Network Management Department

Network management is responsible for developing and supporting relationships between providers and us to allow our members access to cost-efficient medical care by providing:

- Valuable health information on our plans and contract information
- Claims enhancement programs
- Continuing education
- Accessibility to our staff through visits, telephone communication and email
- Continuous enhancements to our various communication technologies
- Guidance for your office staff on policies and procedures
- Assuring accurate information in claims payment systems (e.g., tax identification number, national provider identifier number, address, panel status)
- Compliance with state and federal regulatory requirements

Network management is available to provide information, answer questions, address concerns and assist in resolving any issues you or your staff may have. You may contact them by email, telephone or postal mail. Please provide the tax identification number, NPI, and if applicable, Medicare numbers for your provider when contacting network management. For contact information, refer the Contact Us page.

Securing Protected Health Information Policy

Our staff will accept and open emails from its business associates and other providers sent via their own secure server technology when the emails contain protected health information, sensitive personal information, and/or business confidential information.

Any emails not containing PHI, SPI, and/or BCI should not be sent via secure server technology. To allow for more efficient and productive exchanges (with documentary email trail), We will encourage external parties to send emails that do not contain PHI, SPI and/or BCI via regular unencrypted email.

Provider Tools and Training

We are committed to providing support to physician practices. We've designed useful tools for health care providers. In addition to below, refer to our Provider Tools and Provider Training and Continuing Education pages for detailed information.

- **Provider website and orientation**
  Our provider website provides a comprehensive resource to providers on how to join, claims and eligibility information, provider education and training, clinical resources as well as standards and requirements.

  The Plan will send a welcome letter to each participating provider. It includes the participating provider's effective date, as well as pertinent information on participating in the network and contacts. In addition, utilize our online Provider Orientation.

  The Plan recommends that all providers and their office personnel become familiar with their provider contract and this provider manual, and other resources available on the Website.

- **Provider directory**
  Plan participating providers can be identified through our provider directory, Find a Doctor or Hospital also known as Provider Finder®. The directory is updated daily. To view Provider Finder, visit the Website and scroll down to Provider Directory under Resources.

  The **Consolidated Appropriations Act** requires providers to verify directory information every 90 days. Refer to the Verify and Update Your Information page to learn more about how to update your information.

- **Blue Review**
  The Blue Review provides announcements, notices, and pertinent day-to-day information for your practice. It is produced monthly. To view the most current Blue Review or archived versions online, visit the Blue Review page.

  The Blue Review will be emailed to you and your team members if we have your current email address. You can submit email addresses using the form on the Blue Review page.

- **Provider access and servicing strategy education opportunities**
  The PASS Group offers customized instructions to all our participating providers. PASS is committed to offering focused and educational opportunities to maximize effectiveness and satisfaction in our networks. Education options include:
  - **Comprehensive education**
    - BlueCard (out-of-state members)
    - ClaimsXten and Clear Claim Connection (C3) web-based auditing reference tool
    - Electronic funds transfer, electronic remittance advice and electronic payment summary
    - Fully funded/insured vs. administrative services only groups
    - Provider website tour
    - Refund & recoupment process
  - **Self-Service education**
    - Availity® for checking patients' eligibility, benefits, claims status, prior authorizations and more
    - Electronic refund management
    - Interactive voice response system – Guided assistance to include FAX back functionality Availity Authorizations & Referrals for inpatient and select outpatient prior authorization, RCR and referrals

Provider customer service

Provider customer service staff is dedicated to serving Plan network providers. Customer service advocates are available to provide prompt inquiry responses concerning:

- Benefits and eligibility
- Claims
- General network concerns, including complaints and appeals

To contact Provider customer service, refer to the numbers listed below or on the member's ID card:

- **Blue Choice PPO, BlueHPN, BlueEdge, EPO and Indemnity (ParPlan) – 800-451-0287**
- **BlueCard** (out of state) – **800-676-2583** (for benefits & eligibility) or **800-451-0287** (for claims status)
- **Federal Employee Program** – **800-442-4607**

Provision of Contract Copies

The Plan shall provide a copy of its contract with a particular participating provider (including without limitation a contract with a physician organization or a physician group in which such participating provider participates) to such participating provider, upon receipt by us of a written request by the participating provider, except in circumstances where the Plans are restricted from providing a participating provider with a copy of the Plan's contracts with a physician organization or physician group specifically because of terms contained in that contract.

Request Sample Maximum Allowable Fees

Participating* providers can request samples of the maximum allowable fees for your specialty as follows:

- Online using the Availity Fee Schedule tool. You can request up to 20 codes per request and get immediate fee schedule results.
- Online using the Fee Schedule Request Form.

* Dental (DDS) providers, contracted with the Dental Network of America, must email DNOA for reimbursement related questions or fee schedule requests. For non-contracting provider reimbursement, contact provider customer service at 800-451-0287 for reimbursement information.

NETWORKS AND ID CARDS

Refer to the following information on our provider networks and how to identify our member plans. In addition, refer to the Network Participation for more information.

Administrative Services Only plans are employer self-funded health benefit plans that contract with us. For claims processing services, provider network access, clerical services, or other administrative responsibilities. Backed by our strength and stability, our ASO accounts are given the flexibility to meet the unique requirements of a self-funded employer group.

Networks

- **Blue Choice PPO**
  - Blue Choice PPO is our largest plan that provides coverage for individual and family market and group.
  - It is subject to copays, coinsurance and deductibles where applicable.
  - No primary care provider selection or referral requirements.
  - The Blue Choice PPO ID cards will indicate a Network ID of BCA

- **Blue High Performance Network**
  - BlueHPN, a national high-performance network for large ASO groups.
  - Follows the current processes and requirements of our Blue Choice PPO network
  - No PCP selection or referral requirements for in-network providers
  - In the BlueHPN service areas, members have access to emergency care with non-BlueHPN providers
  - In non-BlueHPN service areas, members have access to urgent and emergent care
  - Member ID cards will have the Blue High Performance Network name
  - BlueHPN ID cards will indicate a Network ID of HPN

The following Texas counties are included in the BlueHPN service area:

Atascosa	Comal	Guadalupe	Montgomery
Bandera	Dallas	Harris	Rockwall
Bexar	Denton	Hays	Tarrant
Brazoria	Ellis	Johnson	Travis
Chambers	Fort Bend	Kendall	Williamson
Collin	Galveston	Liberty	

- **Exclusive Provider Organization**
  EPO is an in-network only PPO plan utilizing the Blue Choice PPO network in Texas. This plan provides no coverage for out-of-network services except for medical emergencies or accidents. To receive benefits, members must seek care from network providers. PCP selection is not required.

- **BlueEdge**
  - BlueEdge products utilize the Blue Choice PPO network of providers
  - To receive the highest level of benefits, members must receive medical care from network providers.
  - No PCP selection or referrals are required.
  - Network providers may only bill members in BlueEdge for cost share (coinsurance) and deductibles, where applicable. There are no copayments within the benefit plan.

  A **Health Care Account** is established for each employee enrolled in BlueEdge:
  - The HCA is a specific dollar amount per year for initial health care costs
  - First dollars spent are paid from the HCA and applied toward the deductible.

- Covered services are paid from the HCA until the balance is spent.
- BlueEdge benefits are applied once the HCA is depleted and the self-pay requirement is satisfied, which equals the deductible.

A **Health Savings Account** can be funded by an employer, employee or both:

- Amounts paid for PPO-eligible expenses are applied to meeting the deductible.
- If the member elects, we will pay claims using available HSA account balance until the account is depleted.
- The member may also access their available funds by using a debit card or checkbook issued by the HSA administrator.

Both products provide:

- Preventive/wellness care is covered at 100% in-network even before the deductible is met.
- There are no deductibles or office visit copayments for preventive/wellness services:
- Physicals
- Diagnostic tests
  - Routine lab & x-ray
  - Mammograms
- Well child care and immunizations

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.

ID Card Information

Each Plan member receives an ID card upon enrollment for identification purposes only and does not constitute proof of eligibility. The ID card provides information concerning eligibility and contract benefits and is essential for successful claims filing. The three-character prefix is a critical part of the ID number and identifies what group benefits apply, or which Blue Cross and Blue Shield plan is responsible for payment. It is recommended that you copy the member's ID card for your files at each visit.

When submitting a claim, the prefix should always be entered as it appears on the ID card. If the correct prefix is not provided, the claim may be unnecessarily delayed or denied.

The ID card displays:

- The member's unique identification number
- The employer group number through which coverage is obtained
- The current coverage date
- Plan number
- Network ID
- Applicable coinsurance, copayment, deductible or cost-sharing to covered services

Definitions:

- Cost sharing is the general term used to refer to the member's out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for covered services a member receives and may be subject to an annual out-of-pocket maximum
- Coinsurance, if applicable, is the specified percentage of the allowable amount for a covered service that is payable by the member.
- Copayment is the amount required to be paid to a provider, pharmacy, etc., by or on behalf of a member in connection with the covered services rendered.
- Deductible, if applicable, is the specified annual amount of payment for certain covered services, expressed in dollars that the member is required to pay before the member can receive any benefits for the covered services to which the deductible applies.

If the member does not have their ID card, providers can access the Patient ID Finder tool to obtain our patient ID number and group number by entering patient-specific data elements. This tool is available in our branded Payer Spaces section via Availity® Essentials.

The member is required to report immediately to customer service any loss or theft of his/her ID card. A new ID card will be issued. The member is also required to notify us within 30 days of any change in name, address, marital status or eligible dependents.

Note: The member is not allowed to let any other person use his/her Plan ID card for any purpose.

Texas Department of Insurance Requirements

TDI requires carriers to identify fully insured members who are subject to the requirements of prompt pay legislation. ID cards that reflect an indicator TDI signify members who are subject to the requirements of TDI including prompt pay legislation.

Member Access

Plan members have direct access to all participating primary care physicians as well as to all participating specialty care physicians or providers. A Plan member does not need to obtain a referral from their PCP to seek services/care from a participating specialty care physician or provider.

Plan members receive in-network benefits by selecting services/care from participating Plan physicians and professional providers.

If an out-of-network physician or professional provider is necessary due to network inadequacy or continuity of care, **prior authorization may be required by us**.

Federal Employee Program®

Blue Cross and Blue Shield Service Benefit Plan, commonly referred to as the Federal Employee Program or FEP®, is offered to federal employees and annuitants by participating Blue Cross and Blue Shield Plans. FEP benefits may be updated annually as negotiated by the Blue Cross Blue Shield Association and the Office of Personnel Management.

- FEP group number is 0FEPTX. This group number needs to be entered in Block 11 on the CMS 1500 claim form or in Block 62 on the UB 04 claim form FEP utilizes the Blue Choice PPO network.
- No PCP selection or referrals are required.
- Standard Option members must seek care from a participating Blue Choice PPO provider to receive the highest level of benefits
- Basic Option and Blue Focus members only have in-network level benefits with few exceptions

Enrollment codes

Eligible federal employees, tribal employees and annuitants may enroll in the Federal Employees Health Benefits Program. Refer to the U.S. Office of Personnel Management site for additional information. Three health plans options are offered to FEP members: FEP Blue Focus, Basic Option and Standard Option.

The federal ID card is quite different from Blue Choice PPO ID card. The following is a key to the Service Benefit Plan enrollment codes that appear on the federal ID card.

Enrollment code	Benefits for	Benefit option
104	Self only	Standard
105	Self and family	Standard
106	Self plus one	Standard
111	Self only	Basic

112	Self and family	Basic
113	Self plus one	Basic
131	Self only	FEP Blue Focus
132	Self and family	FEP Blue Focus
133	Self plus one	FEP Blue Focus

FEP Blue Focus Option Plan

FEP Blue Focus is a PPO with a nationwide network including hospitals, physicians, and numerous ancillary/specialty providers which offer:

- An in-network-only benefit program requiring members to use PPO providers to receive benefits.
- A unique design with services categorized by core, non-core, and wrap benefits.
- Core services including full coverage for preventive care, the first 10 office visits per year with a $10 copayment for both PCP and specialists and non-core benefits applies a $500/individual and $1000/ family deductible.
- The FEP enrollment code may be 131, 132 or 133

FEP Basic Option Plan:

- PPO with a nationwide network including hospitals, physicians and numerous ancillary and specialty providers.
- In-network-only benefit program that requires members to use PPO providers to receive benefits with few exceptions.
- Has no calendar year deductible.
- Most services are reimbursed in full of the plan allowance after an applicable member copayment.
- Office visit copayment is $30 for a preferred PCP and $40 for a referred specialist.
- The FEP enrollment code may be 111, 112 or 113

FEP Standard Option Plan

- A PPO with a nationwide network including hospitals, physicians, and numerous ancillary and specialty providers.
- Members must use PPO providers to receive preferred (network) benefits.
- Members may also use non-PPO providers, participating, or non-participating. When a non-PPO provider is used, the member will receive a lower benefit level.
- Office visit copayment is $25 for a preferred PCP and $35 copayment for a preferred specialist.
- Other non-preventive services are first subject to a $350/ individual or $700/ family calendar year deductible.
- The FEP enrollment code may be 104, 105 or 106

FEP Customer Service

We provide a dedicated customer service staff for FEP. The customer service representatives have access to federal member information to give prompt inquiry response to:

- Benefits and member eligibility
- Claims
- Current preferred provider network information
- Formal and informal complaint procedures

The automated phone system also provides information for:

- Benefits
- Eligibility
- Claims

You may contact our FEP customer service by calling **800-442-4607**. Hours: 9 a.m. - 5 p.m. CT Monday through Friday.

FEP customer service may also be contacted in writing at the following address:
FEP Customer Service
P.O. Box 660044
Dallas, TX 75266-0044

Benefits and eligibility and claim status can also be accessed online via Availity® Essentials.

FEP Blue Health Connection[1]

Providers and members benefit from Blue Health Connection. Blue Health Connection is a toll-free service that provides 24-hour health care information available to FEP members. The service enables members to make informed, appropriate health care decisions. Members can call the Blue Health Connection Audio Health Library® at **888-BLUE-432** and get prerecorded information and literature on more than 450 health topics.

Additionally, FEP members can speak to experienced, specially trained nurses who can answer their health care questions. Using non-diagnostic, symptom-based assessment guidelines, the nurses help members identify appropriate sources and time frames for care.

With Blue Health Connection, network physicians and professional providers may benefit through a reduction of after-hour and inappropriate phone calls. We also expect Blue Health Connection to reduce unnecessary hospital emergency visits. Members will receive supportive information, in addition to that given by their physician or professional provider.

Note: Blue Health Connection should only be used by FEP members. However, preferred physicians and professional providers are offered one courtesy call to be used as a demonstration. Preferred providers should identify themselves, so they will not be included in the utilization data for the program.

[1]Blue Health Connection is the name used by Blue Cross and Blue Shield Federal Employee Program for Personal Health Advisor.

ELIGIBILITY AND BENEFITS

We comply with the Eligibility Statement Legislation. For additional information on this legislation, refer to the Texas Department of Insurance site.

Providers are responsible for checking eligibility and benefits prior to rendering services on every member for every visit. 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 Essentials (Refer to the Electronic Commerce page)
- Phone to provider customer service at the numbers listed below or on the member's ID card.
    - **800-451-0287** - Blue Choice PPO, BlueEdge, Blue High Performance Network, EPO, and Indemnity
    - **800-442-4607** – Federal Employee Program
    - **800-676-2583** – Out-of-State Blues Plan member (You must have the three-character prefix from the member's ID card to utilize this service)

When services may not be covered, members should be notified that they may be billed directly.

Refer to the Eligibility and Benefits page for more information.

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, we will accept third-party payment for premium directly from the following entities.

- The Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act
- Indian tribes, tribal organizations or urban Indian organizations; and
- State and federal government programs

We may choose, in our sole discretion, to allow payments from not-for-profit foundations, provided those foundations, meet non-discrimination requirements and pay premiums for the full policy year for each of the members at issue. Except as otherwise provided above, third-party entities, including hospitals and other providers, shall not pay us directly for any or all enrollee's premium.

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 cost share can vary by plan.

The Plan members are required to pay their cost share, if applicable, at the time services are rendered. The provider agrees to pursue and collect from all applicable cost share amounts from members. In no event will provider offer, advertise, or otherwise publicize any waiver or other reduction of any cost share amount.

Verification of Eligibility and Benefits

Under Texas Prompt Pay legislation, providers have the right to request a verification that a particular service will be paid by the insurance carrier. Verification, as defined by the 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 offered.

To initiate a request for verification, contact provider customer service at **800-451-0287** and select the prompt for verification.

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. We will issue requests for verification of services only if we perform the claim processing.

The verification process includes researching eligibility, benefits and authorizations. We will respond to the provider's request with one of the following letters within the required time frames:

- Request for additional information
- Verification notice
- Declination notice

The required elements a network provider needs to supply to initiate verification are as follows:

- Member name
- Member ID number
- Member date of birth
- Name of enrollee or subscriber
- Member relationship to enrollee or subscriber
- Presumptive diagnosis, if known, otherwise presenting symptoms
- Description of proposed procedures or procedure codes
- Place of Service code where services will be provided and if a place of service is other than provider's office or provider's location need name of hospital or facility where proposed service will be provided
- Proposed date of service
- Group number
- If known to the provider, name and contact information of any other carrier, including
- Other carrier's name
- Address
- Telephone number
- Name of enrollee
- Plan or ID number
- Group number (if applicable)
- Group name (if applicable)
- Name of the provider providing the proposed services
- Physician's or professional provider's NPI number

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

Insurance carriers have the right to decline verification to a provider of service. Declination, as defined by TDI, is a response to a request for verification in which a preferred provider carrier does not issue a verification for the proposed medical care of health care services. A declination is not a determination that a claim resulting from the proposed services will ultimately not be paid.

Some examples of reasons for declination may include, but are not limited to, the following policy or contract limitations:

- Premium payment timeframes that prevent verifying eligibility for a 30-day period
- Policy deductible, specific benefit limitations or annual benefit maximum
- Benefit exclusions
- No coverage or change in membership eligibility, including individuals not eligible, not yet effective or membership canceled
- Pre-existing condition limitations

A declination is simply a decision that a guarantee cannot be issued in advance, not a determination that a claim will not be paid. Therefore, if a declination is given, providers cannot bill the member at the time of service except for the applicable copayments, deductibles or coinsurance amounts.

Additional Fees Charged by Providers

- The Plan discourages the practice of participating providers charging members for additional fees beyond required deductibles, copayments and coinsurance.
- Plan participating provider agreements require providers to 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 participating 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 to accept payment responsibility for the non-covered service prior to 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.
- The provider may not charge members any amount more than the applicable cost sharing for covered
- services, including any access fees for concierge services 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 regarding quality, comprehensiveness of care services, reasonable access to appointments, or after-hours coverage.

Room Rate 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 member'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 us at least 30 days prior to the planned effective date.

The Room Rates Notification Form is located on the Forms page. The completed form can be faxed to the applicable fax number listed on the form or mail to your network management consultant. It is also important to notify us if your facility becomes private room only or a wing of the hospital is private room only. Once the information is received, We 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 us

BlueCard® Program

The BlueCard Program links participating providers and the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. The program ensures that members can obtain health care services while traveling or living in another Blue Plan's area. With BlueCard, they receive all the same benefits of their contracting Blue Cross and Blue Shield Plans and access to BlueCard providers and savings.

Providers and hospitals in Texas submit claims for members from other Blue Plans electronically. When a paper claim is submitted, use the following address:
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

The BlueCard Program includes both indemnity and PPO health care benefits. Additionally, the program members access to international hospital coverage.

For detailed information, refer to the BlueCard Provider Manual on the BlueCard Program page.

Blue Distinction

The Blue Distinction® Specialty Care Program is a national center of excellence program designating health care providers that demonstrate expertise in delivering quality specialty care safely, effectively and cost-efficiently. The goal of the program is to help consumers find both quality and value for their specialty care needs, while providing a credible foundation for employers to design benefits tailored to meet their quality and cost objectives.

Some member benefit plans include a requirement to utilize our Blue Distinction Centers when providing specialty care.

Blue Distinction® Centers:

- Providers are recognized for their expertise in delivering specialty care.

Blue Distinction® Centers+:

- Providers recognized for their expertise and cost-efficiency in delivering specialty care.
- Quality remains key: only those providers that first meet nationally established objective quality measures for Blue Distinction Centers will be considered for designation as a Blue Distinction® Center+.

Blue Distinction® Specialty Care has various areas of specialty care:

- Bariatric surgery
- Cardiac care
- Knee and hip replacement
- Maternity care
- Spine surgery
- Substance use treatment and recovery
- Transplants
- Fertility care
- Cellular immunotherapy
- Gene therapy

To learn more – go to the Blue Distinction page.

MEMBER RIGHTS AND RESPONSIBILITIES

As one of our providers, you are obligated to be aware of member's rights and informed of their responsibilities. Our members may refer to their benefit booklet for a listing of their rights and responsibilities, which are also included below. You can also access these documents on our site.

Member Rights	Member Responsibilities
You have the right to:	You have the responsibility to:
Receive information about the organization, its services, its practitioners and providers and subscribers' rights and responsibilities.	Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.
Make recommendations regarding the organization's subscribers' rights and responsibilities policy.	

Communication Rights	Communication Responsibilities
You have the right to:	You have the responsibility to:
Participate with practitioners in making decisions about your health care.	Follow the plans and instructions for care you have agreed to with your practitioner.
Be treated with respect and recognition of your dignity and your right to privacy.	Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.
A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.	
Voice complaints or appeals about the organization or the care it provides.	

PROVIDER ROLES AND RESPONSIBILITIES

Provider's roles and responsibilities will differ among the various specialties; however, certain responsibilities will be shared by all of our providers.

Primary Care Provider Role

A provider who has contracted with us as a PCP will agree to provide or direct all medical care for the Plan member including preventive, acute and chronic health care management and:

- Provide the same level of care to our patients as provided to all other patients.
- Ensure that it provides information regarding treatment options in a culturally competent manner.
- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. PCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the provider or on-call provider; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the provider or on-call provider and the phone number is provided.
- Always be available to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to members. Such requests must be responded to within one hour.
- Meet required Patient Appointment Access Standards (for more detail refer Quality Improvement Program in this manual)
- Keep a central record of the member’s health and health care that is complete and accurate.
- Complete required prior authorizations for services or request RCR when applicable.
- Provide copies of X-ray and laboratory results and other health records to specialty care providers to enhance continuity of care and to preclude duplication of diagnostic procedures.
- Provide us, upon request and at no charge, copies of medical records when requested by BCBSTX for the purpose of claims review, quality improvement, risk adjustment or auditing.
- Enter all reports received from specialty providers into the member’s health record.
- Assume the responsibility for arranging and prior authorizing hospital admissions in which they are the admitting provider or delegate this responsibility to the admitting specialty providers.
- Assume the responsibility for care management as soon as possible after receiving information that a Plan member has been hospitalized in the local area on an emergency basis.
- Coordinate inpatient care with the specialty providers so that unnecessary visits by both providers are avoided.
- Maintain and operate his/her office in a manner protective of the health and safety of their personnel and our patient in accordance with Texas Department of Health standards.
- Cooperate with us for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers’ compensation, third-party liens and other third-party liability. Our contracted providers agree to file claims and encounter information with us even if the provider believes or knows there is a third-party liability
- Only bill members for copayments, cost share (coinsurance) and deductibles, where applicable. The PCP will not offer to waive or accept lower copayments, cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member’s insurance coverage.
- Agrees to use their best efforts to participate with our Plan's Electronic Funds Transfer and Electronic Remittance Advise under the terms and conditions set forth in the EFT agreement and as described on the ERA enrollment form.

Referrals to Specialty Care Providers

Plan members have direct access to all participating Plan primary care and specialty care providers. No referral is required.

Prior to referring a Plan member to an out-of-network provider for non-emergency services, if such services are also available through an in-network Plan provider, as a participating network provider you must contact Medical

Management for authorization and complete the appropriate "Out-of-Network Enrollee Notification" form. Refer to Authorization Process section for how to submit requests.

If information received for an out-of-network referral does not satisfy established criteria, the case will be referred for Peer Clinical Review to our Physician Reviewer for review. Additional medical information may be necessary in these cases.

- **Emergencies** – Physician or professional providers must admit patients to a participating facility unless an emergency exists that precludes safe access to a Plan facility or if the admission is approved by BCBSTX for a non-Plan facility because of extenuating circumstances. When appropriate, the patient should be transferred to a Plan facility as soon as medically possible.
  Note: For behavioral health emergency information, refer to the Behavioral Health section of this manual.
- **Benefit Decision** — The decision to provide treatment is between the patient, the PCP or the Plan provider or the out of Plan healthcare provider if the member has out of network benefits. We determine what is covered and payable under the benefit plan.
- Referral notification is not verification and does not guarantee payment. Payment will be determined after the claim is filed and is subject to the following:
  - Eligibility
  - Other contractual limitations, including, but not limited to:
  - Cosmetic procedures
  - Failure to prior authorize services
  - Limitations contained in riders, if any
  - Claims Processing Guidelines
  - Payment of premium for the date on which services are rendered (Federal Employee Participants are not subject to the payment of premium limitation).

Prior to referring a Plan enrollee to an out-of-network provider for non-emergency services, if such services are also available through an in-network Plan provider, as a participating network provider you must complete the appropriate form below:

- Out-of-Network Care – Enrollee Notification Form for Regulated Business (use this form if "TDI" is on the member's ID card.
- Out-of-Network Care - Enrollee Notification Form for Non-Regulated Business (use this form if "TDI" is not on the member's ID card).

As a referring network physician, you must provide a copy of the completed form to the enrollee and retain a copy in his or her medical records files.

Role of the Specialty Care Provider

A participating Plan provider who provides services is expected to:

- Provide the same level of care to Plan patients as provided to all other patients.
- Ensure that it provides information regarding treatment options in a culturally competent manner.
- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. Specialty providers will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the provider or on-call provider; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the provider or on-call provider and the phone number is provided.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Meet required Patient Appointment Access Standards (for more detail refer to the Quality Improvement Program of this provider manual).
- Request required prior authorizations for services or request RCR when applicable.
- Keep a central record of the member's health and health care that is complete and accurate.
- Provide inpatient consultation within 24 hours of receipt of the request. Emergency consultation to be provided as soon as possible.

- Provide us, upon request and at no charge, copies of medical records when requested by the
- Plan for the purpose of claims review, quality improvement, risk adjustment or auditing.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the Plan patient in accordance with Texas Department of Health standards.
- Cooperate with us for the proper coordination of benefits involving covered services and collecting of third-party payments including workers' compensation, third-party liens, and other third-party liability. We contracted providers agree to file claims with us even if the provider believes or knows there is a third-party liability.
- Only bill for cost share (copayments, coinsurance and deductibles) where applicable. Specialty care providers will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member's insurance coverage.
- Agrees to use their best efforts to participate with our Plan's electronic funds transfer and electronic remittance advise under the terms and conditions set forth in the EFT agreement and as described on the ERA enrollment form.

Role of the OB-GYN

A female Plan member has direct access to all Plan participating Plan participating primary care providers and specialty care providers including an OB-GYN – no referral is required.

- The access to health care services of an obstetrician or gynecologist, includes, but is not limited to:
- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions
- Diagnosis, treatment, and access to a specialist for any disease or condition within the scope of the designated professional practice of a credentialed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts.

When abnormalities are discovered, the Plan participating OB-GYN can directly manage and coordinate a woman's care for obstetrical and gynecological conditions. Also, any services rendered outside of the OB-GYN's office, such as lab and ultrasound, must be performed by facilities contracted for the Plan network.

Note: Non-prescription contraceptives and associated care vary by employer benefit program. To verify coverage for this type of service, call our provider customer service at **800-451-0287**.

Obstetrical and Newborn Care Notifications

After the first prenatal visit, the Plan participating provider's office should provide notification of the Plan member's obstetrical care to us via the Availity Authorization and Referrals tool. OB ultrasounds may be performed in the provider's office and do not require prior authorization.

Extensions beyond the normal length of stay (48 hours for a vaginal delivery and 96 hours for a C-Section may require prior authorization.

Notes:

- Maternity care is subject to a one-time office visit copayment. This copayment should be collected at the time of the initial OB office visit.
- Providers will be reimbursed for the initial OB visit separately from the "global maternity care" and should submit a claim for this service at the time of the initial OB visit.
- All subsequent office visits for maternity care and delivery are considered as part of the "global maternity care" reimbursement. Submit claim upon delivery.

Please refer to the Maternity Care and Delivery section of the Current Procedural Terminology (CPT®) and our Global

Obstetrical/OB Maternity Services Policy on the Reimbursement Policy page for billing guidelines.

Provider Complaint Procedure

Plan participating providers are urged to contact the Plan provider customer service area when there is an administrative question, problem, complaint or claims issue at **800-451-0287**.

To appeal a medical management medical necessity determination, contact the medical management department at **800-441-9188**:

- Hours: 6 a.m. – 6 p.m., CT, M-F and non-legal holidays and 9 a.m. to noon CT, Saturday, Sunday and legal holidays
- Messages may be left in a confidential voice mailbox after business hours

Medical management decisions may be formally appealed by phone, fax, or in writing. For appeals of denied claims, refer to Claim Review Process in this manual.

A Plan participating provider may contact the TDI to obtain information on companies, coverage, rights or complaints at **800-252-3439** or utilize their online complaint system.

For all other inquiries, please contact your Network Management office.

Failure to Establish Provider Patient Relationship

Providers may terminate their relationship with a member/patient in certain circumstances and following procedures for notifying us and the member.

Reasons a provider may terminate their professional relationship with a member include, but are not limited to, the following:

- Fraudulent use of services or benefits
- Threats of physical harm to a provider or office staff
- Non-payment of required copayment for services rendered or applicable coinsurance and/or deductible
- Evidence of receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or necessary
- Refusal to accept a treatment or procedure recommended by the provider, if such refusal is incompatible with the continuation of the provider member/ patient relationship (provider should also indicate if he/she believes that no professionally acceptable alternative treatment or procedure exists)
- Repeated refusal to comply with office procedure in accordance with acceptable community standards
- Other behavior resulting in serious disruption of the provider member/patient relationship.

Reasons a provider may not terminate their professional relationship with a member include, but are not limited to, the following:

- Member's medical condition (i.e., catastrophic disease or disabilities)
- Amount, variety or cost of covered health services required by the member; patterns of over utilization, either known or experienced
- Patterns of high utilization, either known or experienced.

When our Network Management receives preliminary information indicating a contracted provider has deemed it necessary to terminate a relationship with a member, they **will review with the provider the following important points. Refer to the Performance Standard section above and if necessary, explain why they may not terminate their relationship with a member.**

- Determine the effective date of termination based on the following: The effective date must be no less than 30 calendar days from the date of the provider's notification letter to the member. Exception: Immediate termination may be considered if a safety issue or gross misconduct is involved – must be reviewed and approved by us.
- A notification letter from the provider to the member/patient is required and must include:

    - Name of member– if it involves a family, list all members affected
    - Member identification numbers
    - Group number
    - The effective date of termination (as determined based on the above).
- A copy of the letter to the member must be sent simultaneously to our applicable Network Management Representative (or director), via email, fax or regular mail to our appropriate network management office.
- A list of our Network Management Office Locations including fax numbers and addresses is available by accessing Contact Us.
- The provider must continue to provide medical services for the member/patient until the termination date stated in the provider's letter.

When our network management receives a copy of the provider's letter to the member, they will:

- Contact the provider to confirm receipt of the letter, review important points outlined above, and address any outstanding issues, if applicable.
- Forward the provider's letter to our applicable customer service area and they will:
    - Send a letter to the member/patient 30 days prior to the termination date, which will include a new designated PCP or outline steps for the member/patient to select a new PCP (or SCP if applicable).
    - Send a follow-up resolution letter to the provider (or IPA/Medical Group if applicable).

If the Provider Agrees to Continue to See the Member:

If the member appeals the termination directly with the provider and agrees to continue to see the member, the provider must immediately notify us in writing of their approval to reinstate the member to their panel (so that our provider customer service can re-assign the PCP to the member if the member requests such or to prevent any future miscommunication).

Risk Adjustment

Risk Adjustment seeks to level the playing field by discouraging adverse selection of members is accomplished via a two-step process:

Risk assessment

- Evaluating the health risk of an individual to create a clinical profile
    - Demographics
    - Medical conditions
    - Rate adjustment
- Determination of the resource utilization needed to provide medical care to an individual
- Medical record documentation for each date of service should include:
    - Conditions that are monitored
    - Conditions that are evaluated
    - Conditions that are assessed
    - Conditions that are treated
- Need for complete and accurate information regarding patient health status/conditions:
    - Diagnosis persistency
    - Personal history
    - Family history
    - Health status
- Annual documentation of coexisting conditions

Risk adjustment

- Submission of risk adjustable diagnoses to Centers for Medicare & Medicaid Services via claim submission.
- Retrospective chart review:
    - Medical record audits to validate that clinical documentation supports information submitted on the associated claims. Health plans are required to conduct independent audits to validate the information submitted to the government for risk adjustment purposes.

If you have specific questions about risk adjustment, risk adjustment validation audits, medical record retrieval or other related topics, please email us.

Laboratory and Radiology Services

Our in-network providers are responsible for ordering and where necessary prior authorizing or requesting RCR, if applicable, outpatient lab and radiology services for plan members.

If outpatient lab or radiology services cannot be performed in the provider's office, the provider must send the Plan member to an in-network lab or radiology provider. To locate participating providers in the Plan network, visit Provider Finder®.

Providers should reference our Reimbursement Policies for information on processing of certain lab and radiology services. In addition, certain ASO groups may be applicable to our Lab Management Reimbursement Policies.

Certain lab or radiology procedures, when performed in a provider's office, the outpatient department of a hospital, or a freestanding imaging center, may require prior authorization or may be applicable to RCR through us medical management or Carelon Medical Benefits Management. Refer to Utilization Management for current prior authorization requirements or lists of services applicable to recommended clinical review and who to contact or by checking eligibility and benefits through Availity.

Lab or radiology services performed in conjunction with inpatient hospitalization, emergency room, outpatient surgery (hospitals and freestanding surgery centers) or 23-hour observation are excluded from these requirements.

Carelon Radiology Services Overview

For details on specific services handled by Carelon and their clinical guidelines access through Carelon's website. The guidelines are consistent with the clinical appropriateness criteria developed by the American College of Radiology. This program helps promote:

- The most appropriate diagnostic imaging exam for the diagnosis;
- Studies are performed in the proper sequence; and
- Member services are maximized by the efficient use of the benefit plan.

Carelon authorization process

To submit an authorization to Carelon, refer to the Authorization Process section of this manual. Carelon will process the requests as follows:

- Carelon will use clinical criteria to either immediately issue prior authorization or forward the case to a nurse or physician for review.
- A physician reviewer may contact the ordering provider to discuss the case in greater detail within two business days of receipt of the request.
- Ordering providers (PCPs or specialists) may also contact Carelon's physician reviewer at any time during the process.
- Medical records are not necessary, unless requested by Carelon.
- There are no administrative denials for lack of information.
- Carelon will provide the ordering provider with an order request number, which will be valid for 30 days from the date issued.
- The servicing provider must write the order/case request number on the claim for the imaging study.
- Issuance of prior authorization is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of a member's health benefit plan.

NETWORK PARTICIPATION

We contract with physicians, facilities and other health care professionals to form our provider networks. Our networks give our members access to quality, accessible and cost-effective health care services.

Provider Onboarding Process

Before you can join the Plan networks or send claims electronically as an out-of-network provider, you will need to be assigned our provider record ID. A provider record ID does not automatically activate network participation. Claims will be processed out-of-network until the provider who has requested network participation on the provider onboarding form has been approved and activated in the network.

Complete and submit the appropriate form or information to us as shown below and indicate whether you choose to participate in network or out of network.

- If you indicate that you want to be a participating provider, when your record ID is assigned, we will send you the appropriate agreements to complete.
- If you indicate that you want to participate out-of-network, your application will generate a provider record ID only.

Refer to the Provider Onboarding Process page for more information. Be sure to include appropriate forms including W-9 and a copy of official IRS documentation (such as SS-4 or 147C).

To set up a BCBSTX provider record ID:

Physician and professional providers:

- Complete the Provider Onboarding Form. For best results, please utilize Google Chrome. Providers who want to be in-network will have additional fields to complete on the form. Providers can select the question mark icon, where available, if they need assistance with those fields.
- Medical school and residency information is required from physicians (MD and DO) who participate in our networks.
- A complete, signed and dated W9 and a copy of each provider's license is required with all new group and solo practitioner Provider Onboarding Form submissions.

Group provider additional onboarding instructions:

- Complete the Provider Onboarding Form using the group information.
- Download the required current Provider Roster from the Provider Onboarding form for providers that need to be affiliated with your group tax ID and billing NPI. (For existing groups – please only send new providers and not a full roster).
- Enter one tax ID per onboarding request, but you can add multiple providers under that tax ID on the roster. Be sure you have the most current version of the roster, or it will not be accepted.

Note: Submitting incorrect rosters or missing rosters may result in your application being returned.

Hospital based providers

- **New individual providers** must complete the Provider Onboarding Form and list the name of each facility they service in the comments section
- **Group providers** should submit by downloading the current roster on the Provider Onboarding Form
    - Enter a Y in the Hospital/ Facility Based Provider column and enter the facility the provider is servicing the "Hospital/Facility Name or NPI" column.
    - Existing contracted groups or clinics should only include the providers they are adding using the provider roster template.

Ancillary providers

Refer to the Ancillary Credentialing Checklist for required documentation to complete the Provider Onboarding Form. The Ancillary Provider Questionnaire must also be completed if indicated on the Ancillary Credentialing Checklist. You will be assigned a case number. Cases are worked on in the order received and may take up to 90 days to complete.

- Incomplete or duplicate applications could result in a delay.
- Completing the credentialing forms in no way guarantees acceptance into any of our networks. We will notify you by letter if credentialing is approved.
- A complete, signed and dated W-9 that includes both your legal name and Doing Business As name, and official IRS notification of Tax ID assignment (such as SS-4 or 147c).

Affiliate providers: If adding an affiliate that meets either of the parameters below, submit your information to the appropriate Network Management office.

- Provider **has been deemed** "Provider Based Status," meaning it is operationally integrated with a main hospital and operates under the same name, ownership and administrative and financial control of a main hospital including license and NPI.
- Provider **has not been deemed** "Provider Based Status" but is required by us to be wholly owned, has its own license and NPI, and is within 35 miles of the acute care hospital. Credentialing is required.

Hospital providers
Submit Information to the appropriate Network Management Office location.

More Information

- When submitting using the Provider Onboarding form, you will receive a confirmation email with a case number.
- Obtaining our provider record ID does not automatically activate the networks.
- When you indicate on the Provider Onboarding Form that you want to be a participating provider, you will be sent the contracts along with instructions on how to complete and submit your contracts. Claims will be processed out-of-network, until the provider is contracted, approved and activated in the network.

Case Status Checker

If you have completed a Provider Onboarding form and would like to check the status, enter the case number you received in your confirmation email in our Case Status Checker.

Network Participation Process

We contract with providers to form our provider networks which are essential for delivering quality, accessible and cost-effective health care services to our members. After submitting your request for a provider record ID and indicating you want to be in-network the appropriate agreements along with instructions on how to complete and submit your contracts will be sent to you.

Claims will be processed out-of-network, until the provider is contracted, approved and activated in the network. Providers may need to be credentialed or verified before networks are active.

Urgent care centers must meet the following requirements:

- Extended hours – UCC must be open weekday evenings until at least 7 p.m. Weekend hours preferred but not required.
- Defibrillator - If not physically adjacent to an Emergency Room, UCC must have a defibrillator in their office.
- Tax ID Number - UCC must have its own provider record and Tax ID number.
- UCC Summary – UCC must complete the Urgent Care Center Summary (included in the application packet) and return it along with their application.
- Claims must be billed on CMS-1500.
- Physicians working at the center must be credentialed by us.
- Providers must have a specialty in emergency medicine, family practice, internal medicine, OB-GYN or pediatrics and must meet our network credentialing criteria.

Facility Based Providers which include, but are not limited to, anesthesia, emergency medicine, hospitalist, neonatology, pathology and radiology, the following information is verified to be in-network:

- Type 1 NPI number
- Texas State Board of Medical Examiners license (temporary permit is acceptable) or appropriate Texas licensure
- Provider must be physically located in the state of Texas
- Certificate/AANA number (applicable to CRNA providers only)
- NCCAA certificate (applicable to Anesthesia Assistants providers only)
- Current credentialing through our in-network facility type listed below.
- Must practice in one of the following facility types:
    - Ambulatory surgical center
    - Cancer center
    - General acute care hospital
    - Hospital-based substance abuse
    - Long-term acute care
    - Pediatric hospital
    - Psychiatric hospital
    - Rehabilitation facility

    Note: Facility based providers practicing in a free-standing emergency room or skilled nursing facility, **who have current credentialing through our in-network facility type listed above**, do not require direct credentialing through us.

    Providers who only provide services at an FSER/SNF and who do not have current credentialing through our in-network facility type listed above will require direct credentialing through us.

Credentialing
Providers who participate in our networks are required to complete a credentialing process prior to acceptance.

When physician and professional providers complete the Provider Onboarding Form, they need to indicate that they want to be in-network and we will send the applicable provider agreements. When we receive their signed agreements, the credentialing process is initiated. You will be notified when your networks are active.

In-Network Information

Once you are part of our networks, we strongly encourage your participation in all electronic options Available including electronic data interchange. EDI transactions help to ensure timeliness, accuracy and security of claims-related information. Please visit the Electronic Commerce page for details on how to sign up for these electronic solutions.

We would like to provide you with more information about becoming a participating provider for us.
Please check out the following:

- Provider Orientation
- News & Updates
- Blue Review

Changes in Status or Changes Affecting Your BCBSTX Provider Record ID

For providers and members to find you in our Provider Directory and for your processed claims to be sent to your correct location, providers need to report all changes to us at least 30-45 days in advance of the effective date of the change. These changes will not become effective until 30-60 days from the date we receive notification.

You may submit changes directly to us by going to Verify and Update Your Information page and submitting a completed form or by contacting your Network Management office.

Please notify us of changes to the following information:

- Name
- Physical address (primary, secondary, tertiary)
- Billing address
- Email address
- Telephone number
- Tax ID
- Specialty or sub-specialty
- Practice information/status
- Board certification
- NPI number change
- TIN/SS number change
- Moving from group to solo practice
- Moving from solo to group practice
- Moving from group-to-group practice
- Back up/covering physicians or professional providers
- Change of ownership
- EFT and ERA details (Refer to Electronic Commerce page for completing changes.)

Note: In-network providers or groups, prior to changing a tax ID or requesting termination from a provider network, (excluding Par Plan Agreement) contact your Network Management Office before completing this form.

You should submit all changes at least 30 days in advance of the effective date of the change. Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new provider record.

Reminders:

- We will not change, add, or delete information related to your provider record ID on a retroactive basis. All changes to your provider record ID will be effective with a future date.
- All provider record ID effective dates will be established as of the date that completed information is received at our office. This will apply to all additions, changes and cancellations.
- Retroactive network participation effective dates will not be established.
- Keeping us informed of any changes you make allows for appropriate claims processing, as well as maintaining the Plan provider directories with current and accurate information.

Providers can check status of their submitted provider onboarding form or the demographic change form by entering their case # from the confirmation email in the Case Status Checker.

Termination of Unused Provider Record ID

We may automatically cancel a provider record ID that does not have any claim dates of service within a 24-month period. Terming of the provider record ID will also result in termination of associated networks. Provider record IDs are specific to billing/rendering NPI's and tax identification numbers.

CREDENTIALING

Providers who participate in our networks are required to complete a credentialing process prior to acceptance. Refer to the following for information on credentialing processes.

Credentialing Process for Office Based Providers

To start the credentialing process, office-based physicians or professional providers submit the provider onboarding form indicating they want to be in-network. Refer to the Provider Onboarding Process for more information and link to the form.

Our Types of Professional Providers Requiring Credentialing List indicates the providers that require credentialing for participation in our managed care networks.

Note:

- Residency must be completed prior to being a contracted provider.
- Physician Assistants must be board certified by the National Commission on Certification of Physician Assistants and maintain certification for continued participation
- For Urgent Care Centers, the physicians and professional providers working at the center must be credentialed by us.
    - **Facility privilege requirements**
      Certain office-based professional specialties who routinely perform procedures in a facility setting, must have privileges at an in-network facility where those procedures are performed. Professional providers should refer to the TX Office-Based Provider Facility Admitting Privileges Requirements List to identify if your specialty requires admitting privileges and for the acceptable facility types.

      You may be permitted to submit a signed Facility Coverage Letter in lieu of privileges, if indicated on the TX Office-Based Provider - Facility Admitting Privileges Requirements List.

      Note: Facility Coverage Letter must be submitted along with the onboarding application. If you do not see your specialty on the list, no admitting privileges or Facility Coverage Letter is required.

    - **Expedited credential process for office-based providers**
      We will provide an expedited credentialing process which allows for a provisional network participation status if the provider applicant has:
        - A valid BCBSTX Provider Record ID for claim payment
        - Submitted a current signed contract/agreement with us
        - Completed the Council for Affordable Quality Healthcare's (CAQH®) Provider Data Portal online application with global or plan specific authorization to us (or if applicable, submits a completed TDI application)
        - A valid license in the state by and in good standing with the Texas Licensing Boards

      Providers will be notified of any missing information once the CAQH credentialing applications is Reviewed for completeness. The review takes on average 8–10 calendar days.
      Important
        - If the applicant does not meet the "provisional network participation" requirements, the applicant must be fully credentialed and approved prior to being made effective.
        - The licensing board for Psychologists (PhDs) does not provide an electronic verification method of a provider's license. PhDs will be fully credentialed and made effective after credentialing approval.
        - Please allow for a sufficient period of time for the full credentialing process to be completed, before calling us for a status update, as credentialing is a very involved process.

- **Initial credentialing and recredentialing process**
  We require physicians and professional providers to use the CAQH Provider Data Portal for initial credentialing and recredentialing. CAQH, a free online service, allows physicians and professional providers to fill out one application to meet the credentialing data needs of multiple organizations. CAQH Provider Data Portal online credentialing application process supports our administrative simplification and paper reduction efforts. This solution also supports quality initiatives and helps to ensure the accuracy and integrity of our provider database.

  Providers can utilize CAQH Provider Data Portal at no cost.

  Texas providers who have a provider type listed in the CAQH Approved Provider Types List must apply for initial or continuing with us through CAQH Provider Data Portal by accessing the CAQH website. Go to Getting Started with CAQH for additional information.

  Exceptions:
  - We requirement of use of CAQH Provider Data Portal does not apply to physicians and professional providers participating through delegated credentialing agreements/contracts or who are solely practicing in a hospital-based environment.
  - Texas physicians and professional providers who do not have a provider type listed in the CAQH Approved Provider Types List must go to the TDI website to access and complete a Texas Standardized Credentialing Application and email us along with the required supporting documents referenced below:
    - State medical licenses
    - Drug Enforcement Administration Certificate
    - Malpractice insurance face sheet
    - Summary of any pending or settled malpractice cases – if within 10 or less years old
    - Curriculum vitae
    - Signed Attestation (page 18 of online application – print & sign)
    - Written protocol (Nurse practitioners only)
- **Getting started with CAQH**
  Activate your Registration with CAQH Provider Data Portal
  Physicians and professional providers must have a CAQH Provider ID to register and begin the credentialing or recredentialing process. Refer to Getting Started with CAQH for information. The requirements for creating and/or updating your CAQH profile is important.

  Failure to finalize your CAQH application within 45 days will cause the credentialing process with us to be discontinued and you will be required to start the process over.

  If you have any questions on accessing the CAQH Provider Data Portal, you may contact the CAQH Help Desk at **888-599-1771** for assistance.

  Visit CAQH for more information about the CAQH Provider Data Portal and the application process or access CAQH Credentialing Frequently Asked Questions.

  Additional Resources
  CAQH contact info
  - Help Desk: **888-599-1771**
  - Hours: 6 a.m. – 8 p.m., CT, Monday – Thursday 6 a.m. – 6 p.m., CT, Friday
  - Online Application System Help Desk Email Address: caqh.uphelp@acsgs.com

- **Credentialing process for ancillary/hospital providers**
- For the ancillary provider specialties listed below, once you have an established provider record ID, you will

need to complete the Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire to begin the credentialing process. Along with the questionnaire, you may need to include additional information by specialty. Refer to the Credentialing and Contracting Process for Ancillary Providers page for the Ancillary Credentialing Checklists by specialty which indicates what additional information by specialty is required. Submit the questionnaire and any additional information to the appropriate email address listed by specialty.

- Ambulance
- Ambulatory surgery centers
- Birthing center
- Brain injury (post-acute) facilities
- Cardiac catheter lab
- Diabetes management
- Disease management (only provider questionnaire is required)
- Durable medical equipment
- Endoscopy center
- Free standing ER
- Free standing imaging
- Hearing aid supplier
- Home dialysis
- Home health
- Home infusion therapy
- Hospice
- Independent laboratories
- Long-term acute care
- Orthotics and prosthetics
- Psychiatric day treatment
- Psychiatric hospital
- Radiation therapy
- Rehab facilities - inpatient only
- Renal dialysis
- Skilled nursing facilities
- Sleep studies center
- Substance abuse facility

When your information is received you will be assigned a case number. Cases are worked in the order they are received. This process can take up to 90 days to complete.

Notes:

- Incomplete or duplicate applications could result in a delay.
- Completion of the credentialing forms in no way guarantees our acceptance into any of our Managed Care, Medicaid, Medicare Advantage or Triwest/VA networks. Provider will be notified by letter when credentialing is approved.
- Once the provider receives confirmation that credentialing is approved, the provider should contact the Ancillary Contracting mailbox listed above by specialty to initiate the contracting process.

- **Verification process for facility (hospital) based providers**

Hospital or facility based are providers who practice primarily in at least one of the facility types in the grid below. All facility affiliations must be listed on the Provider Onboarding Form. Eligible specialties include, but are not limited to anesthesia, emergency medicine, hospitalist, neonatology, pathology and radiology.

Facility type

Ambulatory surgical center	Pediatric hospital

Cancer center	Psychiatric hospital
General acute care hospital	Rehabilitation facility
Hospital based substance use disorder	Substance use disorder facility
Long term acute care	Teaching hospital

- **Note:** Facility based providers practicing in a free-standing emergency room or skilled nursing facility, who have current credentialing through our in-network facility type listed above, do not require direct credentialing through us. Providers who only provide services at an FSER/SNF and who do not have current credentialing through our in-network facility type listed above will require direct credentialing through us.

  Providers should obtain a provider record ID and indicate your request to participate in the networks when completing the form or roster:
  - Ensure all provider information is included on the on-boarding form and roster. Completing this information up front and accurately, in its entirety, will prevent delays in processing. Examples: Name, date of birth, NPI, social security number, gender, tax ID, etc.
  - **New individual providers** must list the name of each facility that they service in the comments section of the Provider Onboarding Form.
  - **Group providers should submit** using the provider roster template. Enter a Y in the Hospital/Facility Based Provider column and enter the facility the provider is servicing in the Hospital/Facility Name or NPI section.
  - **Existing contracted groups should only include the providers they are adding using** the provider roster template.

  For new groups and individual providers, upon receipt of the fully completed Provider Onboarding Form, and roster (for group providers), you will be sent the contracts for which you are eligible to participate along with instructions on how to complete and submit your signed contract(s). Providers will be processed upon receipt of the signed contracts.

- **Credentialing process for hospitals or facilities**

  Our Hospital/Facility Credentialing Program consists of a fully accredited National Committee for Quality Assurance (NCQA) Managed Care Organization (MCO) Standard based program that requires the credentialing of hospital/facility and ancillary providers requesting participation or continued participation in Blue Choice PPO and BlueHPN networks.

  We credential all facility providers that contract to provide health care to Plan members. Hospitals or facilities that wish to participate or continue participation in the network should complete the Facility Credentialing and Recredentialing application. The hospital/facility network representative can provide you with this application. The credentialing/recredentialing process includes the review of each hospital/facility provider's application or recredentialing packet.

  Standard credentialing procedures for the processing of the initial application or recredentialing packet data include but may not be limited to the verification of:
  - Current state licensure from the state and federal licensing bodies
  - Current liability coverage and aggregate rates as defined by the BCBSTX credentialing criteria, and
  - Current accreditations and certifications as defined by BCBSTX credentialing criteria.

  If CMS or Texas Department of State Health Services survey has not been completed within three years of the credentialing/recredentialing decision, an On-Site Assessment may be required at our discretion based on the market's needs.

  All documentation submitted to us for review must meet all credentialing criteria time frames as stipulated

in our credentialing criteria (i.e., expiration dates of liability coverage, DEA, licensure, attestation signature, accreditation/certification, etc.) that is required by all regulatory agencies.

Credentialing Updates

Keeping your information current with CAQH and us is your responsibility.

- **CAQH Provider Data Portal**
  You will be sent automatic reminders to review and attest to the accuracy of your data. Use CAQH Provider Data Portal to report any changes to your practice.

  Note: You must enter your changes into CAQH Provider Data Portal for us to access during the credentialing and recredentialing process. Only health plans that participate in CAQH Provider Data Portal database that you have authorized access will receive any changes.

- **Our Provider File Updates**
  Our members rely on the accuracy of the provider information in our online Provider Finder. Therefore, it's very important that you also inform us of changes to your practice. If you are a participating provider with us, you may request most changes online by using the online Demographic Change Form.

Recredentialing

The process of recredentialing is identical to that for credentialing and is consistent with NCQA and state of Texas requirements.

- **If you are an existing user of CAQH**, you are required to review and attest to your data once every four months.
- **At the time you are scheduled for recredentialing**, We will send your name, via its roster, to CAQH to determine if you have already completed the CAQH Provider Data Portal credentialing process and authorized us or selected global authorization. If so, we will be able to obtain current information and initiate the recredentialing process without having to contact you.
- **If your credentialing application (for recredentialing) is not available to us through CAQH because**
  - **You have not completed the CAQH Provider Data Portal credentialing process** - CAQH will mail you a welcome kit that includes access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to CAQH Provider Data Portal via the internet to complete and submit your application.
  - If you are a physician or professional provider who does not have **a provider type listed in the CAQH Approved Provider Types list**, you must go to the TDI website to access and complete a Texas Standardized Credentialing Application, and fax or mail the completed application along with the required supporting documents referenced below:
- State medical licenses
- Drug Enforcement Administration certificate
- Controlled and dangerous substances certificate
- Malpractice insurance face sheet
- Summary of any pending or settled malpractice cases(s) – if within 10 or less years old
- Curriculum Vitae
- Signed attestation (page 18 of online application – print & sign)
- Written protocol (Nurse practitioners only)

Note: Recredentialing Decision Notification – Upon completion of the recredentialing process, providers are considered approved unless notified otherwise. Notifications of the determinations other than approval will be mailed within 10 business days of the decision.

Facility Privilege Requirements

Certain office-based professional specialties who routinely perform procedures in a facility setting, must have privileges at an in-network facility where those procedures are performed.

Professional providers should refer to the TX Office-Based Provider Facility Admitting Privileges Requirements List to identify if your specialty requires admitting privileges and for the acceptable Facility types. You may be permitted to submit a signed Facility Coverage Letter in lieu of privileges, if indicated on the TX Office-Based Provider - Facility Admitting Privileges Requirements List. Note: Facility Coverage Letter must be submitted along with the onboarding application.

If you do not see your specialty on the list, no admitting privileges or Facility Coverage Letter is required. CAQH Credentialing Frequently Asked Questions

Refer to the "Credentialing Process for Office Based Physicians or Professional Providers" on the Network Participation - How to Join page for more information.

Medical Advisory Committee

The Medical Advisory Committee conducts regularly scheduled meetings, or as needed, to review the provider applicants for credentialing and recredentialing.

The Committee provides peer recommendations for approval or denial of a provider applicant files, reviews regular reports of Blue Choice PPO and BlueHPN credentialing activities and reviews or recommends action to resolve provider appeals. The Committee also reviews and resolves quality of care issues.

Our credentialing process includes a review of each provider applicant's file. Training, experience and the ability to deliver care that meets the medical standards of the community are an integral part of the process. Providers also have the right to be notified of any information obtained during the credentialing process that varies substantially from the information provided on the provider applications. Providers also have the right to correct erroneous information submitted by another party. Providers, upon request, have the right to be informed of the status of their credentialing or recredentialing application.

Note: Initial applicants will be notified of the decision (approval or denial) upon completion of credentialing. Our existing network providers in recredentialing will be notified only if an adverse decision, such as termination, is made.

Credentialing Review Requests

Any provider may seek a review of a decision related to initial credentialing or recredentialing decision on their continued participation in Blue Choice PPO and BlueHPN.

- **Submitting review requests**
  Requests for review must be submitted in writing within 10 calendar days from the date of the denial/termination letter. Written requests should be addressed to the Medical Director. The requests should include any supporting documentation or facts the provider feels would be beneficial for review.

- **Credentialing review process**
  The following table describes the review process:

STAGE	DESCRIPTION
1	The provider submits an appeal request to the credentialing committee.
2	The credentialing committee reviews the appeal request.
3	The provider will be provided with the decision in writing.

- **Provider termination process**
  Providers who do not meet credentialing criteria or have quality of care issues are reviewed by the credentialing committee.

- We may immediately terminate a provider's network participation if we determine that:
    - Continued network participation by the provider poses imminent harm to patient health; or
    - The provider's license has been revoked; or
    - There has been fraud or malfeasance.
- Written notice shall be provided to the provider of the reasons for termination and the affected provider networks.
- A provider may, within 10 days of the written termination notice, request an appeal in writing.
- A provider may, within 30 days of the written termination notice, request in writing that a review of the termination decision be conducted by a different Advisory Peer Review Panel to consider whether the termination action was correct under the terms of the provider contract/agreement.
- We will not notify members of the provider's termination until 30 days prior to the effective date of such termination or the time the Advisory Peer Review Panel makes a formal recommendation. However, if a provider is terminated for reasons related to imminent harm,
- We may notify members immediately.
- Within 60 days following receipt of the provider's written request for review, we will notify the provider of its review decision.
- Upon request, we will provide the provider with a copy of the recommendation of the Advisory Peer Review Panel, The panel's recommendation must be considered by us but is non-binding.

UTILIZATION MANAGEMENT

A utilization management review determines whether a benefit is covered under the health plan using evidence-based clinical standards of care as well as determining the appropriate site of care for certain services.

We may utilize designated vendors such as Carelon Medical Benefits Management and Alacura Medical Transportation Management, LLC to provide certain outpatient prior authorization or RCR services.

Refer also to the **Behavioral Health Programs** section of this provider manual for information on BH utilization management reviews.

The following are types of utilization management reviews:

- **Prior authorization** (sometimes referred to as precertification or preauthorization) is a utilization management process that determines whether medical services are:
  - Medically necessary or experimental/investigational and covered under the member's plan
  - Provided in the appropriate setting or at the appropriate level of care
  - Of a quality and frequency generally accepted by the medical community
  - Being rendered by a provider in or out of the member's network

  Note: Prior authorization is not a verification and does not guarantee payment. Payment will be determined after the claim is filed and is subject to eligibility, contractual limitations and payment of premiums on the date of service.

- **Notifications** can be submitted for inpatient services that are not subject to prior authorizations. By submitting a notification, the plan in turn will let the provider know what days or units are covered initially so that concurrent review is submitted when required for additional days or units. When a provider submits a notification for a service that is exempt from required prior authorizations, no review is conducted on that service.

- **Recommended clinical review** are optional reviews for medical necessity and appropriate site of care submitted before services are completed for an inpatient or certain outpatient covered services that do not require prior authorization and helps limit the situations where a service may be denied based upon medical necessity retrospectively. Refer to the recommended clinical review page for more information.
  - **Note:** Beginning Jan. 1, 2027, we'll start to remove recommended clinical review as an option for our commercial members. Throughout 2027, we'll reduce recommendations that you complete a recommended clinical review request, and we expect to remove this option entirely from our utilization management process by the end of 2027. With this change, services that previously allowed recommended clinical review may require prior authorization. Be sure to check eligibility and benefits prior to render services via Availity® Essentials or your preferred vendor. Refer to the Utilization Management page for more information.

- **Post-service medical necessity reviews** may occur after the service is rendered. During a PSMNR, we review clinical documentation to determine whether a service or drug was medically necessary and covered under the member's benefit plan. We may also conduct a post-service utilization management review if you do not obtain a required prior authorization before the services were rendered.

Services Applicable to Prior Authorization or RCR

To determine if specific services or categories have required prior authorization or if RCR option is applicable, whether a service is managed by our Medical Management or an external vendor such as Carelon or Alacura and if you are in-network for your patient:

- Refer to Utilization management for the required prior authorization or RCR lists, which are updated when new services are added or when services are removed.

- Use Availity Essentials or your preferred vendor to check eligibility and benefits. Refer to eligibility and benefits page for more information on Availity.
- Refer to the recommended clinical review page for code lists where recommended clinical review may be available.
- You can also call customer service at the toll-free telephone number on the member's identification card.

Prior Authorization Exemptions

Under Texas legislation, providers may qualify for an exemption from submitting prior authorization requests for particular health care services for all fully insured and certain ASO groups. Only services subject to required prior authorizations are eligible for an exemption. Providers can check Provider Correspondence Viewer via Availity Essentials to determine if they have been issued a PA exemption for a particular service.

We request you submit a notification to determine if the service is covered and the initial length of stay or initial units for services with a PA exemption. Notification can be submitted via Availity Authorizations & Referrals or by calling the number on the member's ID card. A notification acknowledgement for the specific services allowable per the PA exemption will be provided. Any days/units beyond what is outlined in the notification acknowledgement or covered by the initial PA exemption if a notification is not submitted, will require submission of an extension request (or concurrent review) and may be subject to a medical necessity review. Refer to the Prior authorization exemption page for qualifications for an exemption and other information.

Responsibility for Required Prior Authorization

In-network providers are responsible for obtaining prior authorization when it may be required. If prior authorization is not obtained for the applicable services, the in-network provider could be sanctioned based on our contractual agreement with the provider and the member will be held harmless for the provider sanction.

The member is responsible for prior authorization if they use out-of-network or out-of-state providers. Also, refer to the BlueCard® Provider Manual for more information on prior authorization responsibilities.

When to Request a Utilization Management Review

Time frames are listed below for contacting the Plan for utilization management review:

Type of Request	Type of Service	Time Frame
Prior authorization or required notifications	Certain inpatient and outpatient services as designated on prior authorization lists on the Utilization Management page. Submit required notification for services when provider has a prior authorization exemption for the service.	Prior to the delivery of services and preferably seven days in advance
Recommended clinical review option	For elective inpatient admissions when prior authorization is not required. Certain outpatient services refer to list on Recommended Clinical Review page.	Inpatient - minimum of two days prior to admission and preferably seven days in advance Outpatient - Prior to the delivery of services and preferably seven days in advance

Notifications	Urgent/emergent admissions	Within the later of 48 hours or by the end of the next business day of an emergency hospital admission.

Observation and Prior Authorization

Observation does not require prior authorization. However, if patient converts from observation to inpatient, the admission may require prior authorization or maybe applicable to RCR.

Utilization Management Review Information

The following outlines important information about utilization management reviews. Clinical Criteria — Prior authorization and RCR requests are reviewed using our Medical Policy, Carelon Care Guidelines and/or MCG Guidelines® which promotes consistent decisions based on nationally accepted, physician-created clinical criteria. The criteria are customized to reflect our medical policy and local standards of medical practice. Internally developed criteria for Extended Care are based on established industry standards, scientific medical literature and other broadly accepted criteria, such as Medicare guidelines. Diagnosis, procedure, comorbid conditions and age are considered when assigning the length of stay/service.

Note: Clinical review criteria is available upon request for cases resulting in non-certification.

- **Physician review** — A case will be referred to a physician reviewer if the information received does not meet established criteria. In any instance where there is a question as to medical necessity, experimental/investigational nature, or appropriateness of health care services, the ordering/referring/treating physician or the admitting/ attending physician or their delegate shall be afforded a reasonable opportunity to discuss the plan of treatment with the physician reviewer prior to the issuance of an adverse determination. The physician reviewer will attempt to contact the servicing physician or professional provider by telephone prior to issuance of an adverse determination. Physician advisors who are third parties hired by a facility are not eligible.

- **Notification of decision**— Written notification letters are sent to the member and provider. The approved length of stay or service and the authorization numbers are included. Letters of notification of benefit denial determinations include the reason for denial and an explanation of the appeal process.

- **Benefit decision** — The decision to provide treatment is between the patient and the provider. Once the decision has been made, we determine what benefits are allowed under the existing health plan.

Note: Prior authorization and RCR confirms the medical necessity of the service or admission but does not guarantee payment. Payment is subject to, but not limited to eligibility, contractual limitations and payment of premium on the dates of service.

Refer to **Authorization Process** section for information on appealing adverse determinations and post service medical necessity reviews to determine whether a service or drug was medically necessary and covered under the member's benefit plan.

Payment will be determined after the claim is filed and is subject to the following:

- Eligibility
- Other contractual provisions and limitations, including, but not limited to:
    - Cosmetic procedures
    - Pre-existing conditions
    - Failure to prior authorize
    - Limitations contained in riders, if any
- Claims processing guidelines

- Payment of premium for the date on which services are rendered (Federal Employee Participants are not subject to the payment of premium limitation).

Accessibility of Medical Management Criteria

Medical management review criteria is available to our participating providers upon request. Links to our Medical Policy and Carelon Care Guidelines are also available on our site. To receive MCG Guidelines on a specific condition, please contact the Medical Management Department at **800-441-9188**.

Certain Service Authorization Guidelines

The following information provides guidelines for prior authorization or RCR for certain specific services.

- **Home health services**
  The following general guidelines apply to home health services:
  - Services must be ordered by a physician and require a physician signed treatment plan.
  - The patient is certified by the physician as homebound under Medicare guidelines.
  - The needs of the patient can only be met by intermittent, skilled care by a licensed nurse, physical, speech or occupational therapist, or medical social worker.
  - The needs of the patient are not experimental, investigational or custodial in nature.
  - Home health services may require authorization prior to service being rendered

- **Hospice**
  Hospice benefits are available for patients with a life expectancy prognosis of six months or less. Treatment is generally palliative and non-aggressive in nature and is provided in the home. Inpatient admissions for pain management or caregiver respite may also be available depending on current group coverage. When prior authorization is required, submit requests for hospice services prior to services being rendered.

- **Home infusion therapy**
  Plan members requiring home infusion therapy are not required to be homebound to receive services. When prior authorization is required, submit requests for home infusion therapy services prior to services being rendered.

Prior Authorization or Recommended Clinical Review for Inpatient Care

The Plan provider is required to admit the member to a participating facility, except in emergencies. The healthcare provider is responsible for submitting required prior authorizations or when no prior authorization is required has the option to request a RCR for an elective inpatient admission including:

- Elective acute (Medical, hospice, maternity, surgical, transplant)
- Elective post-acute (Long term acute care, rehab, skilled nursing facility)

The provider must also notify us of extensions of care.

When an admission does not meet the clinical screening criteria, the Medical Management Department will refer the case to a physician reviewer. If the referring physician or professional provider disagrees with the physician reviewer's decision, they may request an appeal.

Submit required prior authorizations or optional RCR for elective (non-emergency) admissions at least seven days before the date of admission by accessing Availity Authorizations & Referrals or contacting the Medical Management Department at **800-441-9188**.

- **Urgent/emergent admission procedure:** Notification is encouraged within two business days of an urgent/emergent admission.
- **Admission on day of surgery:** Preoperative evaluation, testing, pre-anesthesia assessment and patient education will routinely be performed on an outpatient basis, or on the morning of surgery.

Emergency Care Services

Emergency care services are services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily function, cause serious dysfunction of any organ or part of the body, cause serious disfigurement, or in the case of a pregnant woman, cause serious jeopardy to the health of the fetus. **Emergency room services do not require prior authorization.**

- **Emergency inpatient admissions rendered outside of the Plan's service area**
  The attending physician/provider or member must notify our Medical Management Department of an emergency inpatient admission outside the Plan's service area within the later of 48 hours or by the end of the next business day.

When appropriate, the provider and the Medical Management Department will work together to arrange transportation of the member back to the service area for inpatient care at a participating facility.

Extension of an Existing Prior Authorization or RCR

An extension of an existing authorization or RCR issued by us or Carelon can be requested by a physician or provider up to 60 days prior to the expiration of the existing authorization or RCR. Concurrent review is performed when an extension of a previously approved inpatient length of stay is needed, or an extension of a previously approved extended care service is required.

The Plan provider is responsible for obtaining an extension prior to the expiration of the previously approved length of stay or service.

Please have the following information readily available when requesting an extension:

- Change of diagnosis/comorbid conditions
- Deterioration of the patient's condition
- Complications
- Additional surgical intervention, if applicable
- Transfer plans to another facility or to a specialty bed/unit, if applicable
- Treatment plan necessitating inpatient stay.

Extension review procedure
Review will begin upon request for the extension. The Medical Management Department may contact the admitting provider or hospital Medical Management Department for additional information. If the clinical screening criteria are not met, the case will be referred to a physician reviewer for a determination.

We utilize MCG Guidelines which promotes consistent decisions based on nationally accepted, physician-created, clinical criteria. Diagnosis, procedure, comorbid conditions and age is considered when assigning the inpatient length of stay.

If the information does not satisfy the criteria at any point of the admission, the case is referred to a physician reviewer for determination. Only a physician reviewer may deny a prior authorization or discontinue benefit certification. When a denial of benefits is determined, the Medical Management Department notifies admitting physician or professional provider and the hospital by telephone and letter. The confirmation letter of the benefit determination will be mailed to the member, facility and provider (if other than the PCP).

Discharge planning
Discharge planning is initiated as soon as the need is recognized during the hospital stay. When additional care is

medically necessary following a hospital admission, the Medical Management Department will work with the hospital discharge planning staff and the admitting provider in coordinating necessary services within the Plan network.

Submitting Authorization Requests

After determining whether an external vendor or us manage the requests, use the following to submit your prior authorization, RCR or out-of-network referrals. Electronic options are preferred to help expedite your request.

Services managed by Medical Management at BCBSTX

- Use the Availity's Authorizations & Referrals tool (HIPAA-standard 278 transaction) for electronically submitting requests for prior authorization, RCR, referrals and notifications for PA exempted services. Additionally, providers can also check the status of previously submitted requests or update applicable existing requests.

  The benefits of using this online functionality:
  - No separate user enrollment needed
  - Direct access within the Availity portal
  - Simplified 5-step process:
    - Log in to Availity
    - Select **Patient Registration** menu option, choose **Authorizations & Referrals**, then **Authorizations***
    - Select **Payer BCBSTX**, then choose your organization
    - Select a **Request Type** and start request
    - Review and submit your request

    Choose Referrals instead of Authorizations if you are submitting a referral request. If you are not yet registered with Availity, sign up at no charge. If you need registration assistance, contact Availity Client Services at **800-282-4548**.

- **Fax or mail**:
  If online tools are not available, prior authorization may also be initiated via fax at: Toll-free **800-252-8815** or **800-462-3272** and the recommended clinical review form can be faxed to us using the appropriate fax number listed on the form or mail to:
  BCBSTX
  PO Box 660044
  Dallas, TX 75266-0044
- **Phone:** Contact using the number on the member's ID Card or call **800-441-9188**.

Services managed by Carelon

- Use the Carelon Provider Portal
- **Phone:** Contact their call center at **800-859-5299**. Please note - do not submit medical records unless requested by Carelon. If a PSMNR is requested, the provider can respond in the Carelon provider portal. Do not submit medical records to us for Carelon requests for medical records.

Appeals for Carelon can be submitted:

- **Phone:** 800-859-5299
- **Fax :** 888-583-1005
- **Mail:** Attention: Prior Authorization Dept
  Appeals 540 Lake Cook Rd
  Deerfield, IL 660015

Services managed by Alacura

- **Phone:** (Quickest Channel): 866-671-4834

- **Fax:** 866-671-4995
- **Online:** Alacura Provider Portal
- **Email:** Texas.UM@alacura.com

The authorization number must be entered on the electronic or paper claim.

- **Electronic submission** — Enter the authorization number in REF 2300 - Prior Authorization, REF01=G1, REF02=Prior Authorization number.
- **Paper submission** – enter the authorization number in Block 23 on the CMS-1500 Claim Form

Our Medical Management Appeals

Expedited appeal process

We have an expedited appeal process for appeals of adverse determinations based on medical necessity, experimental/investigational or appropriateness of care that involve life-threatening, urgent or emergency services and continued stays for hospitalized patients. Notification of the appeal determination will not exceed one working day from the receipt of all necessary information or 72 hours from the appeal request, whichever is sooner. All appeals are reviewed by a physician or professional provider not previously involved in the case, who is in the same or similar specialty as would manage the condition under review.

Standard appeal process

We have a standard appeal process for appeals of adverse determinations for a denial of service based on medical necessity, experimental/investigational, or appropriateness of care. Written notification of the appeal determination will be provided no later than 30 calendar days after the date we received the appeal request. All appeals are reviewed by a physician or professional provider not previously involved in the case who is in the same or similar specialty as would manage the condition under review.

Provider request for case match review

A provider may request a case match review by submitting in writing, within 10 working days of an appeal denial, good cause for a specialty physician review. The request will be reviewed, and the appealing provider shall be notified no later than 15 working days from the date of the request.

To appeal an adverse determinations for medical necessity or experimental/investigational

To appeal an adverse determination for medical necessity or experimental/investigational, a provider may write to:
BCBSTX Medical Management
Attention: Appeals Department
1001 E. Lookout Dr.
Richardson, TX 75082-4144

Appeal requests may also be submitted by:
Fax: 866-221-3607
Phone: 855-896-2701

Appeal process for denials of out-of-network requests and non-covered benefits

The appeal of a denial of a service that is not covered per the member's coverage documents is considered a complaint and is resolved via the BCBSTX complaint process.

To request such a review, contact customer service at the telephone number shown on the member's ID card.

Case Management Services

Case management services help identify appropriate providers through a continuum of services while ensuring that available resources are being used in a timely and cost-effective manner.

Cases that may be appropriate for referral to case management include:

- Transplants
    - Solid organ
    - Bone marrow
- Infectious disease
- Internal medicine
- Oncology
- Pulmonary
- High-risk obstetrics
- Catastrophic events
    - Closed head injury
    - Spinal cord injury
    - Multi-system failure

Referrals to case management
Case management referrals are accepted by telephone, fax or in writing.
Contact the Case Management Department by:

- **Phone:** 800-462-3275
- **Fax:** 800-778-2279
- **Mail:** Blue Cross and Blue Shield of Texas Case Management Department
  PO Box 833874
  Richardson, TX 75083-3874

For information on behavioral health case management, call **800-528-7264** between the hours of 8 a.m. – 5 p.m. CT.

Evaluation of New Technology

Following review by our Advisory Panel, the Medical Advisory Committee evaluates new technologies, medical procedures, drugs and devices by assessing current clinical literature appropriate government agency regulatory approvals, medical practice standards and clinical outcomes. The Medical Advisory Committee comprises participating physicians, professional providers, pharmacists and other related medical personnel. This committee reviews each new area of medical technology and makes a recommendation concerning whether the service should be eligible for coverage. Providers may submit new technology requests for evaluation via email.

Continuity of Care Program Criteria

Continuity of medical care is considered, based on written criteria and medical necessity, for a limited period when a provider's managed care agreement is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when Plan members are required to change health plans based on an employer group change. Termination of the provider's managed care agreement shall not release a provider from the obligation to continue ongoing treatment of a member of "special circumstance" (as defined by applicable law and regulation) or us or payer from its obligation to reimburse the provider for such services at the rate set forth in their agreement.

For example:

- A member becomes effective with the Plan while actively receiving health care services by providers not in the Plan network and whose current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of the care, or
- A member's provider leaves the Plan network and the member's current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of the care.

Continuity of care may extend coverage for care with out-of- network providers until the course of treatment for a specific condition is completed. The providers and our obligations will continue until the earlier of the appropriate transfer of the member's care to another Plan participating provider (whichever is applicable), the expiration of 90

days from the effective date of termination of the provider or up to nine months in the case of a member who at the time of the termination has been diagnosed with a terminal illness. If coverage for care with an out-of- network provider is certified due to pregnancy, it will be continued through the postpartum checkup within the first six weeks of delivery.

Continuity of care is considered when a member has special circumstances such as:

- Acute or disabling conditions
- Life-threatening illness
- Pregnancy 13th week and beyond

Continuity of care procedure

The procedure for initiating continuity of care is as follows:

- A member or provider may initiate a request for continuity of care by calling customer service or Medical Management.
- A provider may initiate a request by contacting Medical Management.
- Medical Management reviews all requests.
- Cases that do not meet criteria are referred to a physician reviewer for determination.
- Medical Management notifies the provider and member of the continuity of care decision via letter.
- If the request for continuity of care is approved, Medical Management completes an out-of-network referral and a letter is mailed to the servicing provider.
- If continuity of care is denied, the member has the following options:
    - Continue care/treatment with his/her out-of-network provider at the out-of-network benefit level;
    - Choose a Plan participating provider (whichever is applicable);
    - Receive treatment under the direction of their PCP (if applicable); or
    - File a formal complaint by contacting customer service.
    - Medical Management staff and Medical Director review continuity of care criteria at least annually.

FEP Prior Authorization and Medical Policies

For information on FEP medical policies and utilization management guidelines, please visit FEP Blue and select the **Policies & Guidelines** link at the bottom of the page. For Plan Brochures, select **Tools and Resources** at the top of the page, then **Brochures & Resources and Plan Brochures**.

All inpatient hospital admissions require prior approval/prior authorization and there are other services that require prior approval before plan benefits are available. Some plans may have penalties if prior authorization is not obtained. Please refer to the FEP Blue site for additional information or contact customer service at **800-634-3569**. Some plans may have penalties if prior authorization is not obtained.

Obtaining FEP prior approval/authorization:

- For medical services, phone **800-441-9188**
- For behavioral health services, phone **800-528-7264**

CLAIMS

This information assists providers with information for claims including requirements, policies, and timely filing and who to contact with questions. Prior to submitting your claims, please review the following guidelines:

Timely Filing

Provider must promptly submit a claim for covered services to us in accordance with applicable policies and procedures. For a clean claim for which COB applies, the filing period does not begin for submission of the claim to the secondary payer until provider receives notice of the payment or denial from the primary payer. If provider fails to comply with submitting timely, provider forfeits the right to payment unless they have certified that the failure to timely submit the claim is a result of a catastrophic event.

Plan claims must be submitted within 365 days of the date of service. For institutional claims, the timely filing period begins as of the date of service listed in the "Through" field of the "Statement Covers Period" of the UB-04. For professional claims, the filing period begins on the date service was rendered unless otherwise indicated by the provider contract and/or member's health benefit plan. Providers must submit a complete claim for any services provided to a member. Claims that are not submitted within 365 days from the date of service are not eligible for reimbursement. Claims submitted after the designated cut-off date will be denied on a provider claim summary.

Plan network providers may not seek payment from the members for claims submitted after the 365-day filing deadline. Please ensure that statements are not sent to Plan members, in accordance with the provisions of your Plan contract.

Corrected claims must be filed with the appropriate bill type and filed according to the claims filing deadline as listed in this manual or in the member's contract. If a provider is unable to submit the corrected claim electronically, they must submit the paper claim with a Corrected Claim Form.

If a provider feels that a claim has been denied in error for untimely submission, the provider may submit a request for claim review. Refer to the Claim Review Form and instructions.

If a claim is returned to the provider of service for additional information, it should be resubmitted to BCBSTX within 90 days. The 90 days begin with the date BCBSTX mails the request. The claim should be returned with the letter received or with an Additional Information Form.

Prompt Pay Overview

We comply with the Texas Prompt Pay Act requiring insurance carriers to pay clean claims subject to the Act's requirements within certain specified statutory payment periods. Insurance carriers that do not comply with the Prompt Pay Act's standards may owe statutory penalties to the provider.

- **Prompt pay legislation - penalty**
  Providers are eligible for statutory prompt pay penalties under the Texas Prompt Pay Act only when certain requirements are met including:
  - A claim is made for a member of a plan that is fully insured by us
  - The patient's insurance plan is regulated by TDI
  - The claim is submitted to the Plan as a clean claim
  - The provider files the claim by the statutory filing deadline
  - The provider is a contracting preferred provider
  - The services billed on the claim are payable

  The **Plans** proactively monitor the timeliness of its payments for eligible claims and issues penalties to providers when determined penalties are owed. If you believe statutory penalties are due and have not received a penalty payment from the Plan, you may request a review of penalty eligibility by contacting the Plan's provider customer service at **800-451-0287**.

- **Prompt pay legislation – definition of a clean claim**
  To be eligible for Prompt pay penalties, providers must submit a clean claim. A clean claim includes all the data elements specified by TDI in prompt pay rules or applicable electronic standards. Each specified data element must be legible, accurate and complete.

  For non-electronic submissions by institutional providers, a claim should be submitted using the CMS Form UB-04.1 The UB-04 claim form must include all the required data elements set forth in TDI rules,2 including, if applicable, the amount paid by the primary plan.[3]

  For non-electronic submissions by professional providers, a claim shall be submitted on a CMS Form 1500 claim form.

  Electronic claims by professional or institutional providers must be submitted using the ASC X12N 837 format to be considered a clean claim. Providers must submit the claim in compliance with the Federal Health Insurance Portability and Accountability Act requirements related to electronic health care claims, including applicable implementation guidelines, companion guides, and trading partner agreements.[4]

  A claim that does not comply with the applicable standard is a deficient claim and will not be penalty eligible.[5] When the Plans are unable to process a deficient claim, it will notify the provider of the deficiency and request the correct data element.

  At times, deficient claims contain sufficient information for our adjudication and payment. Rather than requiring the provider to correct the deficiency before payment is issued, we consider it in the best interest of providers to pay deficient claims as soon as possible. However, because deficient claims are not clean claims, they are not eligible for penalties even if we pay the claim outside of the applicable payment period.[6]

- **Prompt pay legislation – statutory claim payment periods**
  When a contracting provider submits a clean claim that meets all the requirements for Texas Prompt Pay Act coverage, the insurer must pay the claim within 30 days if it was submitted in electronic format and within 45 days if it was submitted in non-electronic format or as defined byTDI.[7] If a claim is deficient, the statutory period does not commence unless and until the provider corrects the unclean data element(s). The payment period for clean corrected claims is determined by the format of the corrected submission, without regard to the manner in which the original claim was received.

  The Plan may extend the applicable statutory payment by requesting additional information from the treating provider within thirty days of receiving a clean claim.[8] Such a request suspends the payment period until the requested response is received.

  [9]The Plans must then pay any eligible charges within the longer of 15 days, or the number of days remaining in the original payment period at the time the request was sent.[10]

- **Prompt pay legislation – statutory penalty amounts**
  There are three tiers of penalty calculation under the Texas Prompt Pay Act, depending on when the claim was paid. For claims submitted by institutional providers, half of the amount calculated in each tier is owed to the provider and the other half is owed to TDI.[11]

  Tier 1: For payments 1 - 45 days late, the total penalty is equal to 50 percent of the difference between the billed charges and the contracted rate.[12]
  Tier 2: For payments 46 – 90 days late, the total penalty is equal to 100 percent of the difference between the billed charges and the contracted rate.[13]
  Tier 3: For payments more than 90 days late, the total penalty is equal to the Tier 2 amount plus 18% annual interest on that amount, accruing from the date payment was due to the date the claim and penalty are

paid in full.[14]

- **Prompt pay legislation – COB**
  COB is necessary when more than one plan is responsible for claim payment. Claims that involve coordination of benefits are subject to special rules under the Texas Prompt Pay Act.

  When providers are aware of multiple plans potentially involved in claim payment, information related to all applicable plans must be submitted for the claim to be clean. The provider must submit the claim first to the primary plan and then to any secondary or tertiary plans. The order of payer responsibility is determined by TDI guidelines, which have adopted the uniform rules of the National Association of Insurance Commissioners.[15]

  When the Plans are the secondary payers of a claim submitted in non- electronic format, the amount paid by the primary plan is a required data element and must be submitted in field 54 for the claim to be clean.[16] Thus, the applicable statutory payment period for a secondary plan does not begin unless and until it receives the primary plan's adjudication information.

  If the Plan determines that a secondary plan has paid an amount owed by the primary plan in error, it may recover the amount of its overpayment from the primary plan or from the provider if it has already been reimbursed by the primary plan.[17] For purposes of calculating Texas Prompt Pay Act penalties for secondary claims, the contracted rate and billed charges are reduced in proportion to the percentage of the claim owed after the primary plan's payment.[18]

[1] Ex. C, Tex. Ins Code § 1301.131(b).
[2] Ex. B, 28 Tex Admin. Code § 21.2803(b)(3).
[3] Ex. B, 28 Tex. Admin. Code § 21.2803(b)(3).
[4] Ex. Ex. B, 28 Tex. Admin. Code § 21.2803(e)
[5] Ex. D, 28 Tex. Admin. Code § 21.2802(10)
[6] Ex. E, Report on the Activities of the Technical Advisory Committee on Claims Processing (Sep. 2004), at pp. 6-7.
[7] Ex. F, Tex. Ins. Code § 1301.103.
[8] Ex. G, Tex. Ins. Code § 1301.1054(a)
[9] Ex. G, Tex. Ins. Code § 1301.1054(b).
[10] Ex. G, Tex. Ins. Code § 1301.1054(b).
[11] Ex. H, Tex. Ins. Code § 1301.137(l).
[12] Ex. H, Tex. Ins. Code § 1301.137(a).
[13] Ex. H, Tex. Ins. Code § 1301.137(b).
[14] Ex. H, Tex. Ins. Code § 1301.137(c).
[15] Ex. J. 28 Tex Admin. Code § 3.3507.
[16] Ex. B, 28 Tex. Admin. Code § 21.2803(d)(1).
[17] Ex. K, Tex. Ins. Code § 1301.134(e)-(f).
[18] Ex. L, 28 Tex. Admin. Code 21.2815(e).

Coordination of Benefits

Members occasionally have two or more benefit policies and insurance carriers take this into consideration and we coordinate the benefits to determine which carrier is primary and secondary. The following assists providers in understanding the coordination of benefits clause from the contracting perspective.

Provider agrees to cooperate with us in the coordination of benefits, to make inquiries regarding, and provide relevant information to us relating to, any other coverage held by the member, and to abide by the COB, subrogation and duplicate coverage policies, procedures and our rules.

This information applies to our members' health benefit policies. Please note, some Administrative Services Only (self-funded groups) may elect not to follow our general COB rules.

When the member's health benefits policy is issued by another Blues plan, also known as the HOME plan, the COB provision is administered by that HOME plan, not us. Therefore, the member's HOME plan health benefits policy will control how COB is applied to that member.

Per our COB contract language, the providers have agreed to accept our allowable amount (as defined by the contract) less any amount paid by the primary insurance carrier.

When we are determined to be the secondary carrier and the claim has been processed by us, the only patient share amount that may be collected from the member is the amount shown on our provider claim summary.

The primary carrier does not consider the member's secondary coverage. This means that once the claim is processed as secondary by us, any patient share amount shown to be owed on the primary carrier's explanation of benefits is no longer collectible. If you have questions regarding a specific claim, please contact provider customer service at **800-451-0287**.

- **Subrogation**
  We attempt to coordinate benefits whenever possible, on potential subrogation cases with third parties to help reduce overall medical costs.

  Potential other coverage information may be obtained from a variety of sources, including the provider treating a member. Information such as motor vehicle accidents, work- related injuries, slips/falls, etc. should be communicated to us for further investigation.

  In addition, each provider shall cooperate with us for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, third-party liens, and other third-party liability.

  We contracted providers agree to file claims and encounter information with us even if the physician or professional provider believes or knows there is a third-party liability.

To contact us regarding:
- Coordination of benefits, phone **888-588-4203**
- Subrogation cases, phone **800-582-6418**

COB information may be requested from our members to update information for claim processing.

Reimbursement and Medical Policies

We provide various policies for use in processing our claims.
- Reimbursement policies (formerly Clinical Payment and Coding Policies) are based on criteria developed using industry standard guidelines. Additional sources are used and can be provided upon request. These policies are not intended to provide billing or coding advice but to serve as a reference for facilities and providers.
- Resources for medical policy and technology assessment review may include, but are not limited to:
  - Medical practice standards published by unaffiliated nonprofit professional associations for the relevant specialty
  - Medical Policy Reference Manual for the Blue Cross and Blue Shield Association
  - Medicare coverage policies in the Medicare Coverage Database including National Coverage Determinations and Local Coverage Determinations
  - Government agencies or regulatory bodies involved in review of clinical standards for the industry

(e.g., FDA)

Refer to the Reimbursement Policies and Medical Policies to review the policies and any updates.

Correct Coding

Providers need to use appropriate CPT, Healthcare Common Procedure Coding System and International Classification of Diseases codes on all claims. Refer to our Claims Filing Tips page for more information.

Provider should also refer to the Modifier Reference Policy on the Reimbursement Policy page for appropriate modifier billing.

- **Splitting charges on claims:** In general, all services provided on the same day should be billed under one electronic submission or when billing on paper, utilize one CMS-1500 claim form when possible. When more than six services are provided, multiple CMS-1500 claim forms may be necessary.
- **Services rendered directly by provider:** If services are rendered directly by the Plan provider, the services must be billed by the Plan provider. However, if the Plan provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services.

  All covered services provided and billed for members by participating provider shall be performed personally by the participating provider and/or under their direct and personal supervision and in their presence, except as otherwise authorized and communicated by us. Direct personal supervision requires that a participating provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.

  Notes:
  - This does not apply to services provided by an employee of a Plan provider e.g., Physician Assistant, Licensed 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 provider.
  - The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a PA, APN or RNFA:

    AS Modifier: A physician should use this modifier when billing on behalf of a PA, APN or RNFA for services provided when these providers are acting as an assistant during surgery. (Modifier AS to be used ONLY if they assist at surgery).

    SA Modifier: A supervising physician should use this modifier when billing on behalf of a PA, APN, of RNFA for non-surgical services. (Modifier SA is used when the PA, APN, or RNFA is assisting with any other procedure that doesn't include surgery.)

- **Billing for non-covered services**
  If we determine in advance that a proposed service is not a covered service, a provider must inform the member in writing in advance of the service rendered. The member must acknowledge this disclosure in writing and agree to accept the stated service as a non-covered service billable directly to the member.

  To clarify what the above means - if you contact us and find out that the proposed service is not a covered service - you have the responsibility to pass this along to the member. This disclosure protects both you and the member. The member is responsible for payment to you of the non-covered service if the member elects to receive the service and has acknowledged the disclosure in writing. Please note that services denied by us due to bundling or other claim edits may not be billed to the member even if the member has agreed in writing to be responsible for such services. Such services are Covered Services but are not payable services according to our claim edits.

- **Surgical procedures performed in the provider's office**
  When performing surgical procedures in a non-facility setting, the provider reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the provider's office. Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the provider's office. To help determine how coding combinations on a claim may be evaluated during the claim adjudication process, you may utilize Clear Claim Connection™ (C3). C3 is a free online reference tool that mirrors the logic behind the auditing software we use. Refer to the Clear Claim Connection page for additional information on access and using C3.

  Please note the provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment vendor. Claims from the surgical equipment or DME vendor will be denied because the global reimbursement includes staff and equipment.

- **Contracted provider must file claims**
  As a reminder, providers must file claims for any covered services rendered to a member enrolled in our health plan. You may collect the full amounts of any deductible, coinsurance or copayment due and then file the claim with us. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with us violate the requirements of your provider's contract with us.

  Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self-pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to us.

- **National drug code billing guidelines for professional claims**
  We request the use of National Drug Codes and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims.

  Where do I find the NDC?
  The NDC is found on the medication's packaging. An asterisk may appear as a placeholder for any leading zeros. The container label also displays information for the unit of measure for that drug. NDC units of measure and their descriptions are as follows:
  - UN (Unit) – If a drug comes in a vial in powder form and has to be reconstituted
  - ML (Milliliter) – If a drug comes in a vial in liquid form
  - GR (Gram) – Generally used for ointments, creams, inhaler or bulk powder in a jar
  - F2 – International units, mainly used for anti-hemophilic factor (AHF)/Factor VIII (FVIII)

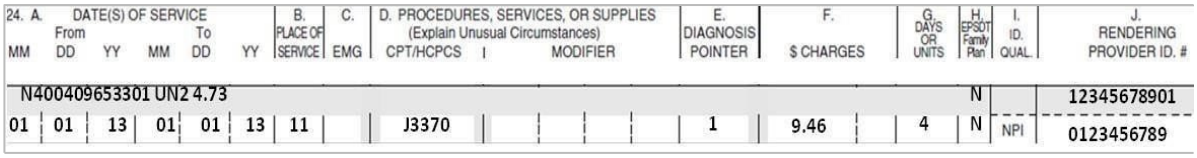
  How do I submit the NDC on my claim?
  Here are some quick tips and general guidelines to assist you with the proper submission of valid NDCs and related information on electronic and paper professional claims:
  - The NDC should be submitted along with the applicable HCPCS or CPT code(s) and the number of HCPCS/CPT units.
  - The NDC must follow the 5digit4digit2digit format (11 numeric characters, with no spaces, hyphens or special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration.
  - The NDC must be active for the date of service
  - The **NDC qualifier, number of units*, unit of measure and price per unit** should also be included

ELECTRONIC CLAIM GUIDELINES (ANSI 5010 837P)

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter N4 in this field.	2410	LIN02
National Drug Code	Enter the 11-digit NDC assigned to the drug administered.	2410	LIN03
Monetary Amount	Enter the monetary amount (charge per NDC unit of product)	2400	SV102
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Units or Basis of Measurement	Enter the NDC unit of measure of for the prescription drug given (UN, ML, GR, or F2)	2410	CTP05

PAPER CLAIM GUIDELINES (CMS-1500)

In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left-justified), immediately followed by the NDC. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of measure (UN, ML, GR, or F2), followed by the quantity (number of NDC units up to three decimal places), one space and the price per NDC unit, as indicated in the example below.



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400409653301 UN2 4.73													N		12345678901
01	01	13	01	01	13	11		J3370		1	9.46	4	N	NPI	0123456789

Home Infusion and Specialty Pharmacy providers, please note: we allow decimals in the NDC Units (quantity or number of units) field. If you do not include appropriate decimals in the NDC Units field, you could be underpaid.

Note: Reimbursement for discarded drugs applies only to single-use vials. Multi-use vials are not subject to payment for discarded amounts of the drug.

Billing Information & Requirements

We do not permit pass-through billing, splitting all-inclusive bills, under- arrangement billing, and any billing practices where a provider or entity submits claims by or for another provider not otherwise provided for in the provider's agreement or in this policy.

- **Pass through billing** occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider. The provider may bill us only for covered services performed directly by provider or its employees. The provider may not bill, charge, seek payment for or submit any claims to us, nor may provider cause such claims to be submitted to us, nor will provider have any recourse against us or any member for amounts related to claims related to such pass-through billing.

  The performing provider is required to bill for the services they render unless otherwise approved by us. We do not consider the following scenarios to be pass-through billing:
  - The service of the performing provider is performed at the place of service of the ordering physician or professional provider and billed by the ordering physician or professional provider.
  - The service is provided by an employee of a provider (i.e., physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider); and the service is billed by the ordering physician or professional provider.
  - The service is billed by the ordering physician or professional provider.

  The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a PA, APN or RNFA:
  - **AS** modifier: A physician should use the AS modifier when billing on behalf of a PA, APN or RNFA, including that providers NPI, for services provided when the PA, APN, or RNFA is acting as an assistant during surgery. Modifier AS is to be used ONLY if the PA, APN, or RNFA assists at surgery.
  - **SA** modifier: A supervising physician should use the SA modifier when billing on behalf of a PA, APN, or RNFA for non-surgical services. Modifier SA is to be used when the PA, APN, or RNFA is assisting with any other procedure that DOES NOT include surgery.

- **Under arrangement billing** and other similar billing or service arrangements are not permitted by BCBSTX and refers to situations where services are performed by one provider, but the services are billed under the contract of another provider, rather than under the contract of the provider that performed the services.

- **All-inclusive billing** - Any testing performed on patients treated by a provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services. The provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to us.

  For all-inclusive billing, all testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

CLIA Certification Requirement

Facilities and providers who perform laboratory testing on human specimens for health assessment, or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988.

Therefore, any provider who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

Limitations and Conditions

Reimbursement is subject to:

- Medical record documentation, including appropriately documented orders when requested and /or applicable
- Correct CPT/HCPCS coding
- Member benefit and eligibility
- Applicable medical policy or reimbursement policies

Assignment

As a reminder, no part of the contract with us may be assigned or delegated by a provider without the express written consent of both the contracted provider and us.

Providers who choose to utilize a third-party billing service remain solely responsible for compliance with the requirements of all applicable provider billing practices under the terms of this contract. It is the responsibility of the provider to ensure claims submitted on their behalf are accurately and appropriately filed.

Fraudulent Billing

We consider abusive or fraudulent billing to include, but not be limited to, the following:

- Misrepresentation of the services provided to receive payment for a non-covered service
- Billing in a manner which results in compensation greater than what would have been received if the claim were properly filed and/or
- Billing for services which were not rendered.

If we determine, in its sole discretion, that a provider has engaged in abusive or fraudulent billing practices, we may take further actions up to and including termination of the provider from any network. Refer to our Fraud and Abuse page for information on reporting concerns.

Providers with Multiple Specialties

If you have obtained a unique Organization (Type 2) NPI number for each specialty, you should bill with the appropriate Individual (Type 1) and Organization (Type 2) NPI number combination accordingly.

In the absence of a unique Organization (Type 2) NPI number for each specialty, you are strongly encouraged to include the applicable taxonomy code* in your claim submissions. Taxonomy codes play a critical role in the claims payment process for providers practicing in more than one specialty. Electronic claims transactions accommodate the entry of taxonomy codes and will assist BCBSTX in selecting the appropriate provider record during the claims adjudication process. For assistance in billing the taxonomy code in claim transactions, refer to your practice management software or clearinghouse guides.

> *The provider taxonomy code set is a comprehensive listing of unique 10-character alphanumeric codes. The code set is structured into three levels—provider type, classification, and area of specialization—to enable individual, group, or institutional providers to clearly identify their specialty category or categories in HIPAA transactions. The entire code set can be found on the Washington Publishing Company site. The provider taxonomy code set levels are organized to allow for drilling down to a provider's most specific level of specialization.

Ancillary Services

It is important that providers submit ancillary claims accurately and completely. To assist, we have provided the following information and guidelines. In addition, refer to the reimbursement and medical policies for specific information.

- **Diabetic education**
  Diabetic education must be administered by or under the direct supervision of a physician. The program should provide medical, nursing and nutritional assessments, individualized health care plans, goal setting and instructions in diabetes self-management skills.

  Claims filing instructions: Must use diabetes as the primary ICD-10 diagnosis for the claim to be paid. The V code for the education/ counseling would be listed as the secondary diagnosis.
    - Use **CMS-1500** claim form
    - Use diabetes as the primary ICD-10 diagnosis
    - Use appropriate procedure codes for services rendered
    - File with your NPI number

- **Durable medical equipment**
  The plan describes DME as being items which can withstand repeated use; are primarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the member's home.

  Benefits are subject to the member's plan and can be provided when the equipment is prescribed by a physician within the scope of his license and does not serve as a comfort or convenience item.

  Benefits could include the following:
  - Rental Charge (but not to exceed the total cost of purchase) or at the option of the Plan, the purchase of DME. The rental versus purchase decision is between the patient and supplier. However, the rental of any equipment should not extend for more than 10 months duration. If the prescription indicates lifetime need, the supplier should attempt to sell the equipment as opposed to renting.
  - Repair, adjustment, or replacement of components and accessories necessary for effective functioning of covered equipment.
  - Supplies and accessories necessary for the effective functioning of covered DME. For additional information on supplies for TENS units, refer to Proper Billing for Supplies for Transcutaneous Electrical Nerve Stimulation Units.
  - Some plans have DME allowable limits

  *Benefits are subject to the member's individual or group contract provisions.

  Prescription or certificate of medical necessity
  A prescription or certificate of medical necessity is required to accompany all claims for DME rentals or purchase. The prescription or CMN also must be signed by the members' attending physician/professional provider.

  When a provider completes and signs the CMN, he or she is attesting that the information indicated on the form is correct and that the requested services are medically necessary. The CMN must specify the following:
  - Member's name
  - Diagnosis
  - Type of equipment
  - Medical Necessity for requesting the equipment
  - Date and duration of expected use

  The CMN is not required in the following circumstances:
  - The claim is for an eligible prosthetic or orthotic device that does not require prior medical review;
  - The place of treatment billed for durable medical equipment or supplies is inpatient, outpatient or office;

- The individual line item for durable medical equipment or supplies billed is less than $500 and the place of treatment is in the home or other;
- The claim is for durable medical equipment rental and is billed with the RR modifier; or
- The claim is for CPAP or Bi-Pap and there is a sleep study claim in file with us that has been processed and paid. Sleep study CPT codes include but are not limited to 95806-95811.

These guidelines apply to fully insured members as well as self-funded employer groups who have opted to follow these guidelines. However, this may not apply to members with the Federal Employee Plan benefits or those from other Blue Cross and Blue Shield plans. To determine if a CMN is required, please call the telephone number listed on the member ID card.

Custom DME
When billing for customized DME or prosthetic/orthotic devices, an item must be specially constructed to meet a patient's specific need. The following items do not meet these requirements:
- An adjustable brace with Velcro closures
- A pull-on elastic brace
- A light weight, high-strength wheelchair with padding added

A prescription is needed to justify the customized equipment and should indicate the reason the patient required a customized item. Physical therapy records or physician records can be submitted as documentation. An invoice should be included for any item that has been provided to construct a customized piece of DME or any P&O device for which a procedure code does not exist.

Repair of DME
Repairs of DME equipment are covered if:
- Equipment is being purchased or already owned by the patient,
- Medically Necessary, and
- The repair is necessary to make the equipment serviceable.

Replacement parts
Replacement parts such as hoses, tubing, batteries, etc., are covered when necessary for effective operation of a purchased item.

Life sustaining DME
Life-sustaining DME is paid as a perpetual rental during the entire period of medical need.
- The vendor owns the DME. The vendor is responsible for monitoring the functional state of the DME and initiating maintenance or repair as needed. The vendor is likewise responsible for conducting the technical maintenance, repair and replacement of the DME. The rental payments to the vendor from us cover these services. When the period of medical need is over, possession of the DME returns to the vendor.
- Attachments, replacement parts and all supplies and equipment ancillary to Life-sustaining DME are considered included in the monthly rental payment. This includes refills of both gaseous and liquid oxygen.
- We do not recognize or support member-owned DME previously obtained from another source.
- Check member eligibility and benefits to determine if DME is considered life sustaining DME.

- **Home infusion therapy**
  - Please make sure all claims are filed with your NPI number electronically or on a **CMS-1500** claim form. Reference the Infusion Services reimbursement policy.
  - A service found on the HIT schedule, as well as the drugs used, will require prior authorization. **Note: All services/drugs that will be administered must be listed in the authorization or they will be denied.**

- Providers should refer to "Factor Products" as identified in the Home Infusion Therapy Drug Schedule posted on our website. The codes are subject to change in accordance with the terms of the agreement.
- Nursing Visits: For nursing visits, prior authorize using procedure codes 99601 and 99602. For extended visits, prior authorize using 99602.
- Always bill using a valid procedure code (CPT, HCPCS and NDC) for a drug and identify the appropriate number of units administered in Field 24g of the CMS-1500 (02/12) form. For example, if the procedure code defines the drug as 1 gram and you administered 20 grams, the CMS-1500 form should reflect 20 units. Please note that J3490 should only be used if there is not a valid procedure code for the administered drug, in which case you would then bill using J-3490 and the respective NDC number.
- If billing for two or more concurrent therapies, use the appropriate modifiers:
  - SH – Second concurrent administered infusion therapy
  - SJ – Third or more concurrently administered infusion therapy
- Per diems not otherwise classified should only be prior authorized if the HIT services are not defined in an established per diem code.
- The per diem for aerosolized drug therapy (S9061) does not include the cost of the nebulizer. The nebulizer must be purchased or rented through a Plan contracted DME supplier.
- The HIT per diems includes supplies and equipment. For example, IV poles, infusion pumps, tubing, etc. for codes that maybe considered incidental to the per diem code.

Home infusion therapy schedule
Codes and pricing are listed on our website under Standards and Requirements then General Reimbursement Information. Providers must verify codes and pricing prior to rendering services.

- **Imaging**

We are contracted with Carelon for managing prior authorization, RCR or post service review for certain outpatient radiology services. For details on specific services including specific procedure codes that require prior authorization or RCR, refer to the Carelon and Utilization Management pages. Providers must contact Carelon to obtain an order request number. Refer to the Carelon page for more information.

Ordering physicians must write the order request number on the requisition for the imaging study. The ordering physician/professional provider is required to contact Carelon, whether the ordering provider is the PCP or the specialist. The PCP will not be expected to obtain the order request number if a specialist orders the test. The order request number must be on the performing provider's electronic or paper claim form.

When the ordering physician/professional provider submits the order through the Carelon ProviderPortal, they will experience suggestions to include imaging sites that have an "A" score.
Note: The ordering provider will still be able to search for additional servicing providers in the member's network.

Performing providers (hospitals and freestanding imaging) may confirm that an order request number was issued as well as clinical guidelines and other educational resources by accessing the Carelon site.

When contacted, Carelon will either issue an order request number or forward the case to a registered nurse or physician for review. Carelon's physician reviewer may contact the ordering physician/provider to discuss the case in greater detail within two business days of receipt of the request. Ordering physicians must write the order request number on the requisition for the imaging study. Issuance of an order request number is not a guarantee of payment. When
submitted, the claim will be processed in accordance with the terms of a member's health benefit plan.

The Carelon process is based upon guidelines from medical organizations and medical literature. The guidelines are consistent with the clinical appropriateness criteria developed by the American College of Radiology. Carelon promotes:

- Ordering the most appropriate outpatient diagnostic or advanced imaging for the diagnosis in question while minimizing unnecessary radiation exposure,
- Performing studies in the proper sequence, and
- Maximizing service to members through the efficient use of their benefit plan.

- **Independent laboratory**

  Plan providers should refer members to in-network lab providers for outpatient lab services. To locate participating labs in the Plans network, visit the online Provider Finder®.

  Claims for lab services may be subject to specific reimbursement policies or lab management policies. Some lab services may require prior authorization or may be applicable to RCR managed by us or Carelon. Refer to the Carelon and Utilization Management pages for more information.

  Some diagnostic tests are not routinely covered without sufficient medical justification. Providers should check eligibility and benefits through Availity or their preferred vendor.

  "STAT" charges are not reimbursable as a separate line item.

  All not otherwise classified procedure codes should be submitted with as much descriptive information as possible.

  File claims electronically with us or submit CMS-1500
  - Use CPT-4 coding structure
  - Must file with your NPI number
  - Must itemize all services and bill standard retail rates

- **Prosthetics & orthotics**
  - File claims electronically with us or submit CMS-1500
  - Must use HCPCS coding structure
  - Need to submit complete documentation when using a not otherwise classified procedure code
  - Must itemize all services and bill standard retail rates
  - Must file with your NPI Number
  - Certain prosthetics & orthotics may not typically be covered. Check eligibility and benefits.

- **Radiation therapy center**
  - Must use appropriate CMS-1500 claim form or electronic equivalent
    Note: Use UB-04 or electronic equivalent, if a facility; or use CMS-1500 if a free-standing facility
  - Must bill negotiated rates according to fees stated in contract.
  - May use CPT code as part of description but must have correct revenue codes if using UB-04.
  - When the member's coverage requires a PCP referral, form locator 63 must be completed with a referral authorization number obtained from us.
  - Must file with your NPI number

Filing Facility Claims Overview

It is important that providers submit facility claims accurately and completely.

Note: References to entering the Secure content area of the General Reimbursement Information section of our site, requires you to obtain the password from your Network Management Office. This is area is only available to participating providers.

The hospitals in the PPO networks agree to:

- Accept reimbursement for covered services on a negotiated price as stated in their contract.
- Provide utilization review and quality management programs to be consistent with those of their peers in the health care delivery system.
- Be responsible for notifying the Utilization Management of an elective admission prior to admission and an urgent/emergency admission within the later of 48 hours or by the end of the next business day.

Coding Facility Claims

The following are general coding guidelines related to facility claims:

- When billing claims to us, revenue codes, CPT and HCPCS codes must be compatible. For example: pathology services must be billed with the appropriate pathology CPT code and the revenue code 031X. All revenue codes should be extended to four digits. If you have questions regarding proper matching of CPT codes to revenue codes, or the relevant billing units, information is provided through the National Uniform Billing Committee site refer to your contract.
- The provider will count the date of admission but not the date of discharge when computing the number of hospital days that Covered Persons was confined.
- The provider must include a discharge diagnosis when submitting claims to us.
- The provider must not submit any interim claims for Covered Services for which a Diagnosis Related Group (DRG) Rate or Case Rate is applicable.
- The correct type of bill must be used when filing claims. A claim with an inpatient TOB must have room and board charges. Refer to the NUBC UB-04 Manual for the valid codes.
- Some facilities may have several NPI (e.g., substance abuse wings, partial psychiatric day treatment). It is important to bill the claim with the correct NPI for the service you provided, or this could delay payment or even result in a denial of a claim.
- The appropriate patient status is required on an inpatient claim. An incorrect patient status could result in inaccurate payments or a denial.
- All accident, emergency and maternity claims require the appropriate occurrence code and the date. Refer to the NUBC UB-04 Manual for the valid codes.
- Late and added charges should be submitted as a corrected claim after the original claim has been processed.
    - For inpatient use: Type of Bill 117 for corrected claim
    - For outpatient use: Type of Bill 137 for corrected claim
- The corrected claim should include all line items previously processed correctly. Corrected claims can be filed electronically. If the corrected claim must be filed on paper, it should be submitted with a Corrected Claim Review Form.
- Preadmission tests provided by the hospital within three days of admission should be combined and billed with the inpatient claim or any services provided on the same day that resulted in an inpatient admission should be combined with the inpatient claim. For outpatient day surgery, services should be billed as one claim to include the day surgery and the pre-op tests.
- Claims for the mother and baby should be filed separately.

Room Rate Update Notifications

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 are the patient's responsibility. Therefore, the accurate information that

you provide assists in adjudicating the claim with the correct patient liability.

A copy of the form is located on the Forms page. For updates, please notify us at least 30 days prior to the planned effective date.

Outpatient Admission Type Hierarchy

The admission type determines the applicable reimbursement. When the claim meets the definition of more than one admission type you would use the hierarchy matrix to determine which admission type will be used to determine the reimbursement. This matrix is located on our website under Standards and Requirements and then the *Secure content section of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr.** then select **Reference Material**. The matrix is listed as "**Admission Type Hierarchy**."

Diagnosis Related Group Facilities

DRG means an all-inclusive method of compensation derived by assigning facility patients into groupings by use of diagnosis, present on admission indicator, procedures, age, sex and discharge status.

Interim bills are not accepted for claims process for DRG reimbursement. Late charges/credits are not accepted on DRG Claims Unless they affect the reimbursement. Information used to determine a DRG:

- All the ICD-10 diagnoses are billed on a claim
- All the ICD-10 surgical procedure codes billed on a claim
- Patient's age
- Patient's sex
- Discharge status
- Present on admission indicator

Note: Outpatient claims – When DRG Cap is contracted, in no instance will the contract rate for outpatient Services be greater than the inpatient service contract rate would be if the outpatient services were done on an inpatient basis, unless (1) the outpatient service method of compensation is a case rate, per diem, or (2) the outpatient services are for chemotherapy or radiation therapy.

Outpatient services for radiation therapy or chemotherapy as defined in the **Admission Type Definitions** posted under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/ Hospital/Ambul. Surg Ctr./Endoscopy Ctr,** select **Reference Material then Admission Type Definitions**.

In addition, refer to the **Admission Type Hierarchy** for more information on **DRGs and Non-Weighted DRGs** posted on the secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr**, select Reference Material then **Admission Type Hierarchy** and **Admission Type Definitions**.

Fixed Fee Arrangements

Fixed-fee arrangements reflect a negotiated rate for services rendered. Different fixed-fee arrangements include inpatient hospital per diems, inpatient hospital case rates, outpatient case rates, and outpatient maximum allowable fee schedules. The Resource Based Relative Value Scale based fee schedule and DRG hospital rates are fixed-fee arrangements. Some facilities may be reimbursed billed charges up to the per diems as defined by the services rendered. Per diems are inclusive of all services and supplies based on the type of provider.

Clinic Charges

We do not reimburse facilities for clinic services, such as professional services by emergency room physicians or professional providers or physicians/ professional providers operating out of a clinic. These services

are considered professional in nature and would be billed under the physician/professional provider's NPI #. Billing professional charges on a UB-04 will generate a denial message instructing the physician/professional provider to resubmit services on a CMS-1500 form.
Note: Professional charges will be allowed on a UB-04 when Medicare is primary for the member.

Diabetic Education

Diabetic education must be administered by or under the direct supervision of a physician. The program should provide medical, nursing and nutritional assessments, individualized health care plans, goal setting and instructions in diabetes self-management skills.

Claims filing instructions: Must use diabetes as the primary ICD-10 diagnosis for the claim to be paid. The V code for the education/counseling would be listed as the secondary diagnosis.

Trauma

Trauma Definition – ICD – 10 codes must be in the Principal Diagnosis Field. A list of the **current Trauma Admission Type ICD-10-CM Diagnosis Codes** for facility claims is located under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./ Endoscopy Ctr**, select **Reference Material** then **Trauma Admission Type ICD-10- CM Diagnosis Codes**. **Note:** Trauma claims will be paid as designated in your contract.

Provider Based Billing

Provider Based Billing means the method of split billing allowed by Medicare for clinic or physician owned, controlled or affiliated with the hospital and the clinic/practice can be designated with provider-based status by CMS.

Refer to the **Admission Type Definitions** posted under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr**, select **Reference Material** then **Admission Type Definitions**.

Services rendered and/or provided in the provider-based practices are not compensated by us when billed by the hospital as outpatient hospital services. All services including but not limited to surgery, lab, radiology, drugs, and supplies, rendered and/or provided in a provider-based clinic or physician office are to be billed on a CMS-1500 form or in an equivalent electronic manner, using the "office" place of service and will be compensated according to the applicable professional fee schedule.

- The facility services that are not compensated will not be considered patient responsibility.
- Any services referred to or rendered by the hospital, such as lab and radiology, should be billed separately on a UB-04 by the Hospital.
- Excluded from this definition are Medicare crossover claims, Medicare Advantage, Medicaid, and non-participating Indian Health Service providers.

Provider based billing claim examples
Scenario 1 – Split billing with in-office lab

Physician Claim:

Place of Treatment	Procedure	Compensation
22 – Outpatient Hospital	99212	Based on Facility RVU

Hospital Claim Example #1

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0510	99212	

Hospital Claim Example #2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00

Correct billing
Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based on Non-Facility RVU
	A6250	
	80053	
	80061	
	J1205	

Scenario 2 - Split billing lab referred to hospital
Physician Claim

Place of Treatment	Procedure	Compensation
22 – Outpatient Hospital	99212	Based on Facility RVU

Hospital Claim Example #1

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0510	99212	

Hospital Claim Example #2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0761	11042	

	0761	99212	

Correct billing

Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based on Non-Facility RVU
	11042	
	A6250	
	80053	
	80061	
	J1205	

Hospital Claim Example #2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0300	80053	Based on Contract Lab Schedule
	0300	80061	

Scenario 3 - Split billing with in-office surgery and lab referred to hospital

Physician Claim

Place of Treatment	Procedure	Compensation
22 – Outpatient Hospital	99212	Based on Facility RVU

Hospital Claim Example #1

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0361	11042	
	0761	99212	

Hospital Claim Example # 2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0361	11042	
	0510	99212	

Correct billing

Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based on Non-Facility RVU
	11042	

	A6250	
	J1205	

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0300	80053	Based on Contract Lab Schedule
	0300	80061	

Diagnostic Services and Treatment Room Claims

Treatment room claim means the claim billed with NUBC revenue codes 0760 or 0761 and with appropriate CPT/HCPCS codes representing the specific procedures performed or treatments rendered within the treatment room setting.

Treatment room is used to bill for specific procedures performed or treatments rendered in the treatment room setting of the hospital. Use of the appropriate revenue code(s) describing treatment room along with the CPT/HCPCS code describing the procedure performed or treatment rendered is required. Refer to your contract language for additional information.

Refer to the Admission Type Definitions posted under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr,** select **Reference Material** then **Admission Type Definitions.**

Diagnostic services and treatment room claim examples

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	According to contracted outpatient rates
	0270	A6250	
	0300	80053	
	0300	80061	
	0361	11042	

Correct billing

Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based **on Non-Facility** RVU
	11042	
	A6250	
	J1205	

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0300	80053	Based on Contract Lab Compensation
	0300	80061	

Treatment room claim example

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	According to contracted outpatient rates for Treatment Room
	0270	A6250	
	0300	80053	
	0300	80061	
	0761	11042	

Ambulatory Surgery Center/Outpatient Hospital Surgery Claim Filing

- Must file claims electronically or submit the bill on a UB-04 claim form.
- Must file claims electronically or bill CPT or HCPCS code for each surgical procedure in form locator 44.
- Can bill with ICD-10 CM procedure codes and date procedures was performed in form locator 74 and if applicable 74a-e.
- Use correct NPI in field 56.
- The Admission Type determines the applicable reimbursement. When the claim meets the definition of more than one Admission Type, the Admission Type Hierarchy matrix is used to determine which Admission Type will be used to determine reimbursement. Refer to the Admission Type Hierarchy posted under the *Secure content area of the General Reimbursement Information. After entering, go to **Reimbursement Schedules** and **Related Information** then **Reference Material** located under the **Hospital/Ambul. Surg Ctr./Endoscopy Ctr.** topic.
- Incidental procedures, as defined in the agreements for ancillary providers, are not allowed in an ASC setting.
- Primary procedures will be reimbursed at 100% of the allowed amount; secondary and subsequent procedures will be reimbursed as stated in the provider's contract.
- Outpatient day surgery claims billed with the following revenue codes for prosthetics/orthotics and/or implants will be reimbursed based on the provider's contract:
    - 0274 – Prosthetic/orthotic devices
    - 0275 – Pacemaker
    - 0278 - Other implants

Freestanding Cardiac Lab Centers Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must itemize all services
- Number of units must be billed with each service to be paid appropriately.
- Must use the NPI in field 56.
- Cardiac cath lab procedures must be billed using the appropriate revenue code.
- Refer to your contract or contact your Network Management Office, if you need assistance.

Dialysis Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must bill ancillary services on the same claim with treatment.
- Must itemize all services.
- Must use appropriate revenue codes and CPT/HCPCS codes for services rendered (Refer to the UB-04 manual and your contract).
- Per diem rates include the following charges:
    - Ancillary supplies
    - Laboratory procedures

- Radiological procedures
- Additional diagnostic testing
- All nursing services
- Utilization of in-facility equipment
- IV solutions
- All pharm

Note: The per diem is applicable only on days that an actual treatment is provided.

Freestanding Emergency Centers Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must bill using revenue codes 0450, 0451, 0452 and 0459.
- Must bill with the applicable evaluation and management CPT codes and will be reimbursed based on the provider's contract.

Home Health Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must use appropriate revenue codes and HCPCS codes for services rendered
- Type of bill should be 321 or 327 for corrected claims.
- For additional information, refer also to the Ancillary Services section of this manual and on the General Reimbursement Information page.
- Services must be ordered by a physician and require a physician signed treatment plan or a PA or APN (counter signature by their supervising physician).
- The needs of the patient can only be met by intermittent, skilled care by a licensed nurse, physical, speech or occupational therapist, or medical social workers.
- The needs of the patient are not experimental, investigational, or custodial in nature.

The following are examples of services which would be considered skilled:

- Initial phases of a regimen involving administration of medical gases.
- Intravenous or intramuscular injections and intravenous feeding except as indicated under non-skilled services.
- Insertion or replacement of catheters except as indicated under non- skilled services.
- Care of extensive decubitus ulcers or other widespread skin disorders.
- Nasopharyngeal and tracheostomy aspiration.
- Health treatments specifically ordered by a physician/ANP/PA as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the patient's progress.
- Teaching – the skills of a licensed nurse may be required for a short period of time to teach family members or the patient to perform the more complex non-skilled services such as range of motion exercises, pulmonary treatments, tube feedings, self-administered injections, routine catheter care, etc.

Non-Skilled Service Examples for Home Health Care Claim Filing

The following are considered supportive or unskilled and will not be eligible for reimbursement when care consists solely of these services:

- General methods of treating incontinence, including the use of diapers and rubber sheets.
- Administration of routine oral medications, eye drops, ointments, and use of heat for palliative or comfort purposes.
- Injections that can be self-administered (i.e., a well-regulated diabetic who receives daily insulin injections).
- Routine services with indwelling bladder catheters, including emptying and cleaning containers, clamping tubing, and refilling irrigation containers with a solution.
- Administration of medical gases and respiratory therapy after the initial phases of teaching the patient to institute therapy.
- Prophylactic and palliative skin care, including bathing and application of creams or treatment of minor skin problems.
- Routine care with plaster casts, braces, colostomy, ileostomy and similar devices.

- General maintenance care of colostomy, gastrostomy, ileostomy, etc.
- Changes of dressings in non-infected postoperative or chronic conditions.
- General supervision of exercises that have been taught to the patient or range of motion exercises designed for strengthening or to prevent contractures.
- Assistance in dressing, eating, and going to the toilet.
- Tube feeding on a continuing basis after care has been instituted and taught.

Hospice Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must use appropriate revenue codes and CPT/HCPCS codes for services rendered (Refer to the UB-04 Manual and your contract).
- When prior authorization is required or RCR is available based on the member's benefits, request prior authorization or RCR before services are rendered.
- Must itemize all services and bill standard retail rates.
- Inpatient services and home services cannot be billed together on the same claim.
- Must use NPI in field 56.
- Type of bill must be 811 if non-hospital based, or 821 if hospital based (form locator 4).
- Form locators 12 (Source of Admission) and 17 (Patient Status) are required fields. If either field is blank, the claim will be returned for this information (refer to your UB-04 manual for the correct codes).
- Form locator 63 must be completed with a referral number and a prior authorization number from the PPO.

Radiation Therapy Center Claim Filing

- Must file claims electronically or bill on a UB-04 claim form if the facility is hospital based or on a CMS-1500 if the facility is freestanding.
- Must bill negotiated rates according to fees stated in the contract.
- Must use the appropriate revenue codes and the corresponding CPT/HCPCS.

Skilled Nursing Facility Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must use appropriate revenue codes (e.g., 190-194 and 199) for services rendered (refer to UB-04 manual and your contract).
- Must itemize all services and bill standard retail prices.
- Must use NPI in field 56.
- When prior authorization is required based on the member's benefits, request prior authorization before services are rendered.
- Must initiate prior authorization no later than the 21st day of confinement when Medicare A is primary for patients with PPO secondary coverage.
- Must use a type of bill 211 (form locator4).
- A room and board revenue code must be billed.
- Must use type of bill 131 and attach a copy of the Explanation of Medicare Benefits when filing services for a member who has Medicare Part B only.
- All non-routine items must be supplied by the appropriate provider specialty. For example, a special hospital bed or customized wheelchair provided to the patient must be supplied and billed by a DME provider.

Rehab Facility Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must use appropriate room revenue code ending in eight (8). For example, private rehab room 0118 and semiprivate room 0128.
- When prior authorization is required or RCR is available based on the member's benefits, request prior authorization or RCR before services are rendered.

Hospital Acquired Conditions and Serious Reportable Events Policy

Hospital acquired conditions are those conditions that are acquired by a patient while they are in the inpatient hospital setting and were not present upon admission to the hospital. HAC are those conditions that are acquired by a patient while they are in the inpatient hospital setting and were not present upon admission to the hospital.

Serious reportable events are adverse events that are serious, but largely preventable, and of concern to both the public and providers for purposes of public accounting. SRE earned that name because these events should never happen in medical practice.

We will apply the following principles and guidelines for review and determination of **Hospital Acquired Conditions** (identified by CMS) and **Serious Reportable Events (identified by National Quality Forum)**, to determine whether reimbursement to a provider should be reduced for the additional costs related to the event.

- The error or event must be preventable.
- The error or event must be within control of the provider.
- The error or event must be a result of a mistake by the provider.
- The error or event must result in significant harm.
- Identification of non-payable events will incorporate case-by-case review and determination by our medical director, except when self-reported and without dispute.

If medical records are required to complete a review of a HAC/SRE, the minimum defined record set will include:

- Discharge summary
- Admission history and physical
- Operative reports
- Consultation
- Reports
- Physician progress notes
- Emergency department records (if admitted via the ER)
- Other documentation as determined by the Medical Director.

The following HAC or SRE represent potential areas of responsibility and will be reviewed by a our medical director on a case-by-case basis:

- The HAC for foreign object retained after surgery represents a potential area of responsibility and will be reviewed by our medical director on a case-by-case basis.
- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- The wrong surgical procedure performed on a patient

If it is determined that adjustment of claims is applicable, the provider will be notified. The provider may appeal a decision made by us and instructions will be included in the notification letter.

Claim Filing Process

Providers are encouraged to submit claims electronically using Availity or their preferred vendor. Refer to Electronic Commerce for information.

Our electronic payor ID code is **84980**.

Should you have a question about electronic claims processing, contact your electronic connectivity vendor, e.g., Availity or other connectivity vendor or contact our provider customer service by calling **800-451-0287**.

The member's Identification card provides claims filing and customer service information or contact provider customer service at **800-451-0287**.

If a paper claim needs to be submitted mail to:
BCBSTX

PO Box 66044
Dallas, TX 75266-0044

Claims filing reminders

- We will not accept any screen print sent by providers that have been generated on the provider's
- system.
- All Plan providers are required to use their applicable NPI number when filing Plan claims.
- If the Plan member gives a Plan providers the wrong insurance information, the Plan provider must submit the explanation of benefits from the other insurance carrier. This information must reflect timely filing, and the Plan provider must submit the claim to us within 365 days from the date a response is received from the other insurance carrier.

Provider Tools

We have designed useful tools for providers whether doing research or streamlining billing.
These tools can help you evaluate costs, save time, improve service and more. Refer to the Provider Tools page or the electronic filing section of this manual for more information.

The following information is provided related to submitting claims to us electronically through EDI or using paper claim forms. We recommend providers submit claims electronically.

Electronic Data Interchange

EDI transactions allow providers to submit, view, track and monitor claim status electronically. We offer submission of claims via ANSI 837 Claims Transmissions for both institutional and professional providers. Refer to Electronic Commerce section for more information. Batch submissions are a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N837 Transaction Set and identified by a batch control number. Both our clearinghouse and us may not refuse to process or pay an electronically submitted clean claims because it is submitted together with or in a batch submission with a claim that is deficient.

Required Elements for Clean Claims

We require all providers to file electronic claims using National Standard Format (NSF), American National Standards Institute (ANSI 837) or UB-04 format or paper claims utilizing the CMS-1500 or UB-04 forms. ALL paper claims for health care services must be submitted on one of these forms/formats. All claims must contain accurate and complete information.

If a claim is received that is not submitted on the appropriate form or does not contain the required data elements set forth in Texas Department of Insurance Rules for Submission of Clean Claims and such other required elements as set forth in this provider manual and/ or the Plan provider bulletins on the Plan website, the claim will be returned to the physician or professional provider/submitter with a notice of why the claim could not be processed for reimbursement. Please contact the Plan's provider customer service for questions regarding paper or electronically submitted claims.

The billing provider's NPI number must be listed correctly in the appropriate block on the claim form or the claim will be rejected.

In addition to TDI's clean claim required fields, the following fields are our requested element:

Field #	Description of Field
1	Type of Health Insurance Coverage
11a	Insured's Data of Birth
11b	Other Claim ID
15	Other Date
18	Hospitalization Dates Related to Current Service

20	Outside Lab
26	Patient's Account Number

CMS-1500 Claim Form

We require a CMS-1500 claim form as the only acceptable document for participating physicians and professional providers (except hospitals and related facilities) for filing paper claims. Refer to the website for CMS-1500 user guides. You can obtain claim forms by calling the American Medical Association at **800-621-8335**.

UB-04 Claim Form

The electronic ANSIX12N 8371-Institutional or the UB-04 claim form UB-04 is the standardized billing form for institutional services. For information on the UB-04 billing form, or to obtain an official UB-04 Data Specifications Manual, visit the NUBC website.

Although electronic claim submission is preferred, institutional providers may submit claims in non-electronic format using the CMS Form UB-04. UB-04 is the required format for clean non-electronic claims by institutional providers under the TPPA22. To be considered clean under the TPPA, claims submitted using the UB-04 must include all data elements specified by TDI rules23. Refer to the Texas Department of Insurance Rules for Submission of Clean Claim. Claims that do not comply with these requirements will not be considered for TPPA penalty eligibility.

The following are UB-04 data elements that **we have identified as potentially necessary for claim adjudication**. Failure to submit these elements could result in payment delays as we may need to request the information from the provider to adjudicate the claim.

CMS – 1500 Form Locator Field	Description	CMS – 1500 Form Locator Field	Description
1	Pay To Name And Address	61	Insured's Group Name
8b	Patient Name	64	Document Control Number
29	Accident State	65	Employer Name
38	Party Responsible for Bill	70	Patient's Reason for Visit
48	Non-Covered Charges	71	Prospective Claim System Code
51	Health Identification Number	72	External Cause of Injury Code
52	Release of Information	77	Operating Provider Name and Identifiers
53	Assignment of Benefits	78-79	Oter provider Name and Identifiers
55	Estimated Amount Due		

All claims must include all information necessary for adjudication of claims according to the contract benefits. For submission of paper claims, mail to the following address:

Blue Cross and Blue Shield of Texas
PO Box 660044
Dallas, TX 75266-0044

Note: Each field or block on the UB-04 claim form is referred to as a Form Locator

[22] Ex. C, Tex. Ins. Code §1301.131(b).
[23] Ex.B, 28 Tex. Ins. Code §21.2803(b)(3).

Electronic Processes Overview

Electronic Data Interchange refers to the process of submitting claims data electronically. We strongly encourage the electronic submission of claims.

Using an automated claim filing system gives you more control over claims filed and is the first step in making your office paper-free. Our providers can submit claims through Availity or their preferred vendor.

- **Electronic claim submission**
  Since editing begins prior to an electronic claim entering our processing system, electronic claims are less likely to be returned for additional information and are usually adjudicated more quickly than claims submitted via paper. Electronic submission also enables users to have same day access to their batch reports, which allows for quicker error resolution and expedites the overall revenue management cycle process.

  There are several ways to submit your claims data electronically:
  - You may submit all claims directly through Availity® Essentials. It is designed to be easily integrated into the software system typically used by all providers. A list of approved software vendors can be obtained by contacting the Availity Client Services number at **800-282-4548** or by visiting the Availity site.
  - You can submit BCBSTX claims through most major electronic clearinghouses.
  - You may work through a software vendor who can provide the level of system management support you need for your practice, or you may choose to submit claims through a clearinghouse.
  - You may choose to have a billing agent or service submit claims on your behalf.

- **Payer identification code**
  Providers submitting claims for Blue Choice PPO members via the Availity network must use Payer identification code is 84980. If you use another clearing house, please confirm that the correct electronic payer identifier for us is used with your electronic claim vendor.

  To ensure that electronic claims are received for processing, providers should review their Payer Response Reports after each transmission.

  To obtain the specifications on the response options available to you contact your clearinghouse. If you are currently an Availity customer, please contact Availity Client Services at **800-282-4548** or review their EDI Companion Guide.

- **Payer response reports**
  We supply Payer Response Reports to our EDI partners from the BCBS claims processing systems to submitters of our electronic claims. This report contains an individual Document Control Number in the "Payer ICN" field of the response for each claim accepted. The report is forwarded within 48 hours after transmission is received and can be used as proof of claim receipt within our claims processing system for BCBSTX and Federal Employee Program.

  To ensure that electronic claims are received for processing, providers should review their Payer Response Reports after each transmission.

  To obtain the specifications on the response options available to you contact your clearinghouse. If you are currently an Availity customer, please contact Availity Client Services at **800-282-4548** or review their EDI Companion Guide.

The DCN is significant in that electronic claims can now be traced back to the actual claim received into our claims processing system. An example of a DCN number is 607445D26102X. The first four digits of the DCN indicate the date: 6(year=2016), 074 (Julian date = March 15). The final digit of number "X" indicates an electronic claim. You may see "Informational/Warning" messages on these reports. These messages are generated by the claim application; but no action is necessary. The claim will either be processed, or you will receive a letter notifying you the claim must be resubmitted.

The DCN information and the detailed Payer Response Report provide accepted and rejected claims and give providers the tools they need to track their BCBSTX electronic claims.

If a claim should be rejected, you will need to correct the errors and resubmit the claim electronically for processing. To ensure faster turnaround time and efficiency, we recommend that your software has the capability to electronically retransmit individually rejected claims.

- **Submit secondary claims electronically**
  Our secondary claims can be submitted electronically. To do so requires no explanation of benefits; however, prior payer information must be included in the appropriate loops and segments of the electronic claims submitted to us. All our rules for referral notification and prior authorization requirements must be followed.

- **Duplicate claims filing**
  In many instances, we find that the original claim was submitted electronically, and the receipt was confirmed as accepted. Providers who have an automatic follow up procedure should not generate a paper or electronic tracer prior to 30 days (40 days for paper claims) after the original claim was filed. It is important to realize that submitting a duplicate tracer claim on paper or electronically will not improve the processing time. It only delays processing, as the follow-up claim will be rejected as a duplicate of a claim already in process.

Note: For information regarding Blue Cross Medicare Advantage electronic claim rejections, refer to the Blue Cross Medicare Advantage (PPO)[SM] Supplement.

Electronic Payment and Remittance Options

Providers can take advantage of the following electronic options that offer greater convenience, efficiency and security of information:

- **Electronic remittance advice**
  The ERA file is sent on weekdays to the provider that includes claim payment and remittance data the day after claim finalization, and It includes all claims (whether submitted on paper or submitted electronically). This process allows you to automatically post payments to your patient's accounts.

- **Electronic funds transfer**
  EFT is a secure method of payment that allows the transfer of our payments directly to provider's designated bank account. Reimbursement by EFT is made every weekday. Adding the EFT capability can help you streamline your administrative processes. EFT is the fastest way an insurance company can pay a claim.

- **Electronic payment summary**
  EPS provides the same payment information as the paper provider claims summary. It is received in your office the same day your ERA is delivered and can help streamline the payment and account reconciliation process.

To enroll for EFT, ERA and EPS, use the Transaction Enrollment tool at Availity Essentials. For more information, refer to our Electronic Commerce page.

Paper Provider Claim Summary

Electronic payment and remittance options are preferred. For providers who are not enrolled for EFT and ERA/EPS, the PCS is a paper notification statement or voucher that is mailed with the payment, if applicable, to providers after the processing of a claim has been completed. The content of each summary varies based upon the member's benefit plan and services rendered, and explains payment, remittance information, and any amount of the bill or allowable which is the member's share. The voucher may include multiple transactions.

Claim Review Process

Review this section for information on refunds and recoupments and submitting adjustment requests.

- **Claim reconsideration requests**
  Claim reconsideration requests are submitted electronically for review or reevaluation of situational finalized claim denials online (including BlueCard® out-of-area claims). This method of inquiry submission is preferred over faxed/mailed claim disputes, as it allows you to upload supporting documentation and monitor the status via Availity® Essentials.

  For more details, refer to the Claim Reconsideration Requests page and instructional user guide in the Provider Tools section of our site.

- **Claim review form**
  To request a claim review by mail, complete the Claim Review Form. Include the following:
  - Reason for claim review request – use the Claim Review Form and Ineligible Reason Code List to determine if your claim meets eligibility requirements for review
  - Be as specific as possible in detailing your request for review.
  - It is necessary to provide all required data elements and use the proper form or your review will be rejected.

- **Submission of additional Information**
  At the time the claim review request is submitted, please attach any additional information you wish to be considered in the claim review process. This information may include supporting medical documentation specific to the claim denial and the reason for review, remember to submit only the medical records needed to support the review (HIPAA - minimum necessary).

  The following are examples of what is not considered eligible under this review process (not an all-inclusive list):
  - Membership denials, claim corrections, request for Medicare or other carrier paid amounts, these should be submitted electronically as a corrected claim.
  - Denials related to non-covered benefits – these will not be reviewed for medical necessity – they are non-covered services under the member's benefit plan.
  - Claim status questions regarding a pending claim or pending adjustment.

  To submit **additional information** due to receiving a letter requesting the information from us, it should be submitted using the letter received or the Additional Information Form. To submit electronically, use the **Claim Reconsideration Requests function via Availity® Claim Status tool**, if applicable.

  Examples of requested information (not all inclusive) are medical records, progress reports, operative report, diagnostic test results, history and physical exam, discharge summary, itemized bills.

- **Corrected Claims**

When a provider submits a claim to us and later determines that the claim contained an error (e.g., the wrong diagnosis, date of admission/service, EOMB or other insurance payment information received, any claim previously denied for missing information), then provider will send a corrected claim to us in accordance with applicable policies and procedures. The documentation necessary to substantiate a corrected claim is forwarded to us upon request.

To submit a corrected claim, you should submit it electronically by following instructions under Electronic Replacement/Corrected Claim Submissions or if you must submit paper, it should include a Corrected Claim Form. These forms can be found under Forms. Please file electronically when possible.

- **Under/overpayments**
  Barring any systematic practice to underpay provider by us, we and our providers agree that underpayments or overpayments amounting to less than $50.00 on an individual entire claim will be considered to have been paid in accordance with the terms of the provider's agreement and will not be appealed by provider or us. Rather, we or the provider will write off such under and/or overpayment difference unless our agreement with the applicable ASO Group requires otherwise.

- **Types of disputes & timeframes for requests**
  There are two levels of claim reviews available to you. For the following circumstances, the first claim review must be requested within the corresponding timeframes outlined below:

DISPUTE TYPE	TIMEFRAME FOR REQUEST
Audited Payment	Within 45 days following the receipt of written notice of request for refund due to audited payment
Overpayment	Within 45 days following the receipt of written notice of request for refund due to overpayment
Claim Dispute	Within 180 days following the check date/date of the Plan's Explanation of Payment (EOP), or the date of the BCBSTX Provider Claims summary (PCS), for the claim in dispute

The Plans will complete the 1st claim review within 45 days following the receipt of your request for a first claim review.
  - If your claim has been maintained after review, you will receive a written notification of the claim review determination.
  - If your claim has been overturned after reviewing your payment/PCS will serve as your notification.

If the claim review determination is not satisfactory to you, you may request a second claim review.
  - The Plans will complete the second claim review within 45 days following the receipt of your request for a second claim review.
  - If your claim has been maintained after review, you will receive a written notification of the claim review determination
  - If your clam has been overturned after reviewing, your payment/PCS will serve as your notification.
  - The claim review process for a specific claim will be considered complete following your receipt of the second claim review determination

- **Recoupment process**
  The refund policy for the Plan indicates we have 180 days following the payee's receipt of an overpayment to notify a provider that the overpayment has been identified and to request a refund.* For additional information on the Plan's Refund Policy, including when a provider may submit a claim review and when an overpayment may be placed into recoupment status, please refer to the refund policy within this provider manual.

In some unique circumstances a provider may request, in writing, that the Plan reviews all claims processed during a specified period; in this instance all underpayments and overpayments will be addressed on a claim-by-claim basis.

***Notes:**
The refund request letter may be sent at a later date when the claim relates to Plan accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:

- Self-Funded ERISA (Employee Retirement Income Security Act
- Indemnity plans
- Medicaid, Medicare and Medicare Supplement
- Federal Employees Health Benefit Plan
- Self–funded governmental, school and church health plans
- Out–of–State Blue Cross and Blue Shield plans (Blue Card)
- Out–of–network (non–participating) providers
- Out–of–state provider claims including away from home care
- Overpayments due to a settlement or a finding of medical malpractice or negligence that does not occur within 180 days

Refund requests resulting from settlement or finding of medical malpractice or negligence shall be due within business days, and absent a mutual agreement, we will recover the full amount by offsetting current claims as described in the refund policy.

When a provider's overpayment is placed into a recoupment status, the claims system will automatically off-set future claims payment and generate a PCS to the provider (recoupment process). The PCS will indicate a recouped line along with information concerning the overpayment of the applicable Blue Choice PPO claims.

For additional information or if you have questions regarding the Blue Choice PPO recoupment process, please contact **800-451-0287** to speak with provider customer service.

- **Refund policy**
  The **Plans** strive to pay claims accurately the first time; however, when payment errors occur, the Plan needs your cooperation in correcting the error and recovering any overpayment.

  When a provider identifies an overpayment:
  - Use our Electronic Refund Management (eRM) tool for overpayment reconciliation and related processes. Refer to the eRM section below and the eRM page for more information.
  - Submit your refund using the Provider Refund Form to the following address:
    BCBSTX Refund and Recovery
    Dept 0695
    PO Box 120695
    Dallas, TX 75312-0695

  When the Plan identifies an overpayment:
  If the Plan identifies an overpayment, a refund request letter will be sent to the payee within 180 days following the payee's receipt of the overpayment that explains the reason for the refund and includes remittance form and a postage-paid return envelope. In the event that the Plan does not receive a response to their initial request, a follow-up letter is sent requesting the refund.
  - Within 45 days following its receipt of the initial refund request letter (Overpayment Review Deadline), the provider may request a claim review of the overpayment determination by the Plan by submitting a request via eRM or the Claim Review Form in accordance with the Claim Review Process. In determining whether this deadline has been met, the Plan will presume that the refund request letter was received on the 5th business day following the date of the letter.

- If the Plan does not receive payment in full within the Overpayment Review Deadline, they will recover the overpayment by offsetting current claims reimbursement by the amount due the Plan after the later of the expiration of the Overpayment Review Deadline or the completion of the Claim Review Process provided that the provider has submitted the Claim Review form within the Overpayment Review Deadline.
- Refer to the Recoupment Process in this provider manual.

Note: In some unique circumstances a provider may request, in writing, that the Plan review all claims processed during a specified period; in this instance all underpayments and overpayments will be addressed on a claim-by-claim basis.

For additional information or if you have questions regarding the refund policy, please contact our provider customer service at **800-451-0287** to speak to a customer advocate.

If you want to request a review of the overpayment decision, please view the Claim Review Process and Electronic Refund Management sections within this provider manual.

Reasons for Refund Letters

The Plan's refund request letters include information about the specific reason for the refund request, as follows:

- The services rendered require prior authorization/referral; none was obtained.
- Your claim was processed with an incorrect copay/coinsurance or deductible.
- Your claim was received after the timely filing period; proof of timely filing needed.
- Your claim was processed with the incorrect fee schedule/allowed amount.
- Your claim should be submitted to the member's IPA or Medical Group.
- Your claim was processed with the incorrect anesthesia time/minutes.
- Your claim was processed with in-network benefits; however, it should have been processed with out-of-network benefits.
- Total charges processed exceeded the amount billed.
- Per the member/provider this claim was submitted in error.
- Medicare should be primary due to ESRD. Please file with Medicare and forward the EOMB to Blue Cross and BlueShield.
- The patient has exceeded the age limit and is not eligible for services rendered.
- The patient listed on this claim is not covered under the referenced policy.
- The dependent was not a full-time student when services were rendered; benefits are not available.
- The claim was processed with incorrect membership information.
- The services were performed by the anesthesiologist; however, they were paid at the surgeon's benefit level.
- The services were performed by the assistant surgeon; however, they were paid at the surgeon's benefit level.
- The services were performed by the co-surgeon; however, they were paid at the surgeon's benefit level.
- The service rendered was considered a bilateral procedure; separate procedure not allowed.
- Claims submitted for rental; DME has exceeded purchase price.
- Overpayment was identified, as another insurance carrier is the primary for this patient. We are the secondary carrier, but paid primary in error.

Note: The refund request letter may be sent at a later date when the claim relates to our accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:

- Self-funded ERISA
- Indemnity plans
- Medicaid, Medicare and Medicare Supplement
- Federal Employees Health Benefit Plan

- Self-funded governmental, school and church health plans
- Out-of-state Blue Cross and Blue Shield plans (BlueCard)
- Out-of-network(non-participating) providers

- **Electronic refund management (eRM)**
  eRM is our on-line refund management tool which will help simplify claim overpayment reconciliation and related processes. The eRM application is available at no additional charge. Enjoy single sign-on through Availity Essentials. (Note: You must be a registered user with Availity to take advantage of eRM).

  To register:
  - **Visit** the Availity Essentials website
  - **Receive electronic notifications of overpayments** to help reduce record maintenance costs.
  - **View overpayment requests** – search/filter by type of request, get more details and obtain real-time transaction history for each request.
  - **Settle your overpayment requests** – Have us deduct the dollars from a future claim payment. Details will appear on your PCS or EPS; information in your eRM transaction history can also assist with recoupment reconciliations.
  - **Pay by check** – You will use eRM to generate a remittance form showing your refund details. One or multiple requests may be refunded to us check numbers will show online.
  - **Submit unsolicited refunds** – If you identify a credit balance, you can elect to submit it on-line and refund your payment to BCBS by check, or have the refund deducted from a future claim payment.
  - Stay aware with system **Alerts** – You will receive notification in certain situations, such as if we have responded to your inquiry or if a claim check has been stopped.

  Accessing erM via Availity
  Once you are registered with Availity:
  - Log into Availity Essentials
  - Select Payer Spaces from the navigation menu and choose us
  - Select the Applications tab, then choose Refund Management eRM*

  *New users will be prompted to complete the one-time eRM onboarding form and email verification to gain access to the eRM system.

  If you are unable to access eRM from our branded Payer Spaces, contact your Primary Access Administrator. To identify your Availity Administrators, select My Account under My Account Dashboard on the Availity homepage. Contact Availity Client Services at **800-282-4548** or visit the Availity website for more information or assistance.

- **Appeals and grievance procedures**
  The provider will cooperate with our policies and procedures related to the appeals and grievance process, including, but not limited to, furnishing all relevant information to us, in resolving any grievance or appeal related to the provision of health care services furnished to members under the provider agreement. The provider will forward to us any medical records related to any grievance or appeal at provider's expense within 10 days of our request unless a grievance or appeal is expedited, in which case the provider will immediately provide the medical records to us. The provider will comply and cooperate with our adjudication process for any grievance or appeal. Any member complaints or grievances received by provider related to us will be forwarded to us within 10 days of provider's receipt of such complaints or grievances prior to initiating any dispute under related to either whether a health care service provided by provider is a covered service or the amount of compensation due provider under the provider's agreement for providing a covered service, provider must exhaust any applicable internal appeal process by us as set forth in policies and procedures or as otherwise we communicate to the provider.

PHARMACY

The following applies to members who have our prescription (RX) drug rider. Depending on the member's individual contract, pharmacy services may or may not be provided through our pharmacy plan. Some plans may be carved out to other Pharmacy Benefit Managers. The PBM name is listed on the front of' the member's identification card. Prime Therapeutics is the PBM that provides drug benefits through us.

Pharmacy Network

Our members with a pharmacy card RX drug benefit are normally required to use a pharmacy on the list of independently contracted participating pharmacies to maximize their benefits. This pharmacy network can include retail for up to a 30 or 90-day supply, home delivery for up to a 90-day supply or specialty pharmacy for up to a 30-day supply (except for certain U.S. Food and Drug Administration - designated dosing regimens). Some members' pharmacy-benefit plans include an additional preferred pharmacy network, which offers reduced out-of- pocket expenses to the member if they use one of these pharmacies instead. Pharmacy networks and supply limits are dependent upon the member's benefit plan. Please encourage your patients to use one pharmacy for all their prescriptions to better monitor drug therapy and avoid potential drug-related problems.

Our contracts for home delivery pharmacy services to augment our retail pharmacy network. Members of our plans may receive up to a 90-day supply of maintenance medication (e.g., drugs for arthritis, depression or diabetes) through the home delivery program. If you believe our member will continue the same drug and dose for an indefinite time, please consider writing the prescription for a 90-day supply with three refills. If the patient is starting a new medication for the first time, you should write two prescriptions - one for up to a 90-day supply with three refills and a starter supply for up to 30 days that the patient can fill right away at the local retail pharmacy.

FDA approved specialty drugs for member self-administration typically must be acquired through a specialty pharmacy provider. The member may also bill these drugs under their pharmacy benefit to receive maximum coverage.

Prescription Drug List Evaluation

We use the Prime Therapeutics National Pharmacy and Therapeutics Committee, which is responsible for drug evaluation. P&T consists of independent practicing physicians, pharmacists and other health care professionals who are not employees or agents of Prime Therapeutics. P&T meets quarterly to review new drugs and updates drug information based on the currently available literature.

We remain responsible for the determination of benefit coverage and approvals for prior authorizations, quantity exceptions or step therapy for members who have our prescription drug rider. To submit a request, visit Prior Authorization and Step Therapy Programs.

Prescription Drug List Updates

The prescription drug lists helps providers select cost-effective drug therapy. In addition to the list of approved drugs, the drug list describes how drugs are selected, coverage considerations and special requirements. As a reminder, drugs that have not received FDA approval are not covered under the member's pharmacy benefit for safety concerns.

Our members can have a pharmacy benefit of up to six-tiers. Listed drugs may be covered at generic, brand and specialty-tier levels. Depending on the member's benefit plan, drugs may be split between preferred and non-preferred within these tiers. Based on the benefit plan, members may pay a lower member share (out-of-pocket expense) for prescription drugs in the lower tiers.

For some members, the prescription drug list may only list generics and lower cost brand drugs. For other members, the prescription drug list may reference all covered prescription drugs, and those drugs not listed are not covered. If the drug is not covered, you may be able to submit a coverage exception to us for consideration (based

on the member's benefit plan). Refer to the member's certificate of coverage for more details, including benefits, limitations and exclusions.

Please refer to the Prescription Drug List when prescribing for our members. If needed, call the number on the member ID card for assistance in determining the correct prescription drug list.

We notify physicians of prescription drug list addition and changes through the provider News and Updates and prescription drug list pages. View the Pharmacy Program page for the member drug lists. Members may be notified of changes by direct mail.

Members who are identified as taking a medication that have been deleted from the prescription drug list are sent a letter detailing the change at least 60 days before the effective deletion date. Medications deleted from the prescription drug list may still be available to members at a higher copayment or the medication may not be covered and the member is charged for the full cost of the drug. Both Prime Therapeutics and us provide pharmaceutical-safety notifications to dispensing providers and members regarding point-of-dispensing drug/drug interaction and FDA drug recalls.

Note: The prescription drug list is a tool to help members maximize their benefits. The final decision about what medications should be prescribed is between the provider and the patient.

Generic Drugs

The FDA has a process to assign equivalency ratings to generic drugs. An "A" rating from the FDA means that the drug manufacturer has submitted documentation demonstrating the equivalence of its generic product compared to the brand name product.

BCBSTX supports the FDA process for determining the equivalency and encourages its contracted providers to prescribe drugs that have generic alternatives available and not to add dispense as written to prescriptions unless medically necessary, and if clinically appropriate, coverage criteria that prevent the use of a generic for a particular patient has been met. Most plans require members to pay the difference between the brand-name drug and generic drug plus the prescribed drug's cost share.

If you determine that your patient cannot tolerate the available generic equivalent drug, some member's plans may allow you to submit documentation for consideration to waive any cost share penalties that may be applied to the member otherwise. If approved, the member would only be responsible for their applicable cost share for the brand drug. Call the number on your patient's member ID card for assistance in completing this process.

Drug Utilization Review

BCBSTX and Prime Therapeutics conduct concurrent and retrospective drug utilization reviews to ensure the most appropriate and cost-effective drugs are used safely.

Concurrent DUR occurs at the point of sale (i.e., at the dispensing pharmacy). Pharmacies are electronically linked to Prime Therapeutics' claims adjudication system. This system contains various edits that check for drug interactions, overutilization (i.e., early refill attempts), safe and effective use of prescription opioids and therapeutic duplications. The system also alerts the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist can use his or her professional judgment and call the prescribing provider if a potential adverse event may occur.

Safety checks on prescription opioids address permissible quantity and medication dose, as recommended by the Centers for Disease Control and Prevention and other nationally recognized guidelines. The pharmacist will receive alerts advising if authorization may be required before the full quantity of opioids as prescribed may be dispensed at the point of sale.

Retrospective DUR uses historical prescription or medical claims data to identify potential prescribing and dispensing issues after the prescription is filled. Examples of retrospective DUR include appropriate use of controlled substances, polypharmacy, adherence and generic-utilization programs. These programs aim to promote safety, reduce overutilization and close gaps in care. Retrospective DUR programs are developed based on widely accepted national practice guidelines. Individual letters may be mailed to providers identifying potential drug therapy concerns, together with a profile listing the member's prescription medications filled during the study period, references to national practice guidelines and a survey to be completed.

Covered Pharmacy Services

The following is a list of typically* covered pharmacy services:

- Glucagon and anaphylactic kits
- Insulin, syringes, lancets and test strips
- Any prescription drug unless specifically excluded (e.g., obesity, infertility), provided that the drug is ordered by the member's PCP or a physician/provider to whom the member has been referred
- The member's applicable prescription copayment will apply for each prescription or refill for 30 days
- Oral contraceptives
- Diaphragms
- Preventive vaccinations (e.g., influenza, Tdap, shingles, etc.)
- One applicable copay will apply to most "packaged' item (e.g., inhalers)
- Medications that are approved by the FDA for self-administration

Non-Covered Pharmacy Services

The following is a list of typically* non-covered pharmacy services:

- Any charge for most therapeutic devices or appliances (e.g., support garments and other non-medical substances), regardless of their intended use
- Investigational use of medication
- Medications specifically excluded from benefit (e.g., drugs used for cosmetic purposes)
- Any drug that, as required under the Federal Food, Drug and Cosmetic Act, does not bear the phrase: "Caution: Federal law prohibits dispensing without a prescription," even if prescribed by a physician/ provider (over the counter)
- Drugs that have not received approval from the FDA Nutritional Supplements (coverage requires prior authorization)
- Compounded medications are not a covered benefit under most plans
- Prescriptions obtained at an out-of-network pharmacy, unless in an emergency

*Not all of our plans include pharmacy benefits. We highly recommend checking the member's benefits before prescribing medication.

Authorizations for Pharmacy Clinical Programs

Drugs may require prior authorization, step therapy or quantity limits, view the Pharmacy Program for detailed information, links to forms and program criteria summaries. Providers can submit the TX Standard Prescription Drugs Prior Authorization Form request electronically via the CoverMyMeds® site by attaching the form during the request process. Other physician/provider fax forms are available.

Changes to requirements are published in our Blue Review. If you have additional questions, please call Prime Therapeutics at **800-289-1525**. We allows for certain off- label uses of drugs when the off label uses meet our policy requirements.

For information about the PA medical criteria, review our Medical Policies.

If you are prescribing and/or administering select infusion drugs, you may need to submit a prior authorization

request to administer the drug. Review the prior authorizations list for designated groups of infusion drugs. These infusion drugs are typically covered under the member's medical benefit. Call the number on the member ID card to determine benefits.

Refer to the **Utilization Management** section of this manual for more information.

Specialty Pharmacy Program and Specialty Pharmacy Network

Specialty medications are generally prescribed for people with complex or ongoing medical conditions, such as immune deficiency, multiple sclerosis and rheumatoid arthritis. Due to the unique storage and shipment requirements, some specialty medications may not be readily available at retail pharmacies. The specialty pharmacy program helps deliver these medications directly to members and sometimes providers. Specialty medication coverage is based on the member's benefit and the administration of the medication. Some members may be required to use an in-network specialty pharmacy or be subject to a split fill program for pharmacy benefits to apply.

Most specialty medications will require submitting prior authorization forms. Submit the TX Standard Prescription Drugs Prior Authorization Form electronically through CoverMyMeds. For more information about medical criteria refer to the medical policies.

For those medications that are approved by the FDA for self- administration, our members may be required to use their pharmacy benefit and acquire self-administered drugs (oral, topical and injectable) through an appropriate contracted pharmacy provider and not through the physician’s office. Self-administered drugs must be billed under the member’s pharmacy benefit for your patients to receive coverage. View specialty medications on the Specialty Pharmacy Program page.

If services are submitted on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500), claims for drugs that are FDA-approved for self-administration and covered under the member’s prescription drug benefit, we will notify the provider of the appropriate benefit to re-submit for coverage. In this situation, the following message will be returned on the electronic payment summary or provider claim summary: “Self- administered drugs submitted by a medical professional provider are not within the member’s medical benefits. These charges must be billed and submitted by a pharmacy provider.

The Pharmacy Match program applies for our fully insured plans. For some commercial members, it is an employer group option. This program expands the specialty pharmacy network and uses a dynamic real-time referral process to match members to the best-fit, in-network specialty pharmacy for their pharmacy-benefit prescription. Free Market Health facilitates this streamlined referral process for Prime Therapeutics. To start a patient on a specialty medication with Pharmacy Match, continue to submit any required prior authorization requests to BCBSTX. Once the PA is approved, e-prescribe the patient’s specialty prescription to FMH Pharmacy (NPI: 1366292880), email contact@fmhpharmacy.com, call **412-755-3241** or fax **833-998-4435**. Free Market Health will fax you with the pharmacy assignment, transfer the prescription and contact you for any inquiries or requests related to the prescription. The matched pharmacy will contact your patient to begin onboarding (if not already using that pharmacy) and coordinate delivery.

Some members’ benefit plans may include access to Accredo or other contracted in-network specialty pharmacy providers. To obtain specialty medications through Accredo, follow these steps:

- Collect patient and insurance information.
- Contact Accredo at 833-721-1619 or e-prescribe the patient’s prescription to Accredo.
- Find referral forms by therapy and e-prescribing information at accredo.com/prescribers.
- If your patient has an existing prescription for a covered specialty medication, you can call **833-721-1619** to transfer the prescription.

The Accredo provider portal grants access to varied support tools, such as physician concierge, electronic prior authorization (ePA), interoperability with electronic health records and your patient's status.

We contract with select specialty pharmacies to obtain specialty medications for physician administration to our members. These medications that must be administered to a patient by a provider are typically covered under the member's medical benefit.

Providers should only bill for the administration of the specialty medication(s) when the specialty medication is received from these specialty pharmacies. Providers may not bill for the specialty medication. For a complete list of all in-network specialty pharmacies, including in-network specialty pharmacies for physician-administered medications that are typically covered under the medical benefit, please visit the Pharmacy Program/Specialty Drug Programs section.

If you have questions about the specialty program, a patient's benefit coverage and/or to ensure the correct benefit is applied for medication fulfillment, please call the customer service number on the member ID card.

Split Fill Program

Some of our members have the split fill program as part of their benefit plan. This program applies to select medications that patients are often unable to tolerate. Under this program, members who are new to therapy (or have not had claims history within the past 120 days for the drug) are provided a partial fill, or split fill for up to the first three months of therapy, giving them the opportunity to try the drug at a prorated cost. This allows the member to make sure they can tolerate the medication and any potential side effects before continuing ongoing therapy.

The split fill program applies to specific drugs known to have early discontinuation or dose modification. Each drug is evaluated using evidence-based criteria to determine the frequency and duration of a split fill. Since this list of drugs is subject to change at any time, you can view the current drugs in this program on the pharmacy program webpage.

Members may use any in-network pharmacy that can dispense the medication. Members pay an applicable prorated cost share for each fill received for the duration of the program. Once the member can tolerate the medication, the member will pay the applicable cost share amount for a full supply. All member cost share amounts are determined by the member's pharmacy benefit plan.

Billing Point-Of-Use Convenience Kits

Our reimbursement applies only to the drug component of a point-of-use convenience kit used in the administration of covered, injectable medications. These prepackaged kits include the medication, as well as non-drug supplies, such as alcohol prep pads, cotton balls, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

We periodically check the pricing of these kits to manage costs. Often, the cost of these convenience kits is more than the cost of their components when purchased one item at a time. The non-drug supplies are considered as part of the practice expense for the procedure performed and no additional compensation is warranted. Reimbursement for these kits may be updated based on the FDA-approved drug component.

Billing for Compounded Drugs

Drug compounding is the process of mixing, combining or altering ingredients to create a customized medication. The Medical Policy on Compounded Drugs considers this experimental, investigational and unproven in most cases according.

Compounded drugs should be filed under the appropriate "Not Otherwise Classified" procedure code with the modifier KD. You can review the Compound Drug Schedule through the secure content section of the General Reimbursement Information page.

Pain Pump and Progesterone Therapy

The properties of certain drugs may be altered and combined by a compounding pharmacy to create a customized medication for the use in a pain pump or for progesterone therapy as a technique to reduce pre-term delivery in high-risk pregnancies.

Review the following medical policies related to progesterone therapy (RX501.062) and implantable infusion pumps (SUR707.008) for more information. (**Note:** You will have to agree to the policy disclaimer before accessing the policies webpage, then select Active Policies and choose the policy you wish to reference.)

If you have further questions, please contact provider customer service at 800-451-0287 to speak with a customer advocate.

Billing Unlisted Drug Codes

Most National Drug Codes numbers have either an assigned CPT code or an assigned HCPCS code. CPT codes are referred to as Level I codes and are maintained by the American Medical Association. Level I codes are comprised of five characters in length (e.g.,99211, 30520,).

HCPCS codes are referred to as Level II codes and are maintained by CMS. Level II codes are five characters in length and are comprised of one letter and four numbers (e.g., J1950, J9217, etc.).

In most instances, NDC numbers billed are compared to a list of specific CPT or HCPCS drug code. Claims must be submitted with the most specific description of the CPT/HCPCS code when billing for medications that are used during a patient's visit.

We periodically check the NDC numbers and NDC units submitted with unlisted drug codes to ensure these codes are being billed correctly. If a claim is submitted using an unlisted drug code (e.g., J3490) and a valid CPT/HCPCS code exists for the drug being administered, we will deny the service line and request the provider resubmit the service using the more accurate CPT/HCPCS code.

If a claim is submitted with an unlisted drug code (e.g., J3490) and there is not a more specific CPT/HCPCS code for the drug being administered, the provider will need to provide the necessary information on the claim for us to properly adjudicate the service line. If the claim is received without the necessary information, the service line may be denied and sent back to the provider with a request to resubmit the service along with the necessary information.

To avoid a claim rejection, include the following information when submitting valid unlisted drug codes:

- NDC qualifier, N4
- NDC 11-digit billing number
- NDC product package size unit of measure (e.g., UN, ML, GR, F2, etc.)
- NDC unit to reflect the quantity of drug product billed

To submit narrative supplemental claim information, you can add:

- NDC number
- Drug name
- Product strength of drug administered (e.g., 25 mg/ml, 10 mg/10ml, etc.)
- Single dose vial or multi-dose vial
- Dosage administered (e.g., 5 mg, 10 mg, etc.)

Note: An NDC number will be reimbursed for a maximum of two years after it becomes inactive. After this timeframe, the NDC number is considered obsolete.

For more information, reference the Unlisted/Not Otherwise Classified Coding Policy, the Wasted/Discarded Drugs

and Biologics Policy on the reimbursement policies page and the Drug and National Drug Code Information page. You may also contact provider customer service at **800-451-0287**.

Pharmacy Forms

All our required forms can be downloaded from the Forms section.

FEP Pharmacy Program

Some prescription drugs require prior approval through the retail pharmacy program for federal members. To assist the member with the prior approval process or if you need information about the federal pharmacy programs, please call the following toll-free numbers:

- Retail pharmacy program customer service - **800-624-5060**
- Mail order prescription program - **800-262-7890**

BEHAVIORAL HEALTH

Integrated Behavioral Health Program Overview

We maintain a portfolio of resources that helps members access benefits for behavioral health (mental health and substance use disorder) conditions as part of an overall care management program. The integration of behavioral health care management with medical care management allows our clinical staff to assist in the early identification of members who could benefit from co-management of behavioral health and medical conditions.

Our Integrated Behavioral Health program supports behavioral health professionals and physicians in better assessing the needs of members using these services and engaging them at the most appropriate time and setting.

Updates about the Behavioral Health program will be communicated in News and Updates, Blue Review and on the Behavioral Health Program page.

Behavioral Health Components

The Behavioral Health program includes:
Care/Utilization management:

- Inpatient management for inpatient and residential treatment center services.
- Certain outpatient services

See Behavioral Health Authorizations section below.

Case management programs:
Intensive case management provides intensive levels of intervention for members experiencing a high severity of symptoms.

Condition case management for chronic BH conditions such as:

- Depression
- Alcohol and substance use disorders
- Anxiety and panic disorders
- Bipolar disorders
- Eating disorders
- Schizophrenia and other psychotic disorders
- Attention deficit and hyperactivity disorder
- **Active specialty management** program for members who do not meet the criteria for Intensive or condition case management but who have behavioral health needs and could benefit from extra support or services.
- **Care coordination early intervention (CCEI)®** program provides outreach to higher risk members who often have complex psychosocial needs impacting their discharge plan.

Specialty programs:
Our behavioral health teams may contact providers as needed in support of members utilizing these specialty programs.

- **Eating disorder care team** is a dedicated clinical team with expertise in the treatment of eating disorders. The team includes partnerships with eating disorder experts and treatment facilities as well as internal algorithms to identify and refer members to appropriate programs.
- **Autism response team** whose focus is to provide expertise and support to families in planning the best course of autism spectrum disorder treatment for their family, including how to maximize their covered benefits.
- **Risk identification and outreach** is an industry-leading model for leveraging robust data analytics to optimize solutions for complex healthcare priorities. This multi-disciplinary collaboration between behavioral health, medical, pharmacy and clinical data technology groups is focused on mining, organizing

and visualizing clinically actionable data for at-risk member populations and implementing clinically appropriate and effective interventions at both member and provider levels.

Referrals to other medical care management programs, wellness and prevention campaigns.

Telehealth and Telemedicine Services

Telehealth or telemedicine services give our member greater access to care. Members may be able to access their medically necessary covered benefits through providers who deliver services through telehealth or telemedicine services including intensive outpatient program services. Check the member's eligibility and benefits for coverage information

HEDIS® Indicators

We are accountable for performance on national measures, like the Healthcare Effectiveness Data and Information Sets. Several of these specify time frames for appointments with a BH professional.

- Expectation that a member attends a follow-up appointment for a mental health or substance use diagnosis following a mental health or substance use inpatient admission within seven or 30 days.
- For children (6-12 years old) who are prescribed ADHD medication:
    - One follow-up visit, the first 30 days after medication dispensed (initiation phase).
    - At least two visits, in addition to the visit in the initiation phase with provider in the first 270 days after initiation phase ends (continuation and maintenance phase).
- For members treated with a new diagnosis of alcohol or other drug dependence:
    - Treatment initiation through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization program or telehealth or medication treatment within 14 days following the diagnosis (initiation phase).
    - At least two visits/services, in addition to the treatment initiation encounter, within 34 days of initiation visit (engagement phase)

Clinical Screening Criteria

Our behavioral health team utilizes nationally recognized, evidence based and or state or federally mandated clinical review criteria for its behavioral health clinical decisions including:

- National coverage determinations
- Local and regional coverage determinations
- MCG care guidelines (mental health disorders)
- American Society of Addiction Medicine's ASAM Criteria (addiction disorders)
- Our medical policies and national clinical practice guidelines

The appropriate use of treatment guidelines requires professional medical judgement and may require adaptation to consider local practice patterns. Professional medical judgment is required in all phases of the health care delivery and management process including consideration of the individual circumstances of any member. The guidelines are not intended as a substitute for this important professional judgement. If a specific claim or authorization is denied and there is an appeal, we will provide the applicable criteria used to review the claim or authorization request upon request by the behavioral health professional or physician.

If a behavioral health professional or physician engages in a particular treatment modality or technique and requests the criteria that we apply in determining whether the treatment meets the medical necessity criteria set forth in the member's benefit plan, we will provide the applicable criteria used to review specific diagnosis codes and procedure codes which are appropriate for the treatment type.

Behavioral Health Authorizations

Prior authorization (also called pre-certification or pre-notification) is the process of determining medical appropriateness of the behavioral health professionals and physician's plan of treatment by us or the appropriate

behavioral health vendor for approval of services. When prior authorization is not required, providers may submit an optional RCR to determine medical necessity.

Prior authorization may be required for inpatient and residential treatment center admissions.

Outpatient services may require prior authorization or an RCR may be applicable for the following intensive outpatient behavioral health services before initiation of services for most plans:

- Applied behavior analysis
- Intensive outpatient program
- Repetitive transcranial magnetic stimulation
- Partial hospitalization program

Providers are responsible for requesting prior authorization or RCR on the member's behalf. Payment of benefits is subject to several factors, including, but not limited, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member's policy certificate and/or benefits booklet or summary plan description as well as any preexisting conditions waiting period, if any. As always, all services must be determined to be medically necessary as outlined in the member's benefit booklet. Services determined not to be medically necessary will not be covered.

Behavioral Health Process

Providers may refer to the spec section of this provider manual or the Utilization Management page for the most current process to request prior authorization or RCR.

Behavioral Health Forms

Prior authorization or RCR for certain BH outpatient services may require completion of a forms located under Education and Reference/Forms page.

Note: There are separate forms for Teacher Retirement System of Texas and Employee Retirement System of Texas plans that use the Plan networks.

Failure to Prior Authorize

If contracted providers do not request prior authorization when required for behavioral health treatment, it may result in the same member benefit reductions that apply to medical services. We may request clinical information from the provider for a clinical medical necessity review. Claims determined to be medically unnecessary will not be covered.

Behavioral Health Contacts

Our behavioral health care management services are accessible 24 hours a day, seven days a week, 365 days a year at **800-528-7264** or the number listed on the member ID card. Generally, customer service hours are 8 a.m. – 6 p.m. CT Monday through Friday.

After hours, clinicians are available to handle emergency inpatient prior authorization. Members who are in crisis outside of normal service hours are joined immediately with a licensed BH Clinician. The BH clinician will assist the member, which may include directing them to the nearest emergency room or, when necessary, reaching out to emergency medical personnel (911) as appropriate.

- **Fax: 877-361-7646** or **312-946-3735**
- **Mail:** BCBSTX Behavioral Health Unit
  PO Box 660240
  Dallas, TX 75266-0240

Behavioral health clinical appeals
For information about Behavioral Health Clinical Appeals:

- **Phone: 800-528-7264**
- **Mail:** Blue Cross and Blue Shield of Texas Attention: BH Unit
  PO Box 660240
  Dallas, TX 75266-0240

Call the phone number on the member's ID card to:

- Prior authorize or request RCR for services
- Obtain or submit clinical forms
- Check eligibility and benefits
- Contact customer service

Refer to the Reimbursement Policies page for topics related to behavioral health services.

DISEASE MANAGEMENT PROGRAMS

Condition Management/Disease Management Program Overview

The **Plan** condition management/disease management program provides Plan members with the resources to remain healthy and maintain their quality of life. The program is available to members diagnosed with chronic conditions and specific diagnoses such as asthma, cardiovascular condition clusters (coronary artery disease, peripheral artery diseases, angina and atherosclerosis, congestive heart failure, hypertension, musculoskeletal leading indicators, chronic obstructive pulmonary disease and diabetes or those who need assistance with tobacco cessation, weight management and metabolic syndrome (leading indicators of MetS), oncology, diabetes and coronary artery disease. Member enrollment is voluntary; candidates are identified through continuous recruitment.

Plan takes a comprehensive approach to Condition Management by involving the member, the Plan and the provider in the education and counseling process. Plan will notify providers in writing of the members' enrollment in the program and provide periodic updates on member progress as needed. When appropriate, **Plan** will notify providers of changes in their patients' health status and encourage members to maintain open communication with their provider.

Program Goals

The **Plan** has established the following goals for the condition management program:

- Enhance member self-management skills
- Reduce intensity and frequency of disease-related symptoms
- Enhance member quality of life, satisfaction, and functional status
- Improve member adherence to the provider's treatment plan
- Improve communication among member, provider and health plan
- Facilitate appropriate health care resource utilization
- Reduce avoidable hospitalizations, emergency room visits, and associated costs related to the disease; and reduce work absenteeism and medical claim costs
- Enhance member closure of condition specific gaps in care

Compliance

Periodic assessments are conducted to identify conditions that have a significant impact on members. To identify members appropriate for condition management, risk stratification is performed using pharmacy, lab and medical claims as well as the predictive modeling tool. Based on stratification results, targeted interventions are offered to address members' levels of disease severity.

Members with mild severity may receive educational materials and other self-management tools to support their provider's treatment plan. Each member with the condition receives a seasonal mailer and an outbound call. Members with a moderate or severe condition are eligible for extended program components.

The condition management staff coordinate all chronic condition participant services and collaborates with specialty staff to ensure continuity and coordination of care for those members with a moderate or severe condition. The focus of the condition management program includes the management of chronic conditions such as: Diabetes, coronary artery disease and cardiovascular condition clusters, congestive heart failure, chronic obstructive pulmonary disease, low back pain, oncology and asthma. A hierarchy is used to determine which of multiple conditions a member is experiencing has the highest priority to include the management and support of comorbid conditions.

Physician Collaboration

The condition management program plan of care is designed to support the provider's treatment plan. The provider may be contacted by the clinician or Plan medical director for clinician to clinician consultation as follows:

- Clarification of the member 's treatment plan
- Alert the provider of the patient's condition specific gaps to care
- Obtain information necessary to close a gap in care and/or determine that the gap has already been closed
- Clarification of medications
- Member is non-compliant with treatment
- There are concerns related to member safety and/or quality issues
- Behavior or lifestyle is detrimental to the condition being managed
- Clinician cannot reach the member and has information that could be vital to share with the provider.

We have resources that can help a member plan and manage their health but does not replace the care of a provider. The intent of the physician collaboration is to alert the provider to gaps in health care and outreach to the provider to involve them in facilitating condition specific gap closure. The physician collaboration is designed to respect the provider's knowledge and strengthen the relationship between the provider and their member.

Gap Closure

Gap closure focuses on showing improvement in the members' care through engaging them and their provider in better management of health outcomes. Condition management clinical staff can identify opportunities from claims data that a provider may not be able to identify during a normal office visit. To identify gap closure and health improvement opportunities, the clinician researches a member's claims history through review of claims history available in the medical management system platform.

Gap closures and health improvement opportunities may include the following:

- **Diabetes**
  - No HbA1C in the past 12 months
  - No low-density lipoprotein in the past 12 months
  - No test for microalbuminura in the past 12 months and with Hypertension and not on ACE
  - Inhibitors or ARB in the past 6 months
- **Asthma**
  - Not on controller medications
- **Chronic obstructive pulmonary disease**
  - Bronchodilator adherence
- **Coronary artery disease and cardiovascular conditions cluster**
  - No low-density lipoprotein in the past 12 months

Case Management Program

Complex case management programs focus on the highest risk population with late stage chronic or catastrophic conditions such as transplants, major trauma, rare diseases, and end of life issues. The Utilization Management and Blue Care Connection staff members are trained in medical events that may trigger a referral to complex case management.

Care coordination and early intervention program is a transition of care model that fosters clinical improvement. The program provides pre-admission, inpatient and post-discharge outreach designed to provide educational and safety support to members having an admission for a targeted diagnosis or procedure code that has been identified as having a high potential for readmission or post discharge complications. The program focus is to reduce readmissions, emergency room visits and improve member health outcomes.

NICU. The NICU program is administered internally by specialty RN's along with an assigned neonatologist. The assigned specialist is not one of our employees but is a credentialed, practicing specialist. The focus of the programs is on enhancing and supporting physicians' treatment plan and assisting the member with navigation through the medical care system while maximizing their benefit dollars.

Program components include the following:

- Weekly telephonic case review with the Plan medical director, an assigned neonatologist, and the NICU RN.
- Ongoing telephonic contact between the Plan medical director and the attending neonatologist to discuss the appropriate level of care and treatment
- Coordination of home health and DME
- Social service support for assistance in addressing barriers to discharge

Disease management and complex case management referrals

There are multiple ways in which a member interested in our disease management or complex case management programs can be referred including:

- Medical management
- Discharge planner
- Member or caregiver
- Practitioner

Outcome Measures

The case management program meets state regulatory requirements for case management. Standard reports are produced periodically and summarize:

- Resource utilization
- Goals met
- Overall member satisfaction
- Quality of life and functional status

Women and Health Family Health

Childbirth-related expenses have become one of the largest components of health care costs today. To maintain costs and to assist female members in achieving healthy pregnancy outcomes, we offer a maternity/fertility program, to Plan members.

Whether you are pregnant or planning to get pregnant, we may provide the following resources:

- Ovia Health™ apps feature health trackers and provide videos, tips, coaching and more.
- Well on Target® has self-management programs about pregnancy that members can take online, covering topics such as healthy foods, body changes and labor.

Our maternity specialists will support members by phone from early pregnancy until six weeks after delivery if your pregnancy is high risk.

Note: To ensure **Plan** members the opportunity to participate in these programs, providers must contact the medical care management department at **800-441-9188** or Availity® Authorizations & Referrals immediately, with notification of any pregnancy for their Plan members. Members may also call **888-421-7781** directly to enroll.

Clinical Practice Guidelines

Clinical practice guidelines will be reviewed and revised biannually, as appropriate. Guidelines may be reevaluated and updated more frequently, depending on the availability of additional data and information relating to the guideline topic.

Clinical practice guidelines are reviewed and adopted as the foundation for its disease management programs, quality initiative and provider tools. The guidelines are based upon nationally recognized clinical expert panels and are available to assist physicians in clinical practice.

Clinical practice guidelines are available for asthma, attention deficit/hyperactivity disorder, cardiovascular disease, depression, diabetes, hypertension, metabolic syndrome, tobacco cessation and weight management. To assist in

member education, these guidelines are available to providers by calling the disease management department at **800-462-3275**, or you may access the clinical practice guidelines that are currently available under Clinical Resources.

Preventive Care Guidelines

Promotion of preventive health is a major objective of our QIP. The infant, child, adolescent, adult and preventive care guidelines we have been adopted and are provided to Plan members. The preventive care guidelines are available under Clinical Resources.

FEP Disease Management Program

The FEP disease management program is an integrated approach in managing and preventing chronic conditions by providing member education within the disease process and identifying multidisciplinary efforts to maximize cost and improve quality of life.

The program is available to members diagnosed with asthma, congestive heart failure, coronary artery disease, congestive obstructive pulmonary disease, and diabetes. Member enrollment is voluntary; candidates are identified through continuous recruitment.

QUALITY IMPROVEMENT

Quality improvement is an essential element in the delivery of care and services by Plan participating providers. To define and assist in monitoring quality improvement, our quality improvement program focuses on measurement of clinical care and service delivered by Plan participating providers against established goals.

Information regarding the QIP documents is available by contacting the QIP department at **800-863-9798**.

Objective Goals of the Quality Improvement Program

QIP is an integrated process designed to continually monitor, evaluate, and improve the care and service provided to the Plan members.
The following QIP objectives are designed to assist in meeting Plan goals:

- Facilitate the achievement of public health goals for disease prevention, wellness and safety
- Identify opportunities to improve the outcomes of medical and behavioral health care and service available to the Plan members
- Analyze the existence of health care disparities in clinical areas, including behavioral health, and supported by pharmacy and lab data, to reduce health disparities and achieve health equity
- Assess the cultural, ethnic, racial and linguistic needs of members to deliver culturally competent services
- Monitor and support the needs of members who have disabilities, to assure their access to health care
- Use the practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks to implement a standardized and comprehensive QI Program which will address and be responsive to the health needs of the member population, inclusive of serving the culturally and linguistically diverse membership
- Assess network adequacy and develop networks to meet the needs of the underserved populations
- To develop a comprehensive, meaningful and soundly executed Population Health Management strategy
- Provide staff with training, information and tools that help identify cultural and linguistic barriers and support culturally competent communications
- Develop, implement, and monitor action plans to improve medical and behavioral health care as well as services for the Plan
- Provide communication to Plan practitioners and providers on issues of medical care to promote improvements in the health status of members and satisfaction with Plan
- Develop and distribute information to members that improves knowledge regarding clinical safety, general wellness and disease prevention as it relates to self-care
- Identify opportunities to improve the outcomes, promote delivery and effective management for populations with complex health needs, which may include the following conditions: physical or developmental disabilities, multiple chronic conditions, serious mental illness, organ transplants, HIV/AIDS, progressive degenerative disorders, metastatic cancers and severe behavioral health conditions
- Monitor and ensure compliance with state and federal regulatory requirements and accreditation standards

Quality Initiatives

The Plan conducts interventions/initiatives which are designed to improve the overall health of Plan members. Examples include:

- Preventive care/wellness guidelines
- Clinical practice guidelines
- Product solution group communications: Holistic health coordinators provide the member with resources and guidance that meets their needs. The goal is to empower the member to be an active participant in follow- up visits, to follow-up on any additional medical appointments, and to educate members to be able to self-manage their own care. Web-based management automated communications include standard, chronic and preventive messages:

- Standard messages: Designed to engage and inform members about programs that help them make the most of their health care dollars. These are sent to all subscribers and spouses.
- Targeted chronic condition messages: Automated monthly reminders help members stay on track with appointments, tests and medications for chronic conditions. These are sent to the individual.
- Age and gender-based preventive messages: Automated monthly reminders help members stay on track with preventive services, tests and appointments. These are sent to the individual.
- Targeted outreach to encourage members to receive breast, cervical and colorectal cancer screening as well as other preventive care initiatives as opportunities are identified
- Childhood immunization reminders at four and 14 months of age to encourage compliance with the childhood immunization schedule and well-child visits
- The Plan provider website, which provides information related to health and wellness.
- Create quality improvement tip sheets to help providers satisfy HEDIS measures from the NCQA help ensure our members receive appropriate and effective care. Utilize the link on the Quality Resources page for HEDIS measures tip sheets that are available on Availity Essentials.

For additional information about the above-mentioned interventions or to request samples, please contact the Plan QIP department at **800-863-9798**.

QIP Support

The QIP is supported by the quality improvement department, medical directors, Texas Medical Advisory Committee, Texas Peer Review Committee and network management representatives.

Medical Director Involvement

Our medical directors provide the following services:

- Facilitate communication of quality improvement activities with participating Plan providers
- Serve as a liaison between participating Plan providers and us
- Chair the Texas Medical Advisory Committee and the Texas Peer Review Committee to facilitate initiatives, including credentialing and review of quality-of-care issues
- Participate in the Quality Improvement Committee, which supports the development and periodic review of policies, procedures, practice guidelines, clinical criteria, QI outcomes studies and initiatives utilized in the Plan QIP

Quality Improvement Committee

The Plan Clinical Quality Improvement Committee establishes priorities for the QI Program, evaluates the clinical and operational quality and integrates quality improvement activities among all Plan departments. CQIC monitors QI activities for consistency with Plan-wide goals and business objectives. CQIC provides comprehensive reports on QI program activities to the Enterprise Quality Improvement Oversight Committee at least twice a year annually.

The responsibilities of the committee include but are not limited to the following:

- Centralize and coordinate the integration of all quality improvement activities
- Provide guidance on quality management priorities and projects; approves the quality projects to undertake, and monitors progress in meeting goals
- Adopt clinical practice guidelines, general standards of care, clinical review criteria and policies of medical practice based on current medical evidence, the our demographics and other local or regional factors
- Analyze and evaluate summary data from quality improvement activities and make recommendations for improvement utilizing:
    - Quality measurement studies
    - Quality improvement projects
    - Quality of care and service data, including access to services
    - Member, physician and provider satisfaction surveys
    - Complaint and appeal review

    - Pharmacy programs review
    - Utilization and case management review
    - Wellbeing Management
    - Administrative services
- Recommend policy decisions
- Identify needed actions
- Ensure follow-up, as appropriate
- Review and approve the annual QI program evaluation, work plan and program description
- Monitor QI activities of all contractors to which Plan delegates quality improvement, utilization management, case management, condition management, credentialing, physician office
- review, claims processing or customer member services activities.
- Review, approve/deny, and recommend actions and communications to delegates when a delegate is determined to be non-compliant with our performance requirements,
- regulatory, certification or accreditation requirements and standards.
- Provide quarterly reports to the Enterprise Quality Improvement Oversight Committee.
- Review outcome measurements and improvement results. Ensure that the implementation of action plans has received the support of management.
- Reassess activities continuously to determine whether optimal results have been achieved and are sustained. Review results from population-based studies to assess patterns/trends derived from statistical data, which identify opportunities for improvement.
- Review and approve any recommendations/action plans provided by the sub-committees.
- Provide coordination and monitoring of the medical management programs including review and approval of the medical management program description, goals and objectives, clinical review criteria, quality management projects, performance measures, annual Program evaluation and program impact.

Texas Medical Advisory Committee and Texas Peer Review Committee

The Texas Medical Advisory Committee and the Texas Peer Review Committee serve in an advisory capacity to our medical director responsible for peer review of credentialing and recredentialing (TMAC/TPRC Chair) and the Plan regarding health care delivery issues that affect members and network physicians and health care professionals or practitioners. Additionally, the TMAC and TPRC committee members participate in the development, implementation and evaluation of required peer review activities to include credentialing and recredentialing activities designed to evaluate the credentials of a physician or other health care professional/practitioner (e.g., physical therapist, speech therapist, occupational therapist, etc.) for participation in Plan networks. The TMAC/ TPRC serves a peer review function by evaluating the clinical health care services delivered by participating physicians and health care professionals/practitioners. The responsibilities include but are not limited to the following:

- Review and act upon completed credentialing files of applicants that have been recommended for participation
- Make recommendations regarding continued physician or health care professional/ practitioner participation in the Plan credentialed networks
- Access, monitor and evaluate utilization, quality of care and service issues related to specific physicians or health care professional/practitioners
- Recommend corrective action plans when opportunities to improve care or service are identified for specific physicians or health care professionals/practitioners
- Review appeals from physicians and other health care practitioners of adverse credentialing/ recredentialing determinations by TMAC and TPRC.
- Recommend one of the following actions for each applicant:
    - Approve for participation
    - Defer the decision. Pending receipt of additional information
    - Deny participation for not meeting credentialing criteria
- Facilitate adequate access for members to a full continuum of appropriately credentialed providers
- Coordinate the provider's recruitment, servicing and credentialing activities

- Communicate policies, procedures and guidelines established by Plan to participating providers and disseminate information regarding the results of Quality Improvement Program activities

Network Management Involvement

- Facilitate adequate access for members to a full continuum of appropriately credentialed providers
- Coordinate the provider's recruitment, servicing and credentialing activities
- Communicate policies, procedures and guidelines established by the Plan to participating providers and disseminate information regarding the results of Quality Improvement Program activities

Ad Hoc Onsite Physician Office Review Nurses

The POR nurses conduct site reviews on an ad hoc basis to determine if office sites meet accepted standards and assess medical recordkeeping practices. They also perform medical record review to assess documentation and collect data for QI studies.

Responsibilities of the QIP Department

The Quality Improvement Program Department responsibilities include, but are not limited to the following:

- Initiate quality of care complaint investigation and resolution
- Perform HEDIS data collection analysis and interventions
- Develop and maintain QI studies/interventions for clinical and service issues
- Perform analysis and develop interventions related to covered person/physician and professional provider satisfaction
- Maintain compliance with state, federal and other regulatory requirements through periodic assessment.

Responsibilities of Providers

Practitioners or providers will cooperate with our QI activities, to improve the quality of care and services and the member experience including:

- Allowing the organization to use their performance data.
- Communicating patient's treatment regardless of benefit coverage

Patient Appointment Access Standards

We have established the following patient appointment access standards (business days unless otherwise noted):

Access Measure	Standard	Performance Goal
Initial New Patient Visit	Within 30 days of request	90% of physicians evaluated meet or exceed the standard
Preventive Care - Primary Care Provider only (annual physical)	Within 30 days of request	90% of physicians evaluated meet or exceed the standard
Routine Primary Care	Within 15 days of request	90% of physicians evaluated meet or exceed the standard
Urgent Care	Within 24 hours of request	90% of physicians evaluated meet or exceed the standard
Emergency Care During Office Hours After Office Hours	Immediate	90% of physicians evaluated meet or exceed the standard

After Hours Care	24 hours per day, 7 days per week	90% of physicians evaluated meet or exceed the standard
In Office Wait Time	Within 30 minutes of appointment time	90% of physicians evaluated meet or exceed the standard
High Impact or High-Volume Specialists Urgent care Routine care (Non-urgent	Within 5 days of request Within 21 days of request	90% of physicians evaluated meet or exceed the standard

Patient access standards definitions

- **Initial new patient visit:** A get acquainted visit with primary care provider or initial specialty care provider or professional provider visit for non-urgent care.
- **Preventive care:** A preventive health evaluation, without medical symptoms, which may include recommended health screenings, such as well-woman exams and well-child exams.
- **Routine care:** Symptomatic non-routine medical care provided to treat symptoms which are non-life or limb threatening and may include, but are not limited to, intermittent headache, fatigue, colds, minor injuries and joint/muscle pain.
- **Urgent care:** Medical care provided to treat symptoms that are non-life threatening, but which, if
- left untreated, within 24 hours could lead to a potentially harmful outcome such as acute abdominal pain.
- **Emergency care:** Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity that would lead a prudent layperson possessing an average knowledge of medicine and health to believe his or her condition is of such a nature that failure to get immediate medical care could result in:
- **After-hour care/access:** PCPs and SCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable Mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- **In-office wait time:** The average number of minutes the member must wait from the scheduled appointment time until the time the member is actually seen by the physician or professional provider.
- **High volume specialists:** Practitioner types as determined by annual high-volume report are comprised of, but not limited to, the following:
    - Obstetrics/gynecology
    - Cardiovascular disease
    - Orthopedic surgery
    - Psychiatry
    - Psychology
    - Licensed professional counselors
    - Licensed marriage and family therapist
    - Licensed medical social workers-advanced clinical practice
- **High impact specialists:** Practitioner types that treat conditions that have high mortality and morbidity rates or practitioner types where treatment requires significant resources comprised of, but not limited to, the following:
    - Neurology
    - Oncology
- **Performance goals:** The performance goals are monitored by network management through covered person satisfaction surveys, complaints and focused audits.

Ad Hoc Physician Office Review

We recognizes physicians as participants in the health care improvement process. One of the main objectives of QIP is to provide physicians with meaningful and constructive data to improve their practice patterns as necessary. An ad-hoc physician office review is performed based on a referral by the our medical director in conjunction with the Texas Medical Advisory Committee and the Texas Peer Review Committee that serves in an advisory capacity. An ad hoc review may be conducted if there is an indication that a potential quality of care concern exists. A high number of member complaints, a high rate of member turnover or utilization outlier status are examples of such concerns.

Evaluating the care provided in the physician's office focuses on documentation of clinical care, as well as the assessment of the physical structure and medical record keeping practice. All or portions of the following are evaluated during the physician office review and is based on the Medical Directors discretion and reason for on-site review:

- Safety and environment
- Medical recordkeeping practices
- Laboratory services
- Radiology services

Goals of the office review program

- Use objective guidelines to monitor the structural and medical record keeping practices in the physician's office
- Provide a practical approach for evaluating and improving the documentation of the care delivered in the office setting
- Involve physicians in the improvement process by offering appropriate feedback
- Utilize the results of the program in the ongoing managed care contract renewal process

Safety and environment components

The primary objective is to assist in ensuring that patient care is accessible, provided in a safe and hazard-free environment and that the office site provides comfort and privacy for the patient. A physician's staff is expected to maintain office procedures that safeguard against such risks as exposure to infectious disease, theft, abuse or accidental use of drugs and faulty or contaminated patient care equipment.

Laboratory services component

The primary issue concerning the provision of lab services is the accuracy of test results, which can be affected by such factors as training of personnel, equipment maintenance and calibration and expiration date of testing reagents.

The Clinical Laboratory Improvement Amendment requires that all laboratories be certified by the Department of Health and Human Services as meeting minimum performance specifications. Evidence of CLIA certification is required to meet Plan review criteria as well as the state of Texas requirements.

Radiology services component

Issues associated with radiology services include calibration and maintenance of equipment, exposure to radiation, film quality and staff training. The state of Texas requires inspection of radiology equipment every three years and documentation of the training for operation of the equipment. Physicians are required to register the equipment with the state, which grants a certificate of registration. Following each inspection, a letter of compliance is issued. This review is limited to the radiology services component.

Medical record keeping practice component

The organization and adequacy of medical record keeping are assessed in order to assure patient confidentiality and consistency of documentation practices. One to five medical records are evaluated at each office site of potential network PCPs and OB/GYNs.

Medical record documentation component

The medical record serves as a primary source for evaluating the appropriateness and cost-effectiveness of care, in addition to serving as important evidence in the event of litigation. The medical record documentation review consists of reviewing one to five medical records at each office site during focused medical record review.

On-site results are presented to the Medical Director for recommendations and if needed a corrective action plan. If a physician requires a CAP, a re-review is conducted in six months from the date of the CAP or at the discretion of the Medical Director. If a practitioner fails to meet the compliance goal on the CAP re-audit, the results are reported to the Texas Peer Review Committee for recommendations.

An ad hoc review may be conducted if there is an indication that a potential quality of care concern exists. A high number of member complaints, a high rate of member turnover or utilization outlier status are examples of such concerns.

Feedback to physician on the office review

The physician office review is designed to foster continuous quality improvement. The reviewer will conduct an exit interview with the physician or designated staff immediately following the review and if any deficiencies are identified they are reviewed at this time. Copy(s) of the POR summary forms are left with office staff upon completion of the POR.

The Medical Director evaluates any significant issues and recommends action, if necessary. A copy of the review and all associated correspondence is maintained in the physician's file for consideration by the Medical Advisory Committees at the time of recredentialing.

Principle of Medical Record Documentation Introduction

The following Principles of Medical Record Documentation were developed jointly by representatives of the American Health Information Management Association, the American Hospital Association, the American Managed Care and Review Association, the American Medical Association, the American Medical Peer Review Association, the Blue Cross and Blue Shield Association and the Health Insurance Association of America.

Although their joint development is not intended to imply either endorsement of or opposition to specific documentation requirements, all seven groups share the belief that the fundamental reason for maintaining an adequate medical record should be its contribution to the high quality of medical care.

- **What is documentation and why is it important?**
  We require medical records to be maintained in a manner that is current, detailed, organized and which permits effective and confidential patient care and quality review.

How does the documentation in your medical record measure up?

- Is the reason for the patient encounter documented in the medical record?
- Are all services that were provided documented?
- Does the medical record clearly explain why support services, procedures and supplies were provided?
- Is the assessment of the patient's condition apparent in the medical record?
- Does the medical record contain information on the patient's progress and on the results of treatment?
- Does the medical record include the patient's plan for care and follow-up?
- Does the medical record include incidents of recent inpatient care?
- Does the medical record include, when appropriate, medication reconciliation?
- Does the information in the medical record, describing the patient's condition, provide a reasonable medical rationale for the services and the choice of setting that are to be billed?
- Does the information in the medical record support the care given in the case where another Provider must assume care or perform medical review?
- Does the information in the medical record include communication between providers?

Principles of documentation

- The medical record should be complete and legible.
- The documentation of each patient encounter should include: the date, the reason for the encounter, appropriate history and physical exam, review of lab, X-ray data and other appropriate ancillary services, assessment, and plan for care (including discharge plan, if appropriate).
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record.
- Relevant health risk factors should be identified.
- The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient adherence, should be documented.
- The written plan for care should include treatments and medications specifying frequency and dosage, any referrals and consultations, patient/family education, and specific instructions for follow-up.
- The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision-making.
- All entries to the medical record should be dated and authenticated.
- The CPT/ICD-10 and/or ICD-10 codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

Such documentation is expected in all medical records, to include electronic medical records, of all members for whom the provider is billing for services.

Medical record keeping documentation frequently asked questions

Why do we need to do office reviews?
We have a responsibility to our members to help ensure that their care is provided in a safe, professional environment, and that medical records are maintained in such a way as to be confidential and secure and to document the care provided.

Are we obligated to allow this review?
Yes, according to the contract the Physician signed, we will have access, at reasonable hours and times, to the treatment and billing records of member to verify claims information, and to review other records necessary for verifying compliance with the terms of the agreement, i.e., practice standards for quality and utilization.

How long will the review take?
The office and medical record review will take approximately one to one and a half hours. If lab or X-ray services are provided, the review will take longer.

What do we have to do to be ready?
Provide five of our member medical records, or a mock record or template, as requested in the confirmation letter provided before the review date. Have one person from the office available to tour the office with the reviewer and to be available for information, if needed.

What happens if we get a bad review?
If deficiencies are found, a corrective action plan may be requested and a reaudit may be conducted within six months.

PRIVACY POLICIES

The following information provides a summary of our privacy policies and procedures:

- **Consent and authorization:** This refers to the permission a person must give us to use or disclose his or her Protected Health Information. We will be dealing mostly with authorizations.
- **Use, disclosure and minimum necessary:** These rules talk about when and\ how to use or disclose PHI. In most cases, we must use or disclose only the least amount, the minimum necessary, of PHI needed to do a certain task.
- **Individual's rights:** The person who is the subject of PHI has five major rights.
  The right to ask for access to his/her PHI and receive a copy or view it on location
  The right to ask for an amendment to his/her PHI
  The right to receive a listing of all recorded disclosures of his/her PHI
  The right to ask for further restrictions on the use and disclosure of his/her PHI
  The right to ask that any communication with the person regarding his/her PHI be carried out through confidential means that differ from the normal methods of contact, such as mail to the home address.
- **Business associates:** Outside persons or entities that carry out a function on behalf of us are our BAs. They must follow the privacy regulations, too, and be allowed to access only certain PHI, as outlined in their contract.
- **Administrative requirements:** There are several things that we must do to oversee compliance with the privacy regulations. They include such activities as naming a privacy officer, creating a privacy office, writing privacy policies and procedures, sending out a notice of privacy practices, and training its workers about its privacy policies.

CORPORATE PRIVACY POLICIES

Our corporate privacy policies are listed below. Authorized management in the division is responsible for implementing these policies and associated procedures, except where noted.

Policy No. 1: Documentation of Privacy Policies and Procedures

Authorized management in each of our applicable operational areas provide annual written certification to the privacy office regarding the accuracy of the operational area's privacy policies and procedures in compliance with this policy. In addition, each operational area is responsible for modifying, amending and implementing the policies and procedures as necessary throughout the year to ensure continued compliance with this policy and applicable laws and regulations. All policies and procedures are subject to our privacy office review to ensure continued compliance.

Workers in each operational area must be provided access to and receive training on all relevant corporate privacy policies and procedures and any departmental/divisional privacy policies.

Policy No. 2: Privacy Security Complaints

Privacy and security complaints are responded to in writing following receipt of a complete, written complaint or as required by state law or regulation and in accordance with any appropriately approved corporate procedures. Each complaint is entered into our incident tracking database in a timely manner.

Policy No. 3: Safeguarding PII & BCI

Privacy and security complaints are responded to in writing following receipt of a complete, written complaint or as required by state law or regulation and in accordance with any appropriately approved corporate procedures. Each complaint is entered into our incident tracking database in a timely manner.

Policy No. 4: Training of Privacy Policies and Procedures

Management in each of our operational area is responsible for complying with this corporate privacy policy and accompanying corporate privacy procedure. In addition, each operational area is responsible for the development, communication and compliance of relevant departmental/divisional procedures that support this privacy policy. All departmental/divisional privacy policies and procedures are subject to our privacy office review annually to ensure continued compliance with our privacy program.

Policy No. 5: Disclosure Tracking

BAs must track, and record disclosures of PHI as required by law and in accordance with relevant corporate/divisional/departmental procedures. Our operational area management is responsible for complying with this corporate privacy policy and accompanying corporate privacy procedure. In addition, they are responsible for the development and compliance with relevant divisional/departmental procedures that support this policy. Divisional/departmental privacy procedures are subject to our privacy office review annually.

Policy No. 6: Authorizations

We must obtain a signed Standard Authorization Form from a member or the member's personal representative, prior to disclosure of PII in situations where it is required by law or contract and in accordance with relevant corporate/divisional/departmental policies and procedures.

Policy No. 7: Minimum Necessary

Our workers may only access the minimum necessary PII and BCI needed to perform their job responsibilities. Only our suppliers with appropriately executed agreements are permitted access to and use of only the minimum necessary amount of PII or BCI appropriate to perform their contracted services. Workers, BAs or others that may have access to our system containing PII, are prohibited from directly accessing that system to either view or change:

- Their own PII.

- The PII of anyone that asks for assistance on behalf of themselves; or
- The PII of any other individual, including but not limited to, co-workers, family members, friends, next-door neighbors, acquaintances, etc.

Individuals requesting assistance must be advised to contact customer service using the number on their identification card. This includes workers who are requesting assistance on behalf of themselves or others.

Authorized management in each affected our operational area is responsible for determining and documenting the minimum necessary information required to fulfill routine/recurring and non-routine/non-recurring requests for disclosures of PHI as required by law and in accordance with approved corporate privacy procedures whether working onsite or from a remote location. Management in each of our operational areas is responsible for complying with this corporate privacy policy and accompanying corporate privacy procedure. In addition, they are responsible for the development and compliance with relevant divisional/departmental procedures that support this policy. Divisional/departmental privacy procedures are subject to our privacy office review.

Policy No. 8: Business Associates BCBSTX as a Covered Entity

We require our BAs to execute a written agreement, BAA. The BAA should be signed by the BA entity that signs the service agreement prior to the BA receiving Protected Health Information. Any individual or entity determined to be a BA without an executed BAA cannot receive PHI unless the subject of the PHI, or their authorized personal representative provides appropriate authorization. BAs must not transmit, process, or store data outside of the U.S. BAs may only view data using technology that ensures data remains within the U.S.

BCBSTX as a BA

When we serve as a BA to a covered entity, we will enter a written BAA with the Covered Entity. The BAA must be signed by a person who has signature authority and is usually the same person who signs the underlying agreement.

As a BA, we will only use or disclose PHI as permitted by law and following the terms of the BAA with the covered entity. Ideally, the our standard BAA template will be used. Any exceptions follow corporate procedure PR-08.

Policy No. 9: Disclosure Accounting

We will provide an individual or an individual's personal representative with a disclosure accounting as required by law and in accordance with relevant corporate/divisional/departmental procedures. When we serve as a BA, the request for disclosure accounting will be handled in accordance with the terms of the BA agreement and applicable law. Each request for an accounting of disclosures is entered in our disclosure tracking database per guidelines. Our privacy office is responsible for implementing this corporate privacy policy and the associated corporate privacy procedure. All responses to Individuals for a disclosure accounting are processed by the access control area.

Policy No. 10: Requests to Receive PII by Alternative Confidential Means

We will respond to a request from an individual or an individual's personal representative, to receive PII which includes PHI, SPI and CPI by alternative means or location as required by law ("confidential communications") and in accordance with relevant corporate/divisional/department procedures. Requests to receive PII by these alternative means will be documented, timely and implemented, as appropriate. All requests are entered into our privacy rights tracking tool for tracking purposes.

Policy No. 11: Requests to Access PII

We evaluate and provide a written response to the individual or their personal representative's request to inspect and obtain a copy of the individual's PII which includes PHI, SPI and CPI as permitted by law and in

accordance with any relevant corporate/ divisional/departmental procedures. Each request to access PII is entered into our privacy rights tracking tools to ensure appropriate review and completion. Our workers and BAs may not access PII:

- That is not required as part of their job responsibilities or
- On behalf of family members, friends, or acquaintances, even if the workforce member or BA is an individual's personal representative.

Our workers and BAs are required to direct inquiries for access to such PII through the appropriate operational area. Workers in each of our operational areas are responsible for complying with this corporate privacy policy and accompanying corporate privacy procedure.

Policy No. 12: Personal Representatives

We will disclose appropriate PII which includes PHI, SPI and CPI to personal representatives of an individual when the personal representative follows the same procedures as the individual in accordance with the law. The designation of an individual as a personal representative must be documented as required by law and in accordance with relevant corporate /divisional /departmental policies and procedures.

Any personal representative who is a worker or BA may not access systems on behalf of themselves, family members, friends or acquaintances. Workers must not use their position or resources within BCBSTX to assist co-workers, family members, friends, next-door neighbors, acquaintances, etc. These individuals must contact us using the number on their ID card. Workers in each of our operational areas are responsible for complying with this corporate privacy policy and accompanying corporate privacy procedure.

Policy No. 13: De-Identification of PII

Our workers and BAs will de-identify PII whenever possible in accordance with applicable law and approved corporate policies and procedures. Workers in each of our operational areas are responsible for complying with this corporate privacy policy and accompanying corporate privacy procedure.

Policy No. 14 Verification of Identity and Authority

All workers in each of our operational areas are responsible for complying with this corporate privacy policy and accompanying corporate privacy procedure.

Each operational area must establish procedures/guidelines that address the process for the authenticating/verifying the identities of staff from our external partners (providers, customers, BAs etc.) prior to disclosing an individual's PII via the telephone to limit the possibility of an impermissible disclosure.

Any worker or BA, who is an individual's personal representative, may not access our systems on behalf of themselves or the individual for whom they are a personal representative. These individuals must contact us using the number on the member ID card.

Policy No. 15: Disclosure of PII in Group Market Situations

Prior to releasing information to self-insured group health plans or insured group health plans and its BAs, workers must confirm that a signed BA agreement between the parties has been received and on file. Upon receipt of a BAA in draft or signed, Workers must forward the contract to our appropriate division designee, such as the divisional privacy officer, for appropriate processing.

Policy No. 16: Notice of Privacy Practices

Our privacy practices notices contain the necessary information required by HIPAA, GLBA and information required by state law. We issue the PPN to each subscriber of an insured group health plan upon their enrollment, annually, and when any material changes are made regarding our privacy practices as stated in the PPN. A single PPN sent to the subscriber is effective for all dependents covered under that subscriber. The PPN is posted on our member portal website and on each of the Medicaid/Medicare microsites. In

addition, a PPN is provided to any individual who requests a copy. We reviews the PPN at least once annually and as required by law.

Policy No. 17: Requests to Restrict PII

We evaluate and respond to all requests to restrict PII which includes PHI, SPI and CPI upon receipt of a completed Restriction Request Form from the individual or individual's personal representative as permitted by law and in accordance with approved corporate procedures. Decisions regarding the request shall be made in writing to the individual or the individual's personal representative. In addition, we will take reasonable steps as required by law to communicate restriction request of PII to appropriate BAs.

We will review and adjudicate any such restriction requests as appropriate. If we approve any such restriction requests, we must comply with the agreed restriction except for purposes of treating an individual in a medical emergency and certain other circumstances.

Policy No. 18: Requests to Amend PII

In its role for treatment, payment and health care operations, we accept and processes requests to amend PII. We evaluate and respond to all requests to amend PII which includes PHI, SPI and CPI upon receipt of a completed Amendment Request Form from the individual or individual's personal representative as permitted by law and in accordance with approved corporate procedures. Decisions regarding the request shall be made in writing to the individual or the individual's personal representative. In addition, we will take reasonable steps as required by law to communicate amended PII to appropriate BAs.

Policy No. 19: Use and Disclosure of PII

- **Abuse, neglect or domestic violence situations**
  Except where required by law, workers or our BAs will not disclose an individual's PII, for the purpose of reporting possible cases of abuse, neglect, or domestic violence. If disclosure is required, only the minimum necessary information will be disclosed.

- **Decedents**
  Workers and our BAs may request or disclose the PII of deceased individuals without obtaining an authorization in the following situations:
    - To an executor, administrator, or other person that has authority to act on behalf of a deceased individual as a personal representative of the individual's estate.
    - To family members and others who were involved in the care or payment for care of the decedent prior to death, PII, that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the covered entity.
    - To other individuals as may be permitted by law.

  If we maintain decedent health information for longer than 50 years, following the date of death of the individual, this information is not subject to the HIPAA Privacy Rule.

- **Fundraising**
  We may use or disclose PII for fundraising activities on behalf of itself or any other entity as permitted by law. The privacy office should be contacted prior to committing to those activities. We may solicit its employees for charitable and other fundraising purposes.

- **Genetic information**
  We may not use or disclose genetic information for underwriting purposes unless the policy is a long-term care policy.

- **Health oversight activities**
  Workers may disclose an individual's PII without the individual's authorization to a health oversight agency or an entity authorized to act on behalf of a health oversight agency for health oversight activities authorized by law. Workforce members are required to verify the identity and authority of the party requesting the information.

- **Law enforcement, averting a serious threat to health or safety, disaster relief, judicial and administrative proceedings including prohibited purposes related to reproductive health care**
  Any request received for any of the above reasons regarding PII should be immediately routed to our legal department.

- **Limited data sets**
  We may use a limited data set for the purpose of research, health care operations, or public health as permitted by law.

- **NPI**
  We have obtained an NPI number for the purpose of determining whether an individual is eligible for enrollment in one of our government programs. The access and use of an NPI, to determine this eligibility, expands our covered entity status to that of an insurer and a provider as defined by HIPAA. Operational areas that need to utilize this NPI must develop appropriate procedures that will limit the sharing of PII between us, both as an insurer and a provider prior to use.

- **Offshore data storage**
  Our data, which includes PII and BCI, must not be transmitted to, processed in, or stored outside of the US. Our workers and BAs may only view our data from outside of the US using technology that ensures data remains within the U.S. and protected through current encryption standards.

- **Organ donation purposes**
  We may disclose a decedent's PII to organ procurement organizations or other entities engaged in the procurement, banking and transplantation of cadaveric organs, eyes or tissue for donation or transplantation purposes.

- **Psychotherapy notes**
  We will not request, use or disclose an individual's psychotherapy notes. Any of our departments that receives psychotherapy notes will immediately destroy them.

- **Race, ethnicity and language (REL) data**
  We will only collect and use REL data according to the requirements and limitations described in Corporate Policy E.03 - Products and Services Non-Discrimination and in the PO – Use of Race, Ethnicity and Language Data Decision Guidance.

- **Record retention**
  All records (including electronic and hard copies) must be maintained according to the BCBSTX Record Retention Policy.

- **Research projects/initiatives**
  We may only disclose a limited data set, or a de-identified data set for research purposes or as permitted by law. If PII is needed for the project/initiative, our chief ethics, compliance and privacy officer must approve unless our operational area sponsoring the project/initiative engages the PO to set up a process to secure the individual's authorization prior to the release of the PII.

- **Sexual orientation and gender identity**
  We will only collect and use SOGI data according to the requirements and limitations described in the Use of SOGI Data Decision Guidance.

- **Social security numbers (SSN)**
  Various laws require restrictions specific to the use and disclosure of an individual's SSN. Except where allowed by law, Our workers and BAs may not:
    - Publicly display or post an individual's SSN.
    - Print the individual's SSN on any card that is required for the individual to access products or services.
    - Print the individual's SSN on materials that are mailed to the individual through the U.S. (United States) Postal Service, any private mail service, electronic mail, or any similar method of delivery, unless state or federal law requires the SSN to be on the document.
    - Require an individual to transmit their SSN over the internet, unless the connection is secure, or the SSN is encrypted.

- **Special government purposes**
  Requests for disclosure of PII for special government purposes shall be forwarded to the our legal department for review and direction prior to responding to such request per corporate policy.

- **Substance use disorder records**
  SUD patient records are subject to increased confidentiality protections under 42 CFR Part 2. We limit the use and disclosure of sensitive patient records and abides by 42 CFR Part 2 provisions for patient consent and redisclosure.

- **Treatment, payment, and health care operations (TPO)**
  We may use or disclose PII for TPO activities. Some examples include, but are not limited to, sharing PII with a provider for treatment of a member, payment to a provider for health services and utilization or case management.

- **Workers' compensation**
  Only the minimum necessary amount of PII will be disclosed in accordance with state worker's compensation law.

Policy No. 21: Outbound Calls/Text Messages - Telephone Consumer Protection Act Requirements

Our operational areas engaged directly or with a contracted vendor to make outbound calls or send texts to either a landline or cell phone for informational or marketing/advertising (telemarketing) purposes must comply with the requirements described in PR-21 Outbound Calls/Text Messages (TCPA requirements). If required, operational areas must develop and document divisional privacy policies and procedures. Staff involved in these types of activities must be trained in those policies and procedures. These activities are subject to our privacy office review.

Policy No. 22: Breach Notification

We provide notifications to individuals as required by applicable federal and state law and in accordance with relevant corporate, divisional/departmental procedures. In cases where there is no legal obligation, the company may, in its sole discretion, provide breach notification or some form thereof based upon business decision making. Workers in each of our operational areas are responsible for complying with this corporate privacy policy and accompanying procedure.

Policy No. 23: Outbound Emails

Our operational areas that send e-mails for commercial and advertising purposes must have department or divisional privacy policies and procedures consistent and in accordance with this corporate privacy policy

and procedure as well as applicable state and federal laws.

Policy No. 24: Unsolicited FAX Advertisement

Our operational areas that send fax advertisements must have departmental or divisional privacy policies and procedures in accordance with our corporate privacy policy and procedure as well as applicable state and federal laws.

Policy No. 25: Privacy & Security Incident Management

We evaluate and take appropriate action for all privacy and security incidents ("Incident") at BCBSTX, its BAs and other contracted third-party suppliers. An incident is a situation where we, its BAs or contracted third-party supplier has an incident that violates our corporate or divisional or departmental privacy or security policies and procedures, applicable privacy or security laws/regulations, or contract requirements. Each affected our operational area that becomes aware of an incident is responsible for reporting the Incident to their management and DPO or DSO and if applicable to their operational area leadership. The DPO or DSO is responsible for notifying our privacy office and providing all the necessary documentation regarding the Incident. Workers in each of our operational areas are responsible for complying with this corporate privacy policy and procedure.

Policy No. 26: Marketing and Sale of PII

We require authorized management in each of our affected operational areas to review potential marketing and sale activities involving the use or disclosure of PII which includes PHI, SPI and CPI. The operational areas must use the Marketing and Sale of PII Tool Decision Guidance and complete the associated document. The completed document must be sent to the privacy office for review and approval prior to initiating the activity.

For marketing activities that involve financial remuneration (direct or indirect payment), a HIPAA compliant authorization that includes a statement about remuneration may be required unless the communication is related to:

- A face-to-face communication made by a covered entity to an individual; or
- A promotional gift of nominal value offered by the covered entity.

The PO must be notified regarding any transactions that contemplate the sale of PII before any discussions begin.

Workers in each of our operational areas shall be responsible for complying with this corporate privacy policy and accompanying procedures.

Some state laws such as the California Privacy Rights Act have specific requirements related to the potential sale of PII as defined by the law which we must take into consideration before any sale is contemplated

APPENDIX – TERMS, DEFINITIONS AND RULES

Accessibility

The provider will assure that its covered services are readily available, accessible, and provided during regular business hours on business days in a prompt and efficient manner that is always in accordance with provider's scope of practice, applicable community standards, and as set forth in the provider manual. The provider will provide such covered services in the same manner, in accordance with the same standards, and within the same time availability as such services are provided to other patients without regard to the degree or frequency of utilization of such covered services by members or the product in which such individual is enrolled.

Affiliate

Any corporation, firm, limited liability company, partnership or other legal entity that directly or indirectly controls, or is controlled by, or is under common control with, a party, which may include subsidiaries, parent entities and sister companies. As used in this definition, "control" means (i) ownership of fifty percent (50%) or more of the shares of stock entitled to vote for the election of directors, in the case of a corporation; or (ii) any ownership of fifty percent (50%) or more of the equity interests in the case of any other type of legal entity; or (iii) status as a general partner in any partnership; or (iv) any other arrangement whereby a party legally controls, or has the right to legally control, the governing body of a corporation or other legal entity.

Claim

An itemized statement of provider's charges for health care services provided by the provider to a particular member.

Clean Claim

A clean claim is set forth by applicable law for covered services performed at a provider location included in the provider's agreement.

Communication of Treatment Options

Nothing contained in the provider's agreement is intended to prohibit or discourage provider from discussing with or communicating in good faith to a current, prospective or former patient, or patient's legal representative or designee, information or opinions regarding (1) the patient's health care, including but not limited to the member's medical condition or treatment options, including alternative medications, regardless of our coverage limitations, or (2) the policies and procedures.

Complaints

We will maintain a complaint procedure as required by law and the policies and procedures.

Concierge Services

This is a relationship between a patient and a physician in which the patient pays an extra or additional fee to the provider. This may or may not be in addition to other charges.

Cost Share

The portion of provider's payment for a covered service for which a member is responsible, including, but not limited to, copayments, coinsurance, deductibles, reduction of benefits, and any other applicable financial responsibility of the member, pursuant to his or her coverage agreement.

Coverage Agreement

Any policy, contract, Plan document or certificate entered into or issued by a Plan, which entitles members to receive benefits for covered services, and which identifies the covered services that the Plan, or the Plan or the ASO group's designee, has agreed to adjudicate, and, to the extent appropriate, pay for, on behalf of members. A

coverage agreement can be pursuant to an insurance arrangement, an administrative services arrangement, or an arrangement whereby a Plan contracts with us to utilize participating providers. The coverage agreement explains the benefits, limitations, exclusions, terms and conditions of a member's health coverage.

Credentialing

With provider's cooperation in accordance with provider's responsibility under the contract, we or our delegate will maintain credentialing and recredentialing and peer review processes for determining the eligibility of provider, as applicable, to participate in our network.

We will credential and recredential and review the qualifications of provider, as applicable, at least every three years. We may amend its credentialing and recredentialing policies and procedures at any time, at its discretion and upon notice to provider. We retain the right to approve, deny, suspend or terminate any provider's participation with BCBSTX based on its credentialing and recredentialing review.

Culturally Competent

The provider will ensure that it provides information regarding treatment options in a culturally competent manner, including, without limitation, the option of no treatment and ensure that each member with disabilities or who speaks or understands only languages other than English has an effective means of communication with providers in making decisions regarding treatment options.

Duplicate Claim

A duplicate claim means any claim submitted by provider for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim. The term does not include corrected claims.

Hospital Based Physician/Group

A physician/group consisting in whole or part of anesthesiologists, pathologists, radiologists, an emergency department physician, or neonatologists to whom a facility has granted clinical privileges and whose physicians provide health care services to patients of the facility under those clinical privileges.

Incidental Services
The cost of incidental services in support of such covered services, including without limiting the foregoing technical charges for equipment and its purchase, rental and maintenance. Compensation for such incidental services may not be billed separately by provider or another provider or other entity; provided that professional services necessary for the treatment of the member that require the use of equipment that is supplied or arranged for by provider may be billed separately by the person providing those professional services.

In-Network Services

Covered Services provided to members in accordance with the coverage agreements' requirements for in-network benefits as set forth in the applicable coverage agreement.

Medical Records

Provider will establish and maintain an accurate medical record, which may include an electronic record for each member with whom provider has had an encounter that, at a minimum, (i) will include such information about the member and a description of all services rendered to the member as dictated by generally accepted practices and standards, (ii) will be maintained for the period of time required by laws, and (iii) in all instances as required by the policies and procedures ("medical records"). The provider will ensure that a member's medical records are legible, complete, dated, timed and authenticated.

Medically Necessary or Medical Necessity

Health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician or other provider, and not more costly than an alternative service or sequence of treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Notice

A notification required by the provider's agreement or law, that is not a required written notice, but is a notification to one party by the other party: (i) by U.S. mail or email, or, (ii) from us to provider only, provider newsletter or website, and (iii) will be considered received as of: (a) the date on which the recipient receives the notification, or the date upon which the recipient refuses or otherwise fails to accept delivery, or (b) for U.S. mail, on the third business day following its deposit in the U.S. mail, or (c) in our case, for News and Update or provider site, the date that the notification is posted by us.

Participating Provider

Licensed and credentialed health care service providers and practitioners that have an agreement with us to provide in-network services to members according to the terms of their coverage agreements and the policies and procedures.

Payment

For covered services provided to members that are documented on a clean claim and otherwise meet the standards for payment under the provider's agreement, provider will accept, through: (i) cost share and (ii) payment from us, the amounts set forth in the provider's agreement as full reimbursement for arranging and providing covered services to members, in accordance with the terms of the provider's agreement and its applicable attachments, policies and procedures, and the coverage agreement. To qualify for payment of a claim under the provider's agreement, provider will submit such claims in the format, time frame, and manner set forth in the provider's agreement and policies and procedures. Provider agrees we may make adjustments to amounts previously paid to provider in accordance with the terms of the provider's agreement. Provider agrees and understands that we will not pay for non-covered services. Provider agrees that only clean claims for covered services that are performed at a location included in the provider's agreement are eligible for reimbursement.

Plan

Our ASO group, Blue Cross and/or Blue Shield Plan licensed by the Blue Cross and Blue Shield Association and a subsidiary of such Plan, or any of our other affiliates, or employer, with respect to which we have contracted to provide access to participating providers.

Policies and Procedures

Pertains to the provider manual and any other policies, programs, rules, guidelines, protocols and administrative procedures adopted by us that relate to, without limitation, credentialing and recredentialing processes, medical policies, utilization management and care management processes, quality improvement, peer review, member grievance, concurrent review or any of our other programs. For purposes of this definition, "care management" means a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a member's health needs, using communication and available resources to promote quality, cost-effective outcomes and ongoing individual needs, as developed and approved by the member's

physician. The provider will comply with all our policies and procedures which are hereby incorporated and made a part of the provider's agreement electronic access to the policies and procedures will be provided to the provider. The policies and procedures are subject to change at any time, including, but not limited to, all our medical policies. In the event of a conflict between the terms of the provider's agreement and the terms of the policies and procedures, the terms of the provider's agreement will govern.

Post Service Medical Necessity Reviews

PSMNR may occur after the service was rendered. During a PSMNR, we review clinical documentation to determine whether a service or drug was medically necessary and covered under the member's benefit plan. We may ask you for the information we do not have.

Provider Network

A network of participating providers which has contracted with us to provide health care services to members on certain terms and conditions related to the applicable networks and products covered under the provider's agreement.

Release of Information

Provider authorizes us to publicly release general cost, utilization, and other performance information and data concerning provider or provider's provision of covered services, or data in claims or clean claims, as we deem appropriate, consistent with our existing for future consumer transparency programs, tools and initiatives, as permissible by law.

Utilization Management/Utilization Review

The evaluation by us, or our authorized agent, vendor or subcontractor, or an ASO group, or its UM agent, as applicable, of the medical necessity, appropriateness and efficiency of the use of health care services, in accordance with the provisions of the applicable member's coverage agreement, and policies and procedures, including, but not limited to, for purposes of prior authorization or pre-certification for benefits, concurrent review and retrospective review.

Please note that checking of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, 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.

Consult the member benefit booklet or contact a customer service representative to determine coverage for a specific medical service or supply. Providers may also check Eligibility and benefits to determine if a prior authorization is required

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

BlueCross BlueShield of Texas

Image(s) may have been created or enhanced using artificial intelligence tools.

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