Provider Roles and Responsibilities

Please Note
Throughout this provider manual there will be instances when there are references unique to a particular HMO network. These network specific requirements will be noted with the network name.

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**Please Note**
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**Note:** Providers who provide services to HMO members whose PCP is contracted/affiliated with a capitated IPA/Medical Group must also contact the applicable IPA/Medical Group for instructions regarding the outpatient service preauthorization requirements. Providers who are contracted/affiliated with a capitated IPA/Medical Group are subject to the entity’s procedures and requirements for complaint resolution.

*Continued on next page*
Provider Roles and Responsibilities, continued

The member’s identification card (ID card) provides information concerning eligibility and contract benefits, and is essential for successful claims filing. The alpha prefix is a critical part of the ID number and identifies what group benefits apply. When submitting a claim the alpha prefix should always be entered as it appears on the ID card. If the correct alpha prefix is not provided, the claim may be unnecessarily delayed or denied.

The three (3) characters displayed as the alpha prefix will be indicated in red font as follows:

- **HMO** = HMO Blue Texas
- **BAV** = Blue Advantage HMO

Using the ID Card

Each member receives an identification card (ID card) upon enrollment. Refer to the samples shown on page 5. This card is issued for identification purposes only and does not constitute proof of eligibility. Providers should check to make sure the current group number is included in the member’s records. A copy of the front and back of the ID card is also suggested.

The ID card should be presented by the member each time services are rendered. 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
- The name, provider record, and telephone number of the Primary Care Physician selected by the member
- The PORG of the Primary Care Physician’s Provider Network, if applicable
- Applicable coinsurance, copayment, deductible and/or cost-sharing to Covered Services

**Definitions:**

- **Coinsurance** means, if applicable, the specified percentage of the Allowable Amount for a Covered Service that is payable by the subscriber. The member’s obligation to make coinsurance payments may be subject to an annual out-of-pocket maximum.

- **Copayment** means, the amount required to be paid to a physician and other professional providers, facility, pharmacy, etc., by or on behalf of a member in connection with the services rendered.

Continued on next page
Using the ID Card, continued

- **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 subscriber receives.
- **Covered Services** means, those health services specified and defined as Covered Services under the terms of a member’s health plan.
- **Deductible** means, if applicable, 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.

The member is required to report immediately to HMO 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 HMO within 30 days of any change in name or address. HMO members are also required to notify HMO Customer Service regarding changes in marital status or eligible dependents.

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

Department of Insurance (DOI) Requirements

TDI requires carriers to identify 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 prompt pay legislation.

Other Information

Much of the information you will need is printed on the face and reverse side of your patient’s ID card. Please note the copay amount is on the face of the card. Please call Customer Service if you have questions:

**HMO Blue Texas**
877-299-2377

**Blue Advantage HMO**
800-451-0287

Continued on next page
Provider Roles and Responsibilities, continued

HMO ID Cards

Pictured below is a sample of the HMO Member ID card.

Continued on next page
### Member Eligibility Questions

To confirm eligibility and benefits, the HMO participating Provider may contact HMO Customer Service by calling the appropriate number listed below. When the member does not present an ID card, a copy of the enrollment application or a temporary card may be accepted. HMO also recommends that the member’s identification be verified with a photo ID and that a copy be retained for the Provider’s file.

**HMO Customer Service**  
877-299-2377

**Blue Advantage HMO**  
800-451-0287

**Employees of BCBSTX and dependents**  
888-662-2395

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### Eligibility Statement

HMO complies with the Eligibility Statement Legislation. For additional information on this legislation, please refer to the Texas Department of Insurance (TDI) Web site at [www.tdi.state.tx.us](http://www.tdi.state.tx.us).

### Newborns

Newborns of HMO members are covered for an initial period of 31 days. Coverage continues beyond the 31 days only if the member notifies HMO within 31 days of the birth and pays any additional premium owed. The effective date of coverage will be the date of birth. Newborns of HMO dependents are subject to eligibility requirements established by each employer group and may not be automatically covered for the first 31 days.

### Premium Payments for Individual Plan

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

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

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

Continued on next page
Provider Roles and Responsibilities, continued

**Blue Advantage HMO** has Essential Health Benefits:

- Hospitalization
- Emergency Services
- Laboratory Services
- Maternity and Newborn Care
- Mental Health and Substance Abuse Disorder
- Prescription Drugs
- Habilitative and Rehabilitative services and devices
- Preventive and Wellness Services and Chronic Disease Management
- Ambulatory Patient Services
- Pediatric Services including oral and vision care

The member may have a copay, coinsurance, and/or deductible depending on the services provided.

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

**Verification**

Under the Prompt Pay Legislation, providers of service have the right to request verification that a particular service will be paid by the insurance carrier.

Verification as defined by the Texas Department of Insurance (TDI) is a guarantee of payment for health care or medical care services if the services are rendered within the required timeframe to the patient for whom the services are proposed.

**Verification Procedure**

To initiate a request for verification, please contact HMO Provider Customer Service at **800-299-2377** 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.

The verification process includes researching eligibility, benefits, and authorizations. HMO will respond to the Provider’s request with one of the following letters within the required timeframes:

- Request for Additional Information
- Verification Notice
- Declination Notice

*Continued on next page*
Provider Roles and Responsibilities, continued

Delegated Entity Responsible for Claim Payment

Requests for verification of HMO services will be issued by HMO Blue Texas only if the claim processing will be performed by HMO Blue Texas. If your request is for a service covered under a capitated independent physician association (IPA), medical group, or other delegated entity responsible for claim payment, please make your request for verification directly to the appropriate IPA or entity.

Required Elements to Initiate a Verification

The 13 required elements a Provider needs to supply in order to initiate a verification are as follows:

1) patient name  
2) patient ID number  
3) patient date of birth  
4) name of enrollee or member  
5) patient relationship to enrollee or member  
6) presumptive diagnosis, if known, otherwise presenting symptoms  
7) description of proposed procedure(s) or procedure code(s)  
8) place of service code where services will be provided and if place of service is other than Physician’s office or Provider’s location, name of hospital or facility where proposed service will be provided  
9) proposed date of service  
10) group number  
11) if known to the Provider, name and contact information of any other carrier, including  
a) other carrier’s name  
b) address  
c) telephone number  
d) name of enrollee  
e) plan or ID number  
f) group number (if applicable)  
g) group name (if applicable)  
12) name of the Provider providing the proposed services  
13) Provider’s National Provider Identifier (NPI) number

Note: In addition to the required elements, please be prepared to provide a referral or authorization number for those services which require an authorization. Upon completion of processing, written requests for verification will receive a written notice via U.S. Mail.

Continued on next page
Provider Roles and Responsibilities, continued

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

Some examples of reasons for declination may include, but are not limited to:
1. Policy or contract limitations:
   a. premium payment timeframes that prevent verifying eligibility for 30-day period
   b. policy deductible, specific benefit limitations or annual benefit maximum
   c. benefit exclusions
   d. no coverage or change in membership eligibility, including individuals not eligible, not yet effective or membership cancelled.
   e. HMO is the secondary carrier.

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

Introduction
Provider roles and responsibilities will differ among the various specialties; however, certain responsibilities will be shared by all Providers.

Role of the Provider
• Provide the same level of care to HMO patients as provided to all other patients.
• PCP will be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to members. Such requests must be responded to within one hour.
• Keep a central record of the member’s health and health care that is complete and accurate.
• Complete referrals and preauthorizations through the iEXCHANGE System or by calling 800-413-0869 unless otherwise instructed to call the Utilization Management Department. Department phone numbers and addresses are listed in Section C of this guide. Refer to the detailed information and instructions in Sections C & E for more information on the iEXCHANGE System for referrals and preauthorizations.
Provider Roles and Responsibilities, continued

- Provide copies of medical records when requested by HMO for the purpose of claims review, quality improvement or auditing.
- PCP will assume the responsibility for care management as soon as possible after receiving information that a member on his/her Primary Care Physician list has been hospitalized in the local area on an emergency basis.
- Cooperate with HMO 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. HMO contracted Providers agree to file claims and encounter information with HMO even if the Provider believes or knows there is a third party liability.
- Only bill HMO members for copayments, cost share (coinsurance) and deductibles, where applicable. Provider 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 his/her best efforts to participate with BCBSTX’s Plan’s Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.

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

Obstetrical and Newborn Care

Extensions beyond the normal length of stay (48 hours for a vaginal delivery and 96 hours for a C-Section) require preauthorization through the IEXCHANGE System.

Predetermination Requests

A predetermination of benefits is a voluntary, written request for review of treatment or services, including those that may be considered experimental, investigational of cosmetic.* Prior to submitting a predetermination of benefits request, you should **always check eligibility and benefits first** to determine any pre-service requirements. A predetermination of benefits is **not** a substitute for the preauthorization process.

To submit a predetermination of benefits request, use the Predetermination Request Form, available in the Education and Reference Center/Forms section of our website at bcbstx.com/provider/forms/index.html.

**Mail completed form to:**
Blue Cross and Blue Shield of Texas
Attn: Predetermination Department
P.O. Box 660044
Dallas, TX 75266-0044

*Continued on next page*
Provider Roles and Responsibilities, continued

**Predetermination Requests, continued**

For Urgent Requests Only – Fax to: 888-579-7935
For Status call: 877-299-2377

**Please note:** that the fact that a guideline is available for any given treatment, or that a service or treatment has been preauthorized or predetermined for benefits, or that an RQI number has been issued 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.

**Provider Complaint Procedure**

HMO Blue Texas and Blue Advantage HMO participating Providers are urged to contact Provider Customer Service when there is an administrative question, problem, complaint or claims issue:

**HMO Blue Texas**
800-299-2377

**Blue Advantage HMO**
800-451-0287

To appeal a Utilization Management medical necessity determination, contact the Utilization Management Department:

**HMO Blue Texas**
800-441-9188

**Blue Advantage HMO**
855-462-1785

Hours: 6:00 am – 6:00 pm, CT, M-F and non-legal holidays and 9:00 am to 1:00 pm CT, Saturday, Sunday and legal holidays. Messages may be left in a confidential voice mailbox after business hours.

Utilization Management decisions may be formally appealed by phone, fax, or in writing. For appeals of denied claims, refer to Section F – Filing Claims in this Provider Manual.

*Continued on next page*
Provider Roles and Responsibilities, continued

An HMO participating Provider may contact the Texas Department of Insurance (TDI) to obtain information on companies, coverage, rights or complaints at **800-252-3439** or the Provider may write the Texas Department of Insurance (TDI) at the following address:

Texas Department of Insurance  
P.O. Box 149091  
Austin, TX 78714-9091  
FAX: 512-475-1771  
Email: ConsumerProtection@tdi.texas.gov

For all other inquiries, please contact your local Facility Provider Network Representative.

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Reasons an Ancillary Provider may terminate the professional relationship with a member include, but are not limited to, the following:

- Fraudulent use of services or benefits;
- Threats of physical harm to the Ancillary 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 Ancillary Provider, if such refusal is incompatible with the continuation of the Ancillary Provider and member relationship (Ancillary 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 Ancillary Provider/patient relationship.

Continued on next page
Provider Roles and Responsibilities, continued

Reasons an Ancillary Provider may not terminate the 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 overutilization, either known or experienced;
- Patterns of high utilization, either known or experienced.

When BCBSTX Facility Provider Network Department, receives preliminary information indicating a contracted Ancillary Provider has deemed it necessary to terminate a relationship with a member, the BCBSTX Facility Provider Network Department will:

1. Review with the Ancillary Provider, the following important points:
   a. Refer to the Performance Standard section above – and if necessary explain why they may not terminate the relationship with a member.
   b. 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 HMO.
   c. A notification letter from the Ancillary Provider on the Ancillary Provider’s letterhead to the member is required and must include:
      - Name of member(s) – if it involves a family, list all members affected;
      - Member identification number(s);
      - Group number; and
      - Effective date of termination (as determined based on the above).

Continued on next page
Failure to Establish Ancillary Provider Patient Relationship—Procedures, continued

Provider Roles and Responsibilities, continued

d. A copy of the letter to the member must be sent simultaneously to the applicable BCBSTX Facility Provider Network Representative (or Director), via e-mail, or by fax or regular mail to the appropriate BCBSTX Facility Provider Network area office.

A list of the BCBSTX “Facility Provider Network Offices” including fax numbers and addresses is available by accessing the BCBSTX provider website (link below) and clicking on “Contact Us” in the Related Resources area on the left side of this page.

bcbstx.com/provider/network/network_participation.html

Note: A sample Ancillary Provider letter is available on page B-15.

e. The Ancillary Provider must continue to provide medical services for the member until the termination date stated in the provider’s letter.

When BCBSTX Facility Provider Network Department, receives a copy of the Ancillary Provider’s letter to the member, the BCBSTX Facility Provider Network Department will:

1. Contact the Ancillary Provider to confirm receipt of the letter, review important points outlined above, and address any outstanding issues if applicable.

2. Forward the Ancillary Provider’s letter to the applicable BCBSTX Customer Service area and they will:

   • Send a letter to the member, 30 days prior to the termination date.
   • Send a follow-up resolution letter to the Ancillary Provider.

If the Ancillary Provider Agrees to Continue to See the Member:

If the member appeals the termination directly with the Ancillary Provider and the Ancillary Provider agrees to continue to see the member, the Ancillary Provider must immediately:

   Notify HMO in writing of the approval.

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### Sample of Letter from Ancillary Provider to Member

<table>
<thead>
<tr>
<th>Current Date</th>
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<tbody>
<tr>
<td>Patient Name*</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City/State/Zip</td>
</tr>
<tr>
<td>Phone Number</td>
</tr>
<tr>
<td>HMO Member Number</td>
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<tr>
<td>Group Number</td>
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Dear Patient:

I will no longer be providing services to you as a (insert Ancillary Provider Specialty). I will continue to be available to you for your health care until (date). *(Note: end date must be no less than 30 calendar days from the date of this letter).* After this date, I will no longer be responsible for your medical care.

Upon proper authorization I will promptly forward a copy of your medical record to your new Ancillary Provider. The BCBSTX Customer Service Department is available to assist you in selecting another provider to provide your care. Please call the customer service phone number listed on the back of your member identification card.

Sincerely,

(Provider’s Authorizing Agent Name and Title)

cc: BCBSTX Facility Provider Network Department

*If the Ancillary Provider is terminating the relationship with a family, all member names should be listed in this area.*
Implementation of Factor Drug Program for Hemophilia Members

Provider Roles and Responsibilities, continued

Accredo Health Group, Inc. and Prime Specialty Pharmacy are the two specialty pharmacies for Hemophilia (Factor) Drugs.

Factor drugs, which are specialty medications used to treat hemophilia, often have unique storage or shipment requirements and usually are not stocked at retail pharmacies. HMO contracts with select specialty pharmacies to ensure availability of specialty medications for our members.

As a reminder, Prime Therapeutics (Prime) is the pharmacy benefit manager for most HMO members. If Prime is the pharmacy benefit manager for your patient, please note that HMO contracts with the following specialty pharmacies for hemophilia (factor) products:

- **Accredo Health Group, Inc.**: To contact Accredo regarding hemophilia (factor) products, call 800-800-6606. Referral information may be faxed to Accredo at 800-330-0756.
- **Prime Specialty Pharmacy**: To contact Prime regarding hemophilia (factor) products, call 877-627-MEDS (6337). Referral information may be faxed to Prime Specialty Pharmacy at 877-828-3939.

For those members who have Prime as their pharmacy benefit manager, acquiring hemophilia drugs through these specialty pharmacies will help to ensure maximum benefit coverage.

Lab Services

Quest Diagnostics, Inc. is the exclusive outpatient clinical reference laboratory provider for HMO members*. Note: This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free standing ambulatory surgery centers).

Quest Diagnostics Offers:

- On-line scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a PSC appointment, log onto [QuestDiagnostics.com/patient](http://www.QuestDiagnostics.com/patient) or call 888-277-8772.
- Convenient patient access to over 150 PSCs.
- 24/7 access to electronic lab orders, results, and other office solutions through Care360® Labs and Meds.

For more information about Quest Diagnostics lab testing solutions or to setup an account, contact your Quest Diagnostics’ Provider Representative or call [866-MY-QUEST (866-697-8378)](tel:866-697-8378).

*Continued on next page*
Provider Roles and Responsibilities, continued

For providers located in the HMO Capitated Lab County Listing (BCBSTX Provider website @ bcbstx.com/provider under the Standards & Requirements tab, scroll down to the General Reimbursement Information offering, then go to Reimbursement Schedules & Related Information, then scroll down to HMO – Outpatient Clinical Reference Lab Services.), only the lab services/tests indicated on the Reimbursable Lab Services list (BCBSTX Provider website @ bcbstx.com/provider) will be reimbursed on a fee-for-service basis if performed in the physician’s/provider’s office for HMO members.

Please note all other lab services/tests performed in the physician’s/provider’s office will not be reimbursed. All other lab services must be referred to HMO’s exclusive provider Quest Diagnostics, Inc.


*Note: Physicians/Providers who are contracted/affiliated with a capitated IPA/medical group and physicians/providers who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.

For the County Listing and Reimbursable Lab Services prior to 06/01/2010, visit the BCBSTX Provider website @ bcbstx.com/provider, under the Standards & Requirements tab, scroll down to the General Reimbursement Information offering, then go to Reimbursement Schedules & Related Information, then scroll down to HMO – Outpatient (Physician/Provider) Clinical Reference Lab Services, then refer to the applicable bullet offerings.

Continued on next page
Provider Roles and Responsibilities, continued

HMO is contracted with AIM Specialty Health® (AIM) to manage a statewide Radiology Quality Initiative (RQI) for outpatient diagnostic imaging services. Clinical guidelines can be accessed through AIM’s interactive website at aimspecialtyhealth.com. The guidelines are consistent with the clinical appropriateness criteria developed by the American College of Radiology.

This program helps to 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.

Compliance with obtaining the RQI is required for the outpatient non-emergency diagnostic imaging services. Issuance of an RQI is not a guarantee of payment. Payment is subject to eligibility and contract benefits.

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or 23 hour observation are excluded from this requirement.

Services Requiring an RQI

Ordering physicians (PCPs or Specialists) or professional providers must obtain an RQI from AIM for the following non-emergent outpatient diagnostic imaging services when performed in a physician’s or professional provider’s office, outpatient department of a hospital or freestanding imaging center:

- CT/CTA scans
- MRI/MRA scans
- SPECT/Nuclear Cardiology studies
- PET scans

How to Obtain an RQI from AIM

To obtain the RQI from AIM:

Call: 800-859-5299
Mon – Fri, 6:00 am – 6:00 pm CT
Saturday, Sunday, and Legal Holidays 9:00 am – 12:00 noon CT

Internet: aimspecialtyhealth.com
Fax Requests: 800-610-0050

Note: Fax option is available only for physicians or professional providers who are submitting clinicals for open cases.

Continued on next page
Provider Roles and Responsibilities, continued

**Procedural Terms**

- **RQI**: Contact AIM Specialty Health® (AIM) at **800-859-5299**.
- **Clinical Criteria** – RQI requests are reviewed using AIM’s proprietary criteria. The criteria are based upon the literature and policies from major medical specialty organizations and are consistent with the American College of Radiology’s appropriateness criteria for imaging.
- **Notification** – Notification of the determination is provided to the referring physician/provider within the sooner of, 2 working days after receipt of necessary information to complete the review or 3 calendar days of receipt of the request.
- **Physician Review** – A case will be referred to an AIM Physician Reviewer if the information received does not meet established criteria.

**Accessibility of Clinical Guidelines**

Clinical guidelines can be accessed through AIM’s interactive website at [aimspecialtyhealth.com](http://aimspecialtyhealth.com).

*Continued on next page*
Provider Roles and Responsibilities, continued

Ancillary Providers may submit changes directly to HMO by email to bcbsTX.com/provider. Go to the Network Participation tab, then scroll down to – Update Your Information – and complete/submit the Provider Data Update Notification Form, or by calling Provider Administration at 972-996-9610, press 3, during the hours of 8:00 am – 11:30 am and 1:00 pm – 4:00 pm, Monday through Friday or by contacting your local Facility Provider Network office. Please notify us of changes to the following information:

- Name
- Physical address
- Billing address
- Email address
- Telephone number
- Tax ID or other information
- Specialty
- Certification
- NPI Number change
- TIN number change

Note: If requesting termination from a Network, please contact your local Facility Provider Network office.

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:

- HMO 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 complete applications are received in the corporate BCBSTX office. This will apply to all additions, changes, and cancellations.
- Retroactive Provider Record ID effective dates will not be established.
- Retroactive network participation effective dates will not be established.
- Keeping HMO informed of any changes you make allows for appropriate claims processing, as well as maintaining the HMO Provider Directory with current and accurate information.

Continued on next page
Provider Roles and Responsibilities, continued

Provider Record ID questions or to obtain a Provider Record ID application, please contact Provider Administration at 972-996-9610 during the hours of 8:00 am – 11:30 am and 1:00 pm – 4:00 pm, Monday through Friday.

Blue Cross and Blue Shield of Texas (BCBSTX) Facility Credentialing Program consists of a fully accredited NCQA MCO standard based program that requires the credentialing of hospital and ancillary providers requesting participation or continued participation in the HMO networks. The program is designed with four (4) process modules that include, but are not limited to:

- Initial application or recredentialing data collection and contracting process
- Initial credentialing/recredentialing verification process
- Review by the BCBSTX Facility Provider Credentialing Committee
- Completion of any request of the BCBSTX Facility Provider Credentialing Committee decisions.

Credentialing criteria used in the BCBSTX credentialing program:

- Should be met as a prerequisite to acceptance for contracting in a HMO network;
- Are applied to applicants; and
- Are reviewed/revised at least annually and modified as necessary to meet the requirements of the HMO.

BCBSTX credentials all facility providers that contract to provide health care to HMO members.

Continued on next page
Provider Roles and Responsibilities, continued

Providers who wish to participate or continue participation in the HMO credentialing/recredentialing process should complete the Facility Credentialing and Recredentialing application. The Facility Provider Network Representative/Specialist in their local service area provides this application. The HMO credentialing/recredentialing process includes the review of each provider’s application or recredentialing packet. Participation in the HMO networks requires a provider to meet the following credentialing criteria requirements:

- Meet all state and federal licensing and regulatory requirements;
- Be in compliance with applicable state and federal regulatory bodies or agencies;
- Have an active license that is not revoked, terminated, probated, or suspended;
- Be reviewed and approved by an industry recognized accrediting body as specified in the accreditation/certification established for each facility provider type, as applicable, and;
- Meet any additional credentialing criteria established by BCBSTX.

Initial Credentialing/Recredentialing Verification Process

Standard credentialing procedures for the processing of the presented 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 a CMS or TDSHS survey has not been completed within three (3) years of the credentialing/recredentialing decision, an On-Site Assessment may be required at the discretion of BCBSTX based on the market’s needs.

All documentation submitted for review to BCBSTX must meet all credentialing criteria time frames as stipulated in the BCBSTX credentialing criteria (i.e., expiration dates of liability coverage, DEA and/or DPS, licensure, attestation signature, accreditation/certification, etc.) that is required by all regulatory agencies.

Continued on next page
Provider Roles and Responsibilities, continued

BCBSTX has established a fair and equitable review process by which facility providers may appeal an adverse decision regarding a credentialing/recredentialing decision on their continued participation in the HMO network. Provides must:

- Submit a written appeal and any supporting documentation or pertinent facts that the provider feels would be beneficial in the review process within 60 days of the receipt of the registered letter from BCBSTX. This letter will indicate that an adverse decision has been made regarding credentialing/recredentialing or continuation within the HMO, and;
- Submit the appeal to the appropriate Facility Provider Network Representative/Specialist in your respective service area.

Once the review request has been received by BCBSTX, your local area Facility Provider Network Representative/Specialist will present the review with any and all supporting documentation to the Facility Provider Credentialing Committee (FPCC) for a determination. In the event the FPCC requires additional information, the FPCC will render the request to the Facility Provider Network Representative/Specialist to secure the documentation and submit to the FPCC. Note: The FPCC recommendation is intended to assist the Medical Director in the Provider’s determination for participation in the BCBSTX network(s). The FPCC role is advisory in nature only, and, as such, the recommendation of the committee is not binding.

Upon completion of the review process, the Facility Provider Network Representative/Specialist will forward the final determination in writing to the provider within 60 days of the initial notification to the provider or the date of the request for additional information to present to the FPCC for review.

Continued on next page
## Provider Roles and Responsibilities, continued

### Urgent Care Center (UCC) Criteria

An Urgent Care Center must meet the following requirements:

1. **Extended hours** – UCC must be open weekday evenings until at least 7:00 p.m. Weekend hours preferred but not required.
2. **Defibrillator** – If not physically adjacent to an Emergency Room, UCC must have a defibrillator in their office.
3. **Tax ID Number** – UCC must have its own provider record and Tax ID number.
4. **UCC Summary** – UCC must complete the Urgent Care Center Summary (included in the application packet) and return it along with their application.

### Urgent Care Center Services Billed Using CPT Code S9088

BCBSTX will consider CPT Code S9088 as a non-covered procedure; therefore no reimbursement will be allowed.

Current Procedural Terminology (CPT), copyright 2008 by the American Medical Association (AMA). CPT is a registered trademark of the AMA.

### Room Rate Updated Background

Numerous HMO group and member benefits only provide for a semi-private room. The room rate HMO has on file and loaded in the claims payment system is used to determine the patient’s liability on 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 HMO assists in adjudicating the claim with the correct patient liability.

### Future Updates

For future updates, please notify HMO at least 30 days prior to the planned effective date. You will find the Room Rate Update Notification form on the Blue Cross and Blue Shield of Texas Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) (see downloadable forms). The completed form can be faxed to the fax numbers on the form below or mailed to your Facility Provider Network Representative.

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 our records with the effective date being the latter of:

- The actual effective date of the new rate or
- Date received by HMO

If you have any questions or concerns, please contact your Facility Provider Network Representative.

*Continued on next page*
# Room Rate Update Notification Form

This form is for notification of any room rate changes to your Facility. It is important that Blue Cross and Blue Shield of Texas (BCBSTX) has the most current rates in order to determine the correct patient liability.

<table>
<thead>
<tr>
<th><strong>Provider Name:</strong></th>
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<tbody>
<tr>
<td><strong>Provider City:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>National Provider Identifier (NPI) Number(s):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Private Room Rate:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Semi-Private Room Rate:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Wing (Y/N)?</strong></td>
<td><em>(Please Provide Rate)</em></td>
</tr>
<tr>
<td><strong>Private Room Only (Y/N)?</strong></td>
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</tr>
<tr>
<td><strong>Private Room Only Wings?</strong></td>
<td><em>(Please List Which Wings of the Hospital)</em></td>
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<tr>
<td><strong>Effective Date Of Change:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Information Provider By and Phone #:</strong></td>
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<tr>
<td><strong>Signature:</strong></td>
<td></td>
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<tr>
<td><strong>Date:</strong></td>
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</table>

**FAX Your Completed Form to:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Austin, Corpus Christi, El Paso and San Antonio</td>
<td>210-558-5176</td>
</tr>
<tr>
<td>Dallas/Fort Worth Metroplex and East &amp; West Texas</td>
<td>972-7661103</td>
</tr>
<tr>
<td>Houston, Beaumont and Victoria</td>
<td>713-354-7471</td>
</tr>
</tbody>
</table>

*If you have any questions, please contact your Network Management office.*