Blue EssentialsSM, Blue Advantage HMOSM and Blue PremierSM Provider Manual - Roles and Responsibilities

**Please Note**

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

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Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

The member’s/subscriber’s identification card (ID card) provides information concerning eligibility and contract benefits and is essential for successful claims filing.

Each member/subscriber receives an identification card (ID card) upon enrollment. Refer to the samples shown on the following page. This card is issued for identification purposes only and does not constitute proof of eligibility. Physicians, professional providers, facility and ancillary providers should check to make sure the current group number is included in the member’s/subscriber’s records.

To assist in ensuring that your office always has the most current information for your Blue Essentials, Blue Advantage HMO, and Blue Premier members/subscribers, it is recommended that you copy the member’s/subscriber’s ID card (front and back) for your files at each visit.

The ID card should be presented by the member/subscriber each time services are rendered. The ID card displays:

- The member’s/subscriber’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/Provider (PCP) selected by the member/subscriber
- The PORG of the PCP’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 member/subscriber. The member’s/subscriber’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, professional provider, facility or ancillary provider, etc., by or on behalf of a member/subscriber in connection with the services rendered.
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

- **Cost Sharing** is the general term used to refer to the member’s/subscriber’s out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for Covered Services a member receives.

- **Covered Services** means those health services specified and defined as Covered Services under the terms of a member’s/subscriber’s health plan.

- **Deductible** means, if applicable, the specified annual amount of payment for certain Covered Services, expressed in dollars that the member/subscriber is required to pay before the member/subscriber can receive any benefits for the Covered Services to which the Deductible applies.

The member/subscriber is required to report immediately to Blue Essentials, Blue Advantage HMO, and Blue Premier Customer Service any loss or theft of his/her ID card. A new ID card will be issued. The member/subscriber is also required to notify Blue Essentials, Blue Advantage HMO, or Blue Premier within 30 days of any change in name or address. Blue Essentials, Blue Advantage HMO, and Blue Premier members/subscribers are also required to notify BCBSTX Customer Service regarding changes in marital status or eligible dependents.

**Note:** The member/subscriber is not allowed to let any other person use his/her Blue Essentials, Blue Advantage HMO or Blue Premier ID card for any purpose.

Blue Cross and Blue Shield of Texas (BCBSTX) offers a wide variety of health care products. Each member’s/subscriber’s identification (ID) card displays important information required for billing and determining benefits. When filing a BCBSTX claim, two of the most important elements are the member’s/subscriber’s ID number and group number.

Most members/subscribers with coverage through a Blue Cross Blue Shield Plan are assigned a three-letter alpha prefix that appears at the beginning of their unique identification number. The alpha prefix is very important to the identification number as the prefix acts as a key element in confirming the member’s eligibility and coverage information. Prefixes are also used to identify and correctly route claims to the appropriate Blue Cross Blue Shield Plan for processing.

There are two types of alpha prefixes: plan-specific and account-specific. The plan-specific alpha prefixes are assigned to every Blue Cross Blue Shield plan and start with X, Y, Z or Q.
Please Note

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Important Information Indicated on Member/Subscriber ID Card, cont’d

The first two positions of the prefix indicate the Plan to which the member/subscriber belongs while the third position identifies the product in which the member/subscriber is enrolled in. If the correct alpha prefix is not provided, the claim may be unnecessarily delayed or denied.

**Note:** Generally, ZG identifies a Texas Plan. However, ZG is not the exclusive prefix of HMO plans. Refer to the network IDs listed below and also be sure to check member eligibility and benefits prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as an applicable copayment, coinsurance and deductible amounts and preauthorization requirements.

Identifying the network that a member/subscriber is a part of is now easier with the addition of the three (3) character network ID that will be displayed in a red font. The network ID will appear on medical identification cards where network benefits may apply.

**Examples of Common Network ID:**
- BAV = Blue Advantage HMO and Blue Advantage Plus HMO
- HMO = Blue Essentials and Blue Essentials Access
- HMH = Blue Premier & Blue Premier Access

**Blue Essentials is an HMO network.** Providers who have existing HMO Blue Texas agreements, those agreements will remain in effect under the Blue Essentials name.

The Blue Essentials benefit plan features include:

- HMO product design and benefits
- Members are required to select a PCP and get referrals for services with network providers
- No out-of-network coverage, except for emergency services

Additionally, there is a new benefit plan option effective January 1, 2017, called Blue Essentials Access. This new benefit plan option allows "open access" within the Blue Essentials provider network where PCP selection and referrals are NOT required. All other HMO requirements remain unchanged.

The Blue Essentials Access plan is designed to:

- Allows the member the benefit option of "open access" within the Blue Essentials provider network where PCP selection and referrals are NOT required.
- Helps manage costs and enable flexibility and customization, to include features like predefined deductibles, coinsurance, and copayments for certain health care services
- Provides member’s access to the statewide Blue Essentials network.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Blue Essentials ID Card Sample

HMO = Blue Essentials

![Blue Essentials ID Card Sample](image-url)
Please Note
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Blue Essentials Access
ID Card Sample

HMO = Blue Essentials Access

[Diagram of ID card]

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**Blue Advantage HMO and Blue Advantage Plus HMO - Information**

BCBSTX launched the **Blue Advantage HMO** and **Blue Advantage Plus HMO** network effective January 1, 2014, in all 254 Texas counties. The development of this new cost-effective network is designed to provide affordable quality health care services to the uninsured and underinsured. **Blue Advantage HMO** affords members medical benefits at a lower cost whenever they access care through a participating **Blue Advantage HMO** network provider. **Blue Advantage HMO** and **Blue Advantage Plus HMO** members select a PCP and must have referrals for in-network benefits.

Providers must:

- have privileges at one of the Blue Advantage HMO participating hospitals (unless inpatient admissions are uncommon or not required for the physician's, professional provider's, facility or ancillary provider's specialty) or have someone who will admit on their behalf.
- have a valid National Provider Identifier (NPI) number.
- sign a Blue Advantage HMO agreement.

Additionally, **Blue Advantage Plus HMO** members can choose to self-direct their care under their out-of-network benefits at a higher member cost share.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

**BAV = Blue Advantage HMO**

If **TDI** is present, subject to TDI rules and regulations.
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**BAV = Blue Advantage Plus HMO**

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Blue Premier Information
In 2016, Blue Cross and Blue Shield of Texas (BCBSTX) began offering two HMO products to our employer groups under the names of Blue Premier℠ and Blue Premier Access℠ (Blue Premier). These two product offerings reflect our commitment to offer more choices and increase access to affordable and quality health care services for our members.

Blue Premier was effective Jan. 1, 2016. Members must live or work within the network coverage area to enroll in this product.

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<td>Houston/Beaumont</td>
<td>Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery, and Orange</td>
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<tr>
<td>San Antonio</td>
<td>Atascosa, Bandera, Bexar, Comal, Guadalupe, and Kendall</td>
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Blue Premier offers its members access to a select set of hospitals and providers within the county coverage area listed in the grid above. With this product, members must select a Primary Care Physician/Provider (PCP) and referrals are required to see a specialist.

This product has a geographic restriction where the member must live or work within the network coverage area (listed in the grid above) to enroll into the Blue Premier product.

Blue Premier Access provides the same county coverage (listed in the grid above) as Blue Premier but gives its members the freedom to choose their care without having to select a PCP or get a referral when seeing an in-network provider.

Like the Blue Premier product, Blue Premier Access has a geographic restriction where the member must or work within the network coverage area (listed in the grid above) to enroll in the Blue Premier Access product.

Blue Premier and Blue Premier Access appear on our Provider Finder® under their respective product names. There is a geographic restriction with this product, so member must live or work within the network coverage area to enroll in this product.
Please Note
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HMH = Blue Premier

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**HMH = Blue Premier Access**
Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

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**Blue Premier Information, cont’d**

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit quotes include membership verification, coverage status and other important information, such as an applicable copayment, coinsurance, and deductible amount. It's strongly recommended that providers **ask to see the member’s ID card** for current information and **photo ID** to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

Our growing portfolio of product offerings is part of BCBSTX’s efforts to meet its goal of increasing access and affordability of health care products to our members and the community that we serve. Making it easier for you and your staff to conduct business with us is equally important.

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**Out-of-Network Services**

Blue Premier members do not have any out-of-network benefits. Blue Premier Access members; however, can choose to use an out-of-network provider; it may result in higher out-of-pocket expenses for the member.

As always, if there is a need to obtain covered emergency services, a member may access providers who are not part of the Blue Premier network.

If covered services are not available from participating providers within the access requirements established by law and regulation, Blue Premier and Blue Premier Access will allow a referral to an out-of-network provider, but the following will apply:

- The referral request must be from a participating provider.
- Reasonably requested documentation must be received by BCBSTX
- The referral must be provided within an appropriate time, not to exceed five business days, based on the circumstances and your condition.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Blue Premier Information and Use, cont’d

Out-of-Network Services, cont’d

- When BCBSTX allows a referral to an out-of-network provider, BCBSTX will reimburse the provider at the usual and customary rate or otherwise agreed rate, less the applicable copayment(s), coinsurance and/or any deductible. Member is responsible only for the copayment(s), coinsurance and/or deductible for such covered services. Before BCBSTX approves or denies a referral, a review will be conducted by a specialist of the same or similar specialty as the type of provider to whom a referral is requested.
- Also, court-ordered dependents living outside the service area may visit out-of-network.
### Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

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### Other Information Located on Member/Subscriber ID Cards

Much of the information you will need is printed on the front and back side of your patient’s ID card. Please note the Copay amount is on the front of the ID card. If you have questions, call:

- **Blue Essentials Provider Customer Service** - 877-299-2377
- **Blue Advantage HMO Provider Customer Service** - 800-451-0287
- **Blue Premier Provider Customer Service** - 800-876-2583

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### 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.
Please Note

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Member Eligibility Questions

To confirm eligibility and benefits, the participating physicians, professional providers, facility or ancillary providers may contact the **Blue Essentials, Blue Advantage HMO, and Blue Premier**. Provider Customer Service by calling the appropriate phone 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. **Blue Essentials, Blue Advantage HMO, and Blue Premier** also recommends that the member’s identification is verified with a photo ID and that a copy is retained for his/her file.

**Blue Essentials Provider Customer Service**
877-299-2377

**Blue Advantage HMO Provider Customer Service**
800-451-0287

**Blue Premier Provider Customer Service**
800-876-2583

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

Eligibility Statement

**Blue Essentials. Blue Advantage HMO and Blue Premier** comply with the Eligibility Statement Legislation. For additional information on this legislation, please refer to the Texas Department of Insurance (TDI) web site at [tdi.texas.gov](http://tdi.texas.gov).

Newborns

Newborns of **Blue Essentials, Blue Advantage HMO, and Blue Premier** members are covered for an initial period of 31 days. Coverage continues beyond the 31 days only if the member notifies **Blue Essential, Blue Advantage HMO or Blue Premier** within 31 days of the birth and pays any additional premium owed. The effective date of coverage will be the date of birth.

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

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

Throughout this provider manual there will be instances when there are references unique Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

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, 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.

Covered Services

Blue Essentials, Blue Advantage HMO, and Blue Premier have multiple benefit plan options and riders available to employer groups. Members of Blue Essentials, Blue Advantage HMO, and Blue Premier are entitled to receive an array of benefits as part of the basic benefit plan, which includes preventive care. Different types of services can have different levels of coverage and copayments can vary by plan.

The Blue Essentials, Blue Advantage HMO, and Blue Premier members are required to pay a copayment, if applicable, at the time services are rendered.

Note: For Blue Essentials members, the copayment(s) for basic services shall not exceed fifty percent (50%) of the cost (contract allowable) for covered services.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

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:

- **Blue Essentials** Provider Customer Service
  Call 877-299-2377 and select the prompt for verification
- **Blue Advantage HMO** Provider Customer Service
  Call 800-451-0287
- **Blue Premier** Provider Customer Service
  Call 800-876-2583

**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. Blue Essentials, Blue Advantage HMO or Blue Premier will respond to the physician’s or professional provider’s request with one of the following letters within the required timeframes:

- Request for Additional Information
- Verification Notice
- Declination Notice

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

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

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Required Elements to Initiate a Verification

The 13 required elements a participating physician, professional provider, facility and ancillary provider need to supply to initiate a verification for an Blue Essentials, Blue Advantage HMO or Blue Premier member are as follows:

1) patient name
2) patient ID number
3) patient date of birth
4) name of enrollee or member
5) patient relationship to enrollee or member
6) presumptive diagnosis, if known, otherwise presenting symptoms
7) description of proposed procedure(s) or procedure code(s)
8) place of service code where services will be provided and if place of service is other than the physician, professional provider, facility or ancillary provider’s office or location, need name of hospital or facility where proposed service will be provided
9) proposed date of service
10) group number
11) if known to the participating physician, professional provider, facility or ancillary 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 participating physician, professional provider, facility or ancillary provider providing the proposed services
13) Physician, professional provider, facility or ancillary provider’s National Provider Identifier (NPI) number

Note: In addition to the required elements, please be prepared to provide a referral or preauthorization number for those services which require an authorization. Please also provide your office fax number for your written confirmation. This will expedite the response from Blue Essentials, Blue Advantage HMO or Blue Premier.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

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

Some examples of reasons for declination may include, but are not limited to:

- Policy or contract limitations:
  - premium payment timeframes that prevent verifying eligibility for 30-day period
  - grace period payment timeframes
  - 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.

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, physicians, professional providers, facility and ancillary providers cannot bill the member at the time of service except for the applicable copayments, deductible or coinsurance amounts.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Additional Fees Charged By Participating Physicians, Professional Providers, Facility and Ancillary Providers Beyond Copayments and Coinsurance

• Blue Essentials, Blue Advantage HMO, and Blue Premier discourage the practice of participating physicians, professional providers, facility and ancillary providers charging members additional fees beyond required copayments and coinsurance.

• Blue Essentials, Blue Advantage HMO, and Blue Premier participating physician, professional provider, facility and ancillary agreements require physicians, professional providers, facility and ancillary 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 physician, professional provider, facility or ancillary provider charges additional fees to its entire population of patients in the same manner for non-covered services, and the Blue Essentials, Blue Advantage HMO, and Blue Premier 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 Blue Essentials, Blue Advantage HMO or Blue Premier 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 Blue Essentials, Blue Advantage HMO or Blue Premier claims edits.

• A participating physician, professional provider, facility or ancillary provider cannot require Blue Essentials, Blue Advantage HMO or Blue Premier members to pay any type of “access fee” as a prerequisite to receiving services that are covered under member benefit plans.

• Blue Essentials, Blue Advantage HMO or Blue Premier members who do not pay the ‘access fee’ must not be treated differently from patients who pay the ‘access fee’ with regard to quality, comprehensiveness of care services, reasonable access to appointments, or after-hours coverage.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Roles and Responsibilities
Physician, professional provider, facility or ancillary provider roles and responsibilities will differ among the various specialties; however, certain responsibilities will be shared by all Blue Essentials, Blue Advantage HMO or Blue Premier physician, professional provider, facility or ancillary provider.

Important Note:
Primary Care Physician/Provider (PCP) must utilize Blue Essentials, Blue Advantage HMO or Blue Premier facilities for all care that is rendered to Blue Essentials, Blue Advantage HMO or Blue Premier members.

Definition of Primary Care Physician/Provider (PCP)
A Primary Care Physician/Provider or PCP means a participating physician, physician assistant or advanced practice registered nurse who has agreed to be responsible for providing basic health services, coordinating the care of the individual members, and as applicable referring those members to other participating providers as set forth in their PCP agreement. A PCP may be a family practitioner, internist, pediatrician, and/or obstetrician/gynecologist.

Role of the Primary Care Physician/Provider
The member must contact his/her Primary Care Physician/Provider (family practice physician, general practice physician, internal medicine physician, obstetrics & gynecology physician*, pediatrician, advanced nurse practitioner or physician assistant) for all of his or her health care needs. The member’s chosen PCP will be indicated on the member’s ID card.

* Please note: An Obstetrics & Gynecology physician can choose to be a Primary Care Physician (PCP) or to be a Specialty Care Physician (SCP). If the Obstetrics & Gynecological physician chooses to be a PCP and if the BCBSTX member chooses the Obstetrics & Gynecology physician as their PCP, then the Obstetrics & Gynecology physician must assume and meet all of the BCBSTX PCP roles and requirements indicated under this topic "Role of the Primary Care Physician/Provider".

Each PCP is responsible for making his/her own arrangement for patient coverage when out of town or unavailable. A physician/provider who has contracted with Blue Essentials, Blue Advantage HMO or Blue Premier as a Primary Care Physician/Provider will agree to render to the Blue Essentials, Blue Advantage HMO or Blue Premier member primary, preventive, acute and chronic health care management and:

* Provide the same level of care to Blue Essentials, Blue Advantage HMO or Blue Premier patients as provided to all other patients.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Role of the Primary Care Physician/Provider cont’d

- 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 PCP or on-call physician/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 PCP or on-call physician/provider and the phone number is provided.

- 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.

- Meet required Patient Appointment Access Standards (for more detail refer to Section G - Quality Improvement Program)

- Keep a central record of the member's health and health care that is complete and accurate
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Role of the Primary Care Physician/Provider, cont’d

- Refer the Blue Essentials, Blue Advantage HMO or Blue Premier member to specialty care physicians or professional providers within the same Provider Network.

  Blue Advantage HMO Only Important Note:
  Primary Care Physicians/Providers and Pediatricians will assist with referrals to dental care providers for members under age 20.
  - For Dental – Dental Networks of America – call 800-972-7565
  Primary Care Physicians/Providers and Pediatricians will assist with referrals to vision care providers for members under age 19.
  - For Vision for members under age 19 – call EyeMed Vision Care at 1-866-939-3633.

- When applicable, complete referral authorizations, select outpatient preauthorizations and inpatient admissions through the iExchange System or by calling the Utilization Management Department at 855-896-2701. Department phone numbers and addresses are listed in Section C of this provider manual. Refer to the detailed information and instructions in Sections C & E for more information on the iExchange System for referrals and preauthorizations.

- Provide copies of X-ray and laboratory results and other health records to specialty care physicians or professional providers to enhance continuity of care and to preclude duplication of diagnostic procedures. Provide copies of X-ray and laboratory results and other health records to specialty care physicians or professional providers to enhance continuity of care and to preclude duplication of diagnostic procedures.

- Provide copies of medical records when requested by HMO Blue Texas, Blue Advantage HMO and Blue Premier for the purpose of claims review, quality improvement, risk adjustment or auditing.

- Enter into the Blue Essentials, Blue Advantage HMO and Blue Premier member’s health record all reports received from specialty care physicians or professional providers.

- Assume the responsibility for arranging and preauthorizing hospital admissions in which he/she is the admitting physician or delegate this responsibility to the admitting specialty care physician or professional provider.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Role of the Primary Care Physician/Provider, cont’d

• Assume the responsibility for care management as soon as possible after receiving information that an HMO Blue Texas, Blue Advantage HMO and Blue Premier member on his/her PCP list has been hospitalized in the local area on an emergency basis.

• Coordinate inpatient care with the specialty care physician or professional provider so that unnecessary visits by both physicians are avoided.

• Maintain and operate his/her office or facility in a manner protective of the health and safety of his/her personnel and the Blue Essentials, Blue Advantage HMO and Blue Premier patient in accordance with Texas Department of Health standards.

• Only bill (or collect from) Blue Essentials, Blue Advantage HMO or Blue Premier members for Copayments, Cost Share (Coinsurance) and Deductibles, where applicable. 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.

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

• Agrees to use his/her best efforts to participate with BCBSTX's Plan's Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.

• Assume the responsibility for care management as soon as possible after receiving information that an HMO Blue Texas, Blue Advantage HMO or Blue Premier member, on his/her PCP list, has been hospitalized in the local area on an emergency basis.

• Coordinate inpatient care with the specialty care physician or professional provider so that unnecessary visits by both physicians/providers are avoided.

• Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the Blue Essentials, Blue Advantage HMO or Blue Premier patient in accordance with Texas Department of Health standards.
### Please Note
Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

### Role of the Primary Care Physician/Provider, cont’d
- Cooperate with **Blue Essentials, Blue Advantage HMO or Blue Premier** 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. **Blue Essentials, Blue Advantage HMO or Blue Premier** contracted physicians or professional providers agree to file claims and encounter information with **Blue Essentials, Blue Advantage HMO or Blue Premier** even if the physician or professional provider believes or knows there is a third-party liability.

### Back up PCPs
The PCP designates backup (covering) primary care physicians/providers during the network application process. The covering physician is responsible for filing a claim for any member seen on behalf of the PCP. **The primary care physician/ provider's staff must report any upcoming changes in covering PCP to their Network Management office.**
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Referrals to Specialty Care Physicians or Professional Providers

Referrals to specialty care physicians or professional providers, except OBGyns, must be initiated by the PCP. It is essential that the PCP refer Blue Essentials, Blue Advantage HMO or Blue Premier members requiring specialty care to Blue Essentials, Blue Advantage HMO or Blue Premier participating physicians or professional providers within the same Provider Network, if applicable.

Note: An OBGyn can act as a PCP only if the member chooses the OBGyn as their PCP.

A PCP may not refer to himself/herself as a specialty care physician or professional provider when treating the member who is already on his/her PCP list. Refer to the detailed information and instructions in Section D of this Provider Manual that discusses the iExchange system for referral authorizations.

Once the iExchange system issues a confirmation number to the PCP for the referral to the specialty care physician or professional provider, the system will automatically generate notification letters to the specialty care physician or professional provider and to the Blue Essentials, Blue Advantage HMO or Blue Premier member.

The PCP may provide the Blue Essentials, Blue Advantage HMO or Blue Premier member with the iExchange referral confirmation number to take to appointments with the specialty care physician or professional provider or the specialty care physician or professional provider can access the iExchange system to obtain the referral confirmation number.

If the specialty care physician or professional provider determines that a Blue Essentials, Blue Advantage HMO or Blue Premier member needs to be seen by another specialty care physician or professional provider, the Blue Essentials, Blue Advantage HMO or Blue Premier member must be referred back to the member’s PCP.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Referrals to Specialty Care Physicians or Professional Providers, cont’d

Note: The specialty care physician or professional provider cannot refer to other specialty care physicians or professional providers.

EXCEPTION: Primary Care or Specialty Care OBGyn physicians can directly manage and coordinate a woman’s care for obstetrical and gynecological conditions, including obtaining referrals through iExchange for obstetrical/gynecological related specialty care and testing to other Blue Essentials, Blue Advantage HMO or Blue Premier participating physicians that participate in the same Provider Network as the member’s PCP, if applicable.

Obstetrical and Newborn Care: 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.
### Please Note
Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

### Important Note
Specialty Care Physicians/Providers must utilize Blue Essentials, Blue Advantage HMO or Blue Premier facilities for all care that is rendered to Blue Essentials, Blue Advantage HMO or Blue Premier members.

### Role of the Specialty Care Physician or Professional Provider
An **Blue Essentials, Blue Advantage HMO or Blue Premier** participating physician or professional provider who provides services as a specialty care physician (SCP) or professional provider is expected to:

- Provide the same level of care to **Blue Essentials, Blue Advantage HMO or Blue Premier** patients as provided to all other patients.
- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. 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.
- 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 Section G - Quality Improvement Program*):
  - Keep a central record of the member’s health and health care that is complete and accurate.
### Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

<table>
<thead>
<tr>
<th>Role of the Specialty Care Physician or Professional Provider, cont’d</th>
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<tbody>
<tr>
<td>• <strong>Specialty Care Physicians</strong> must utilize Blue Essentials, Blue Advantage HMO or Blue Premier facilities for all care that is rendered to Blue Essentials, Blue Advantage HMO or Blue Premier members.</td>
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<tr>
<td>• Accept referrals for <strong>Blue Essentials, Blue Advantage HMO or Blue Premier</strong> members in accordance with the services and number of visits requested by the PCP in the same Provider Network, if applicable.</td>
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<tr>
<td>• Report back to the PCP upon completion of the consultation/treatment.</td>
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<tr>
<td>• Provide copies of X-ray and laboratory results and other health record information to the member’s PCP as appropriate.</td>
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<tr>
<td>• Coordinate inpatient care with the PCP so that unnecessary visits by other physicians or professional providers are avoided.</td>
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<tr>
<td>• The Medical Care Management IQMP staff will send written notification of the approval, to include the effective date [first (1st) day of the month following the approved decision] to the member within 30 calendar days of receiving the request for special consideration.</td>
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<tr>
<td>• If the request for special consideration is denied by <strong>Blue Essentials, Blue Advantage HMO or Blue Premier</strong>, the <strong>Blue Essentials, Blue Advantage HMO or Blue Premier</strong> medical director sends a denial letter within 30 days of receiving the request explaining the denial and the member’s right to appeal the decision through the <strong>Blue Essentials, Blue Advantage HMO or Blue Premier</strong> Complaint Process.</td>
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<tr>
<td>• The effective date of the new designation of the non-primary care specialist will not be retroactive and may not reduce the amount of the compensation owed to the original PCP for services provided before the date of the new designation. For further details, contact Provider Customer Service:</td>
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**Blue Essentials** - call 877-299-2377  
**Blue Advantage HMO** – call 800-451-0287  
**Blue Premier** – call 800-876-2583
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Role of the Specialty Care Physician or Professional Provider, cont’d

• The Medical Care Management IQMP staff will send written notification of the approval, to include the effective date [first (1st) day of the month following the approved decision] to the member within 30 calendar days of receiving the request for special consideration.

• If the request for special consideration is denied by Blue Essentials, Blue Advantage HMO or Blue Premier, the Blue Essentials, Blue Advantage HMO or Blue Premier medical director sends a denial letter within 30 days of receiving the request explaining the denial and the member’s right to appeal the decision through the Blue Essentials, Blue Advantage HMO or Blue Premier Complaint Process.

• The effective date of the new designation of the non-primary care specialist will not be retroactive and may not reduce the amount of the compensation owed to the original PCP for services provided before the date of the new designation. For further details, contact Provider Customer Service:
  
  Blue Essentials - call 877-299-2377  
  Blue Advantage HMO – call 800-451-0287  
  Blue Premier - call 800- 876-2583

• Provide inpatient consultation within 24 hours of receipt of the request. Emergency consultation to be provided as soon as possible.

• Provide copies of medical records when requested by Blue Essentials, Blue Advantage HMO or Blue Premier for the purpose of claims review, quality improvement, risk adjustment or auditing.

• Return the member to the care of the referring Blue Essentials, Blue Advantage HMO or Blue Premier PCP as soon as medically feasible.

• Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the Blue Essentials, Blue Advantage HMO or Blue Premier patient in accordance with Texas Department of Health standards.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Role of the Specialty Care Physician or Professional Provider, cont’d

- Cooperate with BCBSTX 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. BCBSTX contracted physicians agree to file claims and encounter information with BCBSTX even if the physician believes or knows there is a third-party liability.

- Only bill Blue Essentials, Blue Advantage HMO or Blue Premier members for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty care physician or professional 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.

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

- Agrees to use his/her best efforts to participate with BCBSTX's Plan’s Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.

Additionally,

- If additional services and/or visits are needed, beyond those authorized by the PCP through the iExchange System or the Utilization Management Department, a new referral authorization must be obtained from the PCP.

- If authorized by the PCP, arrange for hospital admission of the Blue Essentials, Blue Advantage HMO or Blue Premier member into a participating Facility through the Utilization Management Department and assume responsibility for completion of steps required by Blue Essentials, Blue Advantage HMO or Blue Premier to preauthorize the admission.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Specialist as a Primary Care Physician/Provider

Any Blue Essentials, Blue Advantage HMO or Blue Premier member with chronic, disabling or life-threatening illnesses may apply to the Blue Essentials, Blue Advantage HMO or Blue Premier Medical Director to utilize a specialty care professional provider as a primary care physician/provider (PCP), provided that:

- The request for the specialty care physician or professional provider includes certification of medical need, along with all applicable supporting documentation, and is signed by the Blue Essentials, Blue Advantage HMO or Blue Premier member or the specialty care physician or professional provider interested in serving as the PCP.

- The specialty care physician or professional provider must meet Blue Essentials, Blue Advantage HMO or Blue Premier requirements for PCP participation. Refer to above pages titled, Role of the Primary Care Physician/Provider. The specialty care physician or professional provider is willing to coordinate all the Blue Essentials, Blue Advantage HMO or Blue Premier member’s health care needs and accept Blue Essentials, Blue Advantage HMO or Blue Premier reimbursement.

- All physicians or professional providers participating in Blue Essentials, Blue Advantage HMO or Blue Premier must have a current Texas license, be in good standing with the licensing board, the Provider Network and its hospital affiliates and Blue Cross and Blue Shield of Texas, plus meet other credentialing criteria established by Blue Essentials, Blue Advantage HMO or Blue Premier.

- If the request for special consideration is approved by HMO Blue Texas, Blue Advantage HMO or Blue Premier, the Network Management Representative contacts the specialist within 30 days of receiving the request to educate them on the role and responsibilities of the PCP, preventive care guidelines, claim filing instructions and discuss reimbursement. The representative will provide instructions on how to view on the BCBSTX provider website a current directory of participating specialists and professional providers.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Role of OBGyn as a Specialty Care Physician
A female Blue Essentials, Blue Advantage HMO or Blue Premier member has direct access to a Blue Essentials, Blue Advantage HMO or Blue Premier participating OBGyn participating in the same Provider Network as her Primary Care Physician/Provider. 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 referral to a specialist who participates in the same Provider Network as the member’s PCP, 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.

Note: An OBGyn can act as a PCP only if the member actually chooses the OBGyn as their PCP

A female Blue Essentials, Blue Advantage HMO or Blue Premier member may access a Blue Essentials, Blue Advantage HMO or Blue Premier participating OBGyn physician participating in the same Provider Network as her PCP without obtaining a referral from her PCP or calling Blue Essentials, Blue Advantage HMO or Blue Premier.

When abnormalities are discovered, the Blue Essentials, Blue Advantage HMO or Blue Premier participating OBGyn can directly manage and coordinate a woman’s care for obstetrical and gynecological conditions including issuing referrals for obstetrical/gynecological related specialty care and testing to other Blue Essentials, Blue Advantage HMO or Blue Premier participating physicians or providers who participate in the same Provider Network as the member’s Primary Care Physician/Provider.

If the OBGyn physician has issued a referral to another specialty care physician or professional provider and additional follow-up visits are necessary for the member to see the specialty care physician or professional provider, the OBGyn physician is responsible for issuing a new referral or extending the original referral and obtaining referral authorization through the iExchange System.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Role of OBGyn as a Specialty Care Physician, cont’d
Services for all other conditions must be coordinated through the Blue Essentials, Blue Advantage HMO or Blue Premier member’s PCP. Also, any services rendered outside of the OBGyn’s office, such as ultrasound and mammograms, must be performed by Facilities contracted in the same Provider Network as the member’s PCP.

Note: Non-prescription contraceptives and associated care vary by employer benefit program. To check coverage for this type of service, call Blue Essentials, Blue Advantage HMO or Blue Premier Customer Service.

Notification of Obstetrical and Newborn Care
After the first prenatal visit, the Blue Essentials, Blue Advantage HMO or Blue Premier participating physician’s office should provide notification of the Blue Essentials, Blue Advantage HMO or Blue Premier’s member’s obstetrical care through the iExchange System. OB ultrasounds may be performed in the physician’s office and do not require preauthorization.

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.

Note:
- 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.
- Physicians 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 Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Notification of Obstetrical and Newborn Care, cont’d

**FIRST OBSTETRIC VISIT**

If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, refer to the antepartum and postpartum care codes 59400-59426 and 59430. For one to three care visits, refer to the appropriate Evaluation and Management code(s).
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

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 or 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 the BCBSTX provider 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

For Urgent Requests Only – Fax to: 888-579-7935

For Status call:
877-299-2377 (Blue Essentials member)
800-451-0287 (Blue Advantage HMO member)
800-876-2583 (Blue Premier member)

Note: The fact that a guideline is available for any given treatment, or that a service or treatment has been pre-certified or pre-determined for benefits 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.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Physician, Professional Provider, Facility or Ancillary Provider Complaint Procedure

Blue Essentials, Blue Advantage HMO and Blue Premier participating physicians, professional, facility, and ancillary providers are urged to contact Provider Customer Service when there is an administrative question, problem, complaint or claims issue.

- Blue Essentials - call 877-299-2377
- Blue Advantage HMO - call 800-451-0287
- Blue Premier – call 800-876-2583

To appeal a Utilization Management medical necessity determination, contact the Medical Care Management Dept.,

- Call 800-441-9188 (for Blue Essentials Member) Call 855-462-1785 (for Blue Advantage HMO Member) Call 800-876-2583 (for Blue Premier Member)
- Hours: 6 am – 6 pm, CT, M-F and non-legal holidays and 9 am to 12 noon, 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.

A Blue Essentials, Blue Advantage HMO and Blue Premier participating physician or professional provider may contact the Texas Department of Insurance (TDI) to obtain information on companies, coverage, rights or complaints at 800-252-3439 or the physician, professional provider, facility or ancillary provider may write the Texas Department of Insurance (TDI) at the following address:

Texas Department of Insurance
P.O. Box 149091
Austin, Texas 78714-9091

Fax: 512-475-1771
Email: ConsumerProtection@tdi.texas.gov

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

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Failure to Establish Physician, Professional Provider, Facility or Ancillary Provider - Patient Relationship - Performance Standard

Reasons a physician, professional provider, facility or ancillary provider may terminate his/her 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 physician or professional 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 physician, professional provider, facility or ancillary provider, if such refusal is incompatible with the continuation of the physician, professional provider, facility or ancillary provider and member relationship (physician, professional provider, facility or 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 physician, professional provider, facility or ancillary provider/patient relationship.

Reasons a physician, professional provider, facility or ancillary provider may not terminate his/her 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.
Please Note: Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Failure to Establish Physician, Professional Provider, Facility or Ancillary Provider - Patient Relationship - Procedures

When the BCBSTX Network Management Department receives preliminary information indicating a contracted Blue Essentials, Blue Advantage HMO or Blue Premier physician, professional provider, facility or ancillary provider has deemed it necessary to terminate a relationship with a member, the BCBSTX Network Management Department will:

Review with the physician, professional provider, facility or ancillary provider, the following important points:

a. Refer to the Performance Standard section above – and if necessary explain why he/she may not terminate his/her 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. Exceptions: 1) If the provider is a Blue Essentials, Blue Advantage HMO or Blue Premier PCP, the term date must be the last day of the month following the initial 30 calendar days timeframe (due to monthly capitation arrangement with some PCPs); 2) Immediate termination may be considered if a safety issue or gross misconduct is involved – must be reviewed and approved by BCBSTX.

c. A notification letter from the physician to the member is required and must include:
   • Name of the member(s) – if it involves a family, list all members affected;
   • Member identification number(s);
   • Group number; and
   • The effective date of termination (as determined based on the above).

d. A copy of the letter to the member must be sent simultaneously to the applicable Blue Essentials, Blue Advantage HMO or Blue Premier Network Management Representative (or Director), via e-mail, or by fax or regular mail to the appropriate BCBSTX Network Management office.

A list of the BCBSTX Network Management Contracting Office Locations” including fax numbers and addresses is available by accessing the “Contact Us” area on the BCBSTX provider website.

Note: A sample physician, professional provider, facility or ancillary provider letter can be found further in this manual.
### Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

<table>
<thead>
<tr>
<th>Failure to Establish Physician, Provider, Facility or Ancillary Provider-Patient Relationship - Procedures, cont’d</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. The physician, professional provider, facility or ancillary provider must continue to provide medical services for the member until the termination date stated in the provider’s letter. If the physician, professional provider, facility or ancillary provider is a PCP, he/she may refer the member to another Network physician, professional provider, facility or ancillary provider. If the PCP is affiliated with an IPA/Medical Group, he/she may refer the member to a Physician within the IPA/Medical Group. Having a referral on file, if required, will assure the member continues to receive covered benefits until a new PCP is selected and effective.</td>
</tr>
</tbody>
</table>

### When the BCBSTX Network Management Department receives a copy of the Physician, Professional Provider, Facility or Ancillary Provider letter to the member, the Network Management Department will:

1. Contact the physician, professional provider, facility or ancillary provider to confirm receipt of the letter, review important points outlined above, and address any outstanding issues if applicable.

2. Forward the physician, professional provider, facility or ancillary provider letter to the applicable BCBSTX Customer Service area and they will:
   - Send a letter to the member, 30 days prior to the termination date, which will include a new designated PCP or outline steps for the member to select a new PCP (or SCP if applicable).
   - Send a follow-up resolution letter to the physician, professional provider, facility or ancillary provider (or IPA/Medical Group if applicable).

### If the physician, professional provider, facility or ancillary provider agrees to continue to see the member:

If the member appeals the termination directly with the physician, professional provider, facility or ancillary provider and the physician, professional provider, facility or ancillary provider agrees to continue to see the member, the physician, professional provider, facility or ancillary provider must immediately:

- Notify **Blue Essentials, Blue Advantage HMO or Blue Premier** in writing of his/her approval to reinstate the member to his/her panel (so that Provider Customer Service can re-assign the PCP to the member if the member requests such, and/or to prevent any future miscommunication).
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Sample of Letter from Provider to Member

Current Date

Patient Name*
Address
City/State/Zip
Phone Number
[Blue Essentials, Blue Advantage HMO, and/or Blue Premier Member/Subscriber Number]
Group Number

Dear Patient:

I will no longer be providing services to you as a ______ (insert Primary Care Physician/Provider or Specialty Care Physician). 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, and if the physician is a Blue Essentials, Blue Advantage HMO or Blue Premier PCP the end date must be the last day of the month following the initial 30 days). 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 physician/provider. The BCBSTX Customer Service Department is available to assist you in selecting another physician/provider to provide your care. Please call the customer service phone number listed on the back of your member identification card.

Sincerely,

John Doe, M.D.

cc: BCBSTX Network Management Department

* If the physician, professional provider, facility or ancillary provider is terminating the relationship with a family, all member names should be listed in this area.
Panel Closure

Each Blue Essentials, Blue Advantage HMO or Blue Premier member shall select a PCP in accordance with the procedures set forth in the Membership Agreement. Individual PCP, Medical Group or Medical Group PCP agrees to accept Blue Essentials, Blue Advantage HMO or Blue Premier members who have selected or who have been assigned to the PCP unless Individual PCP, Medical Group or Medical Group PCP notifies Blue Essentials, Blue Advantage HMO or Blue Premier that the Individual PCP’s or Medical Group PCP’s entire practice is closed to new patients of Blue Essentials, Blue Advantage HMO or Blue Premier as well as new patients of all other health plans or unless the Individual PCP’s or Medical Group PCP’s practice contains 300 or more Blue Essentials, Blue Advantage HMO or Blue Premier members. Individual PCP, Medical Group or Medical Group PCP must give Blue Essentials, Blue Advantage HMO or Blue Premier not less than ninety (90) days prior written notice of closing their practice to new Blue Essentials, Blue Advantage HMO or Blue Premier members.

Notwithstanding practice closure, Individual PCP, Medical Group or Medical Group PCP agrees to accept all existing patients who are or become Blue Essentials, Blue Advantage HMO or Blue Premier members. Individual PCP, Medical Group or Medical Group PCP agrees that Blue Essentials, Blue Advantage HMO or Blue Premier shall have no obligation to guarantee any minimum number of Blue Essentials, Blue Advantage HMO or Blue Premier members to Individual PCP, Medical Group or Medical Group PCP and that Individual PCP, Medical Group or Medical Group PCP shall accept all patients enrolling as Blue Essentials, Blue Advantage HMO or Blue Premier members.

Key Points:

- 90 days prior written notice to close practice is required.
- PCP may only close his/her practice to Blue Essentials, Blue Advantage HMO or Blue Premier members if he/she closes his/her practice to all other patients, or if he/she has at least 300 or more Blue Essentials, Blue Advantage HMO or Blue Premier members.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Panel Closure, cont’d
Thus, if the PCP has less than 300 Blue Essentials, Blue Advantage HMO or Blue Premier members, he/she can only close his/her practice to those Blue Essentials, Blue Advantage HMO or Blue Premier members if he/she closes his/her practice to BCBSTX PPO members AND patients from all other health plans.

If a Blue Essentials, Blue Advantage HMO or Blue Premier PCP has at least 300 Blue Essentials or Blue Advantage HMO members, he/she can close his/her practice for Blue Essentials, Blue Advantage HMO or Blue Premier members and leave his/her practice open for all other patients.

Allergy Services - Important Notice Regarding Allergy Services
Blue Cross and Blue Shield of Texas (BCBSTX) expects all providers to follow Current Procedural Terminology (CPT®) manual specifications for the diagnosis, treatment, and management of all services provided, including all supporting and supplemental guides, and that care is reflected by appropriate documentation in the patient’s medical record.

Specific to allergy testing and treatment services (CPT codes 95004 and 95165), please see below:

- CPT code 95004 is defined as “Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests.” (2013, AMA CPT Professional Edition, p. 529) A physician may delegate, with appropriate supervision, the performance of certain procedures and/or components of procedures for efficient use of physician, staff and patient time. Although a physician may delegate certain physical tasks of allergy testing, the definition of 95004 requires the physician to personally review the allergy test results -- either by inspecting the test site(s) on the patient or analyzing a detailed report of the objective test findings. Then, using this personal test result review and taking the patient’s full medical history (including known allergies and occurrence of allergy-related conditions such as rhinitis and sinusitis) into account, the physician decides if the patient is an appropriate candidate for immunotherapy.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Allergy Services - Important Notice Regarding Allergy Services, cont’d

This personal review and determination should be documented in the patient’s medical record to fully satisfy the “report” requirements of this code.

CPT Code 95165 is defined as “Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).” (2013, AMA CPT Professional Edition, p. 531) A physician may delegate, with appropriate supervision, the performance of certain procedures and/or components of procedures for efficient use of physician, staff and patient time. A physician may delegate the tasks of physical antigen/serum mixing, patient instruction for serum injection, and providing serum vials to the patient. However, after determining a patient is an appropriate candidate for immunotherapy (as described above) the physician must personally select the allergens for immunotherapy, determine the specific concentrations and dilutions, and order the specific shot schedule. The physicians must also personally monitor the patient’s progress throughout the course of immunotherapy and not merely delegate that responsibility to ancillary (third party vendor) personnel.

In addition, BCBSTX limits payment for allergy serum to the amount actually provided to the patient on a given date of service but no more than 60 units per two (2) months. This policy does not apply to rapid desensitization.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Outpatient Lab Guidelines Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Quest Diagnostics, Inc. is the exclusive outpatient clinical reference laboratory provider for Blue Essentials, Blue Advantage HMO and Blue Premier 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’ Physician Representative or call 866-MY-QUEST.

Only the lab services/tests indicated on the Reimbursable Lab Services List (located on the next pages of this manual) will be reimbursed on a fee-for-service basis if performed in the physician or professional provider’s, office for Blue Essentials*, Blue Advantage HMO and Blue Premier members.

**Please Note:** All other lab services must be referred to the Blue Essentials, Blue Advantage HMO and Blue Premier exclusive lab provider - Quest Diagnostics, Inc.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Outpatient Lab Guidelines

Roles and Responsibilities

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Outpatient Reimbursable Lab Services List

Only the lab services/tests indicated on the Reimbursable Lab Services List (located below) will be reimbursed on a fee-for-service basis if performed in the physician or professional provider’s, office for Blue Essentials, Blue Advantage HMO and Blue Premier members.

<table>
<thead>
<tr>
<th>Outpatient Reimbursable Lab Services List</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection of venous blood by venipuncture</td>
<td>36415</td>
</tr>
<tr>
<td>Collection of capillary blood specimen</td>
<td>36416</td>
</tr>
<tr>
<td>Venipuncture, cutdown; under age 1 year</td>
<td>36420</td>
</tr>
<tr>
<td>Basic metabolic panel</td>
<td>80048</td>
</tr>
<tr>
<td>Electrolyte panel</td>
<td>80051</td>
</tr>
<tr>
<td>Tacrolimos</td>
<td>80197</td>
</tr>
<tr>
<td>Urinalysis, dipstick</td>
<td>81000</td>
</tr>
<tr>
<td>Urinalysis, with microscopy, automated</td>
<td>81001</td>
</tr>
<tr>
<td>Urinalysis, without microscopy, non-automated</td>
<td>81002</td>
</tr>
<tr>
<td>Urinalysis, without microscopy, automated</td>
<td>81003</td>
</tr>
<tr>
<td>Urinalysis, bacteriuria screen, except by culture or dipstick</td>
<td>81007</td>
</tr>
<tr>
<td>Pregnancy test, urine</td>
<td>81025</td>
</tr>
<tr>
<td>Stool for occult blood (Hemoccult)</td>
<td>82270</td>
</tr>
<tr>
<td>Stool for occult blood (Hemoccult single)</td>
<td>82272</td>
</tr>
<tr>
<td>Stool for occult blood</td>
<td>82274</td>
</tr>
<tr>
<td>Glucose, blood, quantitative</td>
<td>82947</td>
</tr>
<tr>
<td>Glucose, blood, reagent strip</td>
<td>82948</td>
</tr>
<tr>
<td>Glucose, blood, monitoring device</td>
<td>82962</td>
</tr>
<tr>
<td>H. pylori; breath test analysis for urease activity, drug administration</td>
<td>83014</td>
</tr>
<tr>
<td>Bleeding time</td>
<td>85002</td>
</tr>
<tr>
<td>Blood count, differential WBC, automated</td>
<td>85004</td>
</tr>
<tr>
<td>Blood count, smear, WBC differential, manual</td>
<td>85007</td>
</tr>
</tbody>
</table>

Note: All other outpatient (physician or professional provider’s office) clinical reference lab services not listed above must be referred to the Blue Essentials, Blue Advantage HMO and Blue Premier exclusive provider – Quest Diagnostics, Inc.
Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

### Reimbursable Lab Services List

#### Outpatient Reimbursable Lab Services List, cont’d

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood count, smear, no WBC differential</td>
<td>85008</td>
</tr>
<tr>
<td>Blood count, spun microhematocrit</td>
<td>85013</td>
</tr>
<tr>
<td>Blood count, hematocrit</td>
<td>85014</td>
</tr>
<tr>
<td>Blood count, hemoglobin</td>
<td>85018</td>
</tr>
<tr>
<td>Blood count, complete CBC &amp; WBC differential, automated</td>
<td>85025</td>
</tr>
<tr>
<td>Blood count, complete CBC, automated</td>
<td>85027</td>
</tr>
<tr>
<td>Blood count, manual, each</td>
<td>85032</td>
</tr>
<tr>
<td>Blood count, platelet, automated</td>
<td>85049</td>
</tr>
<tr>
<td>Coagulation time, Lee and White</td>
<td>85345</td>
</tr>
<tr>
<td>Coagulation time, Lee and White, activated</td>
<td>85347</td>
</tr>
<tr>
<td>Coagulation time, Lee and White, other methods</td>
<td>85348</td>
</tr>
<tr>
<td>Prothrombin time</td>
<td>85610</td>
</tr>
<tr>
<td>Heterophile antibody screen for mononucleosis</td>
<td>86308</td>
</tr>
<tr>
<td>Skin test, coccidioidmycosis</td>
<td>86490</td>
</tr>
<tr>
<td>Skin test, histoplasmosis</td>
<td>86510</td>
</tr>
<tr>
<td>Skin test, tuberculosis, intradermal</td>
<td>86580</td>
</tr>
<tr>
<td>Wet mount for infectious agents</td>
<td>87210</td>
</tr>
<tr>
<td>Tissue exam by KOH slide</td>
<td>87220</td>
</tr>
<tr>
<td>Influenza</td>
<td>87400</td>
</tr>
<tr>
<td>Strep screening, qualitative</td>
<td>87430</td>
</tr>
<tr>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique</td>
<td>87480</td>
</tr>
<tr>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis; direct probe technique</td>
<td>87510</td>
</tr>
<tr>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis; direct probe technique</td>
<td>87660</td>
</tr>
<tr>
<td>Influenza, rapid</td>
<td>87804</td>
</tr>
<tr>
<td>RV, rapid</td>
<td>87807</td>
</tr>
</tbody>
</table>

**Note:** All other outpatient (physician or professional provider’s office) clinical reference lab services not listed above must be referred to the Blue Essentials, Blue Advantage HMO and Blue Premier exclusive provider – Quest Diagnostics, Inc.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Outpatient Lab Guidelines
Roles and Responsibilities

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

<table>
<thead>
<tr>
<th>Outpatient Reimbursable Lab Services List, cont’d</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strep screening, rapid</td>
<td>87880</td>
</tr>
<tr>
<td>Culture of oocyte(s)/embryo(s), less than 4 days</td>
<td>89250</td>
</tr>
<tr>
<td>Assisted embryo hatching, microtechniques (any method)</td>
<td>89253</td>
</tr>
<tr>
<td>Oocyte identification from follicular fluid</td>
<td>89254</td>
</tr>
<tr>
<td>Preparation of embryo for transfer (any method)</td>
<td>89255</td>
</tr>
<tr>
<td>Sperm identification from aspiration (other than seminal fluid)</td>
<td>89257</td>
</tr>
<tr>
<td>Sperm isolation, complex prep (e.g., Percoll gradient, albumin gradient) for insemination or diagnostic with semen analysis</td>
<td>89261</td>
</tr>
<tr>
<td>Sperm identification from testis tissue, fresh or cryopreserved</td>
<td>89264</td>
</tr>
<tr>
<td>Insemination of oocytes</td>
<td>89268</td>
</tr>
<tr>
<td>Extended culture of oocyte(s)/embryo(s), 4-7 days</td>
<td>89272</td>
</tr>
<tr>
<td>Assisted oocyte fertilization, microtechnique: less than or equal to 10 oocytes</td>
<td>89280</td>
</tr>
<tr>
<td>Assisted oocyte fertilization, microtechnique: greater than 10 oocytes</td>
<td>89281</td>
</tr>
<tr>
<td>Sperm evaluation, cervical mucus penetration test</td>
<td>89330</td>
</tr>
<tr>
<td>Thawing of cryopreserved; embryo(s)</td>
<td>89352</td>
</tr>
</tbody>
</table>

Note: All other outpatient (physician or professional provider’s office) clinical reference lab services not listed above must be referred to the Blue Essentials, Blue Advantage HMO and Blue Premier exclusive provider – Quest Diagnostics, Inc.

Outpatient Radiology Services Overview
BCBSTX is contracted with eviCore healthCare (eviCore) to manage preauthorizations for specific outpatient diagnostic imaging services for certain Blue Essentials, Blue Advantage HMO and Blue Premier members.

Providers should refer to the BCBSTX provider website for the current Preauthorizations/Notifications/Referral Requirements Lists and/or by verifying eligibility and benefits to determine if preauthorization through eviCore is required.
Blue Essentials, Blue Advantage HMO, and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO, and Blue Premier. These network specific requirements will be noted with the network name.

Outpatient Radiology Services Overview, cont'

If radiology services cannot be performed in the physicians or professional provider’s office, the physician or professional provider must send the Blue Essentials, Blue Advantage HMO or Blue Premier member to a contracted imaging location within the member’s Provider Network. This includes testing as well as the reading of test.

To locate an Blue Essentials, Blue Advantage HMO or Blue Premier network facility, visit the Online Provider Directory through the Blue Cross and Blue Shield of Texas (BCBSTX) website at https://public.hcsc.net/providerfinder/search.do?corpEntCd=TX1

How to Join Blue Essentials, Blue Advantage HMO and Blue Premier Provider Networks

FOUR EASY STEPS!

➢ Step 1* – Get set up.

Before you can join the BCBSTX Provider Networks – Blue Essentials, Blue Advantage HMO and Blue Premier – you will need to be assigned a BCBSTX Provider Record ID. To get set up, go to “Request a BCBSTX Provider Record ID”

*Note: You must obtain a BCBSTX Provider Record ID before moving to Step 2.

➢ Step 2** – Get contracted.

Complete the BCBSTX Contract/Agreement/Network Participation Online Request Form.

**Note to Primary Care Physicians/Providers: Prior to moving on to Step 3

– Get credentialed, you must have an open office location where a site visit can be performed.

➢ Step 3 – Get credentialed.

Once you have been notified by BCBSTX of your assigned Provider Record ID, you will need to be credentialed. Go first to one of the following (whichever applies):

- the Credentialing Process for Office Based Physicians and Professional Providers,
- or,
- the Credentialing Process for Hospital or Facility Based Providers
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO, and Blue Premier. These network specific requirements will be noted with the network name.

How to Join Blue Essentials, Blue Advantage HMO and Blue Premier Provider Networks, cont’d

➢ Step 4 – Get connected.

Participation in all electronic options available to BCBSTX physicians and professional providers is strongly encouraged.

Electronic data interchange (EDI) transactions help to ensure timeliness, accuracy, and security of claims-related information.

EDI transactions include:
- Availity® (for electronic claim submission and other functions)
- Electronic Funds Transfer (EFT)
- Electronic Remittance Advice (ERA)
- Electronic Payment Summary (EPS)
- Electronic Refund Management (eRM)

For details on how to sign up for these electronic solutions, visit the Electronic Commerce area on the BCBSTX provider website.

Other Important Information

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

➢ Existing Provider Orientation
➢ Blue Review Newsletters
Please Note: Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

### Step 1: To Request a BCBSTX Provider Record ID

Prior to claim submission, rendering providers must request and obtain a BCBSTX Provider Record ID for claim payment. The Provider Record ID associates the provider’s rendering NPI with their billing NPI and Tax Identification Number.

**Note:** Obtaining a BCBSTX Provider Record ID does not automatically activate the BCBSTX provider networks. Claims will be processed out-of-network until the provider has applied for network participation, been approved and activated in the network.

- If you do not already have a Provider Record ID established with BCBSTX that matches your billing information (Rendering NPI, Billing NPI, and TIN), you will need to complete one of the provider record information packets below (Solo or Group).

- If you need the status of a previously submitted Provider Record ID Information Form Packet or have questions regarding the completion of the Provider Record ID Information Form Packet, you will need to 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.

- Once you have received notice of your established Provider Record ID and would like to be a participating network provider, you will need to continue with **How to Join BCBSTX Provider Networks - Step 2 – Get contracted.**

**Solo Provider Record ID Information Form Packet** should be completed by:

- A provider who will not be employing another professional provider
- A provider who will be using his/her social security number for tax purposes
- A provider whose Tax Identification Number (TIN) is legally filed under the provider’s name
- A provider who is not incorporated
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Step 1:
To Request a BCBSTX Provider Record ID, cont’d

**Group Provider Record ID Information Form Packet** should be completed by:

- A provider who has a practice with more than one professional provider
- A provider whose Federal Tax ID has a corporate legal name
- A provider if the billing entity is incorporated
- An existing group *adding a new provider* only needs to complete & submit the Group Member Information Form on page 3 of the Group Provider Record ID Information Form.

*Note: An existing group does not need to complete & submit the entire packet.*

Forward completed Provider Record Form Packet to:

**Fax to:** 972-996-8445 *(preferred method)*  
**or**  
**Mail to:**  
Blue Cross and Blue Shield of Texas  
Provider Administration  
P.O. Box 650267  
Dallas, TX 75265-0267
Please Note: Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

<table>
<thead>
<tr>
<th>Change in Status or Changes Affecting Your BCBSTX Provider Record ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>You may submit changes directly to BCBSTX by email to bcbstx.com/provider, or go to the Network Participation tab, then scroll down to – Update Your Information and complete/submit the Demographic Change 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 Network Management office.</td>
</tr>
</tbody>
</table>

Please notify us of changes to the following information:

- Name
- Physical address (primary, secondary, tertiary)
- Billing address
- Email address
- Telephone number
- Tax ID or other information
- 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

**Note:** If requesting termination from a Network, please contact your Network Management office. Refer to Section A for phone numbers.

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**

- BCBSTX 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.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Change in Status or Changes Affecting Your BCBSTX Provider Record ID, cont’d

- Retroactive Provider Record ID effective dates will not be established.
- Retroactive network participation effective dates will not be established.
- Keeping BCBSTX informed of any changes you make allows for appropriate claims processing, as well as maintaining the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Directories with current and accurate information.

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.

---

Step 2: Request Contract/Agreement/Network Participation

1. You must first obtain a BCBSTX Provider Record ID before requesting a contract/agreement. To get set up with a Provider Record ID, go to "Request a BCBSTX Provider Record ID".

2. After you have obtained a Provider Record ID – to request a contract/agreement from BCBSTX you will need to complete the "BCBSTX Contract/Agreement/Network Participation Online Request Form".

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

Updated 09-04-2018
Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

### Step 2: Request Contract/Agreement/Network Participation - cont'd

**Additional Forms Required by BCBSTX for Credentialing**

If you are a physician or professional provider that requires one of the following additional forms listed below, you must complete the form(s) and submit with your signed contract signature page(s), via fax or email to your "Network Management Office".

- **APN Supervising Physician and Protocols & Duties Supplemental Questionnaire** - required for APN to provide the name of their Supervising Physician and attest to having protocol/duties.
- **APN Supplemental Questionnaire – Prescribing Authority** – required for an APN who plans to prescribe controlled substances and holds a current DEA.
- **Behavioral Health Form** – required to be submitted to BCBSTX for all Behavioral Health providers.
- **Hospital Coverage Letter** – required to be submitted to BCBSTX for those providers who do not have admitting privileges at a participating network hospital.
- **Ophthalmologist Treatment Expertise** – required for Ophthalmologists to indicate if their practice includes retinal surgery.
- **Optometrist Supplemental Questionnaire – Prescribing Authority** - required for Therapeutic Optometrist and Optometric Glaucoma Specialist who plan to prescribe controlled substances and hold a current DEA.
- **PA Supervising Physician and Protocols & Duties Supplemental Questionnaire** – required for Physician Assistants to provide the name of their Supervising Physician and attest to having protocol/duties.
- **PA Supplemental Questionnaire – Prescribing Authority** - required or a PA who plans to prescribe controlled substances and holds a current DEA.

### Credentialing Process for Office Based Physicians, Professional Providers, Facility or ancillary Providers

Beginning in April 2018, BCBSTX will be utilizing the services of a Centralized Verification Organization (CVO). All new and currently contracted providers with BCBSTX will begin to receive notifications from Aperture®, the CVO that BCBSTX will be using. These notifications are regarding initial credentialing events and information about the new common recredentialing date that will be assigned by Aperture. Please send questions regarding the CVO to BCBSTXCredentialing_CVO@bcbstx.com.
Credentialing Process for Office Based Physicians, Professional Providers, Facility or Ancillary Providers

BCBSTX requires full credentialing of all the following office based physicians, professional providers, facility or ancillary providers for participation in their managed care networks:

- MDs and DOs
- DDSs (oral and maxillofacial surgery)
- Licensed Physical Therapists, Occupational Therapists
- Optometrists, Audiologists, Speech and Language Pathologists
- Behavioral Health Providers
- Physician Assistants, Surgical Assistants, Advanced Practice Nurses, Certified Midwives
- Registered Nurse First Assistants
- Podiatrists
- Chiropractors
- Acupuncturists
- Registered Dieticians

Expedited Credentialing Process

BCBSTX 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
- has submitted a current signed BCBSTX contract/agreement
- completes the CAQH Proview database online application with "global" or "plan specific" authorization to BCBSTX (or if applicable, submits a completed TDI application)
- has a valid license in the state by, and in good standing with the Texas Licensing Boards

** Providers will be notified once the CAQH credentialing applications are 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 a quick 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 BCBSTX for a status update, as credentialing is a very involved process.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Credentialing Process for Office Based Physicians, Professional Providers, Facility or Ancillary Providers

Initial Credentialing and Recredentialing Process
BCBSTX requires physicians and professional providers to use the Council for Affordable Quality Healthcare’s (CAQH®) ProView 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 Proview 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 will be able to utilize CAQH ProView at no cost.

Texas physicians, professional providers, facility or ancillary providers who have a provider type listed in the CAQH Approved Provider Types list on the next page must apply for initial or continuing participation with BCBSTX through CAQH ProView by accessing the CAQH website. Go to Getting Started with CAQH.

CAQH Approved Provider Types
CAQH will only accept providers who have a provider type on their approved provider types list below:

<table>
<thead>
<tr>
<th>CAQH Approved Provider Types</th>
<th>Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Osteopathy (DO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Provider Types</strong></td>
<td>Acupuncturist (ACU), Alcohol/Drug Counselor (ADC), Audiologist (AUD), Biofeedback Technician (BT), Certified Registered Nurse Anesthetist (CRNA), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNs), Clinical Psychologist (CP), Clinical Social Worker (CSW), Dietician (DT), Licensed Practical Nurse (LPN), Marriage/Family Therapist (MFT), Massage Therapist (MT), Naturopath (ND), Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN), Occupational Therapist (OT), Optician (OPT), Optometrist (OD), Pharmacist (PHA), Physical Therapist (PT), Physician Assistant (PA), Professional Counselor (PC), Registered Nurse (RN), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP), Hospitalist (HOS), Advanced Practice Nurse (APN), Anesthesia Assistant (AA), Applied Behavioral Analyst (ABA), Athletic Trainers (AT), Genetic Counselor (GC), Surgical Assistant (SA)</td>
</tr>
<tr>
<td><strong>Allied Provider Types</strong></td>
<td></td>
</tr>
</tbody>
</table>

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

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Exceptions

1. BCBSTX's requirement of use of CAQH ProView does not apply to physicians and professional providers participating through delegated credentialing agreements/contracts or are solely practicing in a hospital based environment.

2. Texas physicians and professional providers who do not have a provider type listed in the above CAQH Approved Provider Types list must go to the TDI website to access and complete a Texas Standardized Credentialing Application, and fax or mail to BCBSTX the completed application along with the required supporting documents referenced below:
   - State medical license(s)
   - Drug Enforcement Administration (DEA) Certificate
   - Malpractice insurance face sheet
   - Summary of any pending or settled malpractice case(s) – if within 10 or less years old
   - Curriculum Vitae
   - Signed Attestation (page 18 of online application – print & sign)
   - Written Protocol (Nurse Practitioners only)

Additional Forms Required by BCBSTX for Credentialing

If you are a physician or professional provider that requires one of the additional forms, you must complete the form(s) and forward to BCBSTX.

Refer to the list of forms in this manual or under the "Credentialing Process for Office Based Physicians or Professional Providers" on the Network Participation - How to Join page on the provider website.
Getting Started with CAQH

Activating your Registration with CAQH ProView

Blue Essentials, Blue Advantage HMO and Blue Premier participating physicians, professional providers, facility and ancillary providers must have a CAQH Provider ID to register and begin the credentialing process.

First Time Users: (If you are not registered with CAQH)

1. Once you obtain a BCBSTX Provider Record ID and submit a current signed BCBSTX contract/agreement to BCBSTX, BCBSTX will add your name to its roster with CAQH.

2. CAQH will then mail you access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to CAQH ProView via the Internet.

3. When you receive your CAQH Provider ID:
   a. go to the [CAQH website](#) to register, or
   b. physicians, professional providers, facility or ancillary providers that do not have internet access may submit their application via fax to CAQH by first contacting the CAQH Help Desk at 888-599-1771.

4. After successfully authenticating key information you will be able to create your own user name and unique password to begin using the CAQH ProView database.

*Note: Registration and completion of the online application are free.*
Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

Existing Users

1. **If you have already registered your CAQH Provider ID** and completed your CAQH ProView online application through your participation with another health plan, log into CAQH ProView and add BCBSTX as one of the health plans that can access your information.

2. To authorize BCBSTX to access your data – follow these four (4) easy steps:
   - Go to [https://www.caqh.org/solutions/caqh-proview/](https://www.caqh.org/solutions/caqh-proview/). Select "Providers" under CAQH ProView Login, then enter your username and password.
   - Click the Authorize tab *(located under the CAQH logo)*
   - Scroll down, locate BCBSTX, and check the box beside BCBSTX, or you may select “global authorization”
   - Click Save to submit your changes

Completing the Application Process

The CAQH ProView standardized application is a single, standard online form that meets the needs of all participating health care organizations. When completing the application, you will need to indicate which participating health plans and health care organizations you authorize to access your application data. All provider data you submit through the ProView service is maintained by CAQH in a secure, state-of-the-art data center.

**Materials to refer to that will be helpful while completing the CAQH ProView online application:**

- Previously completed credentialing application
- List of previous and current practice locations
- Various identification numbers (UPIN, NPI, Medicare and Medicaid, etc.)
- State medical license(s)
- Drug Enforcement Administration (DEA) Certificate
- IRS Form W-9(s)
- Malpractice insurance face sheet
- Summary of any pending or settled malpractice cases – *if within 10 or less years old*
- Curriculum Vitae

*Note: When you are ready to begin entering your data, log into CAQH ProView with your user name and password.*
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Getting Started with CAQH, cont’d
After completing the online credentialing application, you will also be asked to:

➢ **Authorize access to your information** – Check the box beside BCBSTX, or you may select “global authorization”.
➢ **Verify your data entry/Attest** – Review the summary of your data for accuracy and completeness, and make any necessary changes.
➢ **Submit supporting documents** – Fax the applicable documents required below to complete your application to CAQH at **866-293-0414**:
  - State medical license(s)
  - Drug Enforcement Administration (DEA) Certificate
  - Malpractice insurance face sheet
  - Summary of any pending or settled malpractice case(s) – if within 10 or less years old
  - Curriculum Vitae
  - Signed Attestation (page 18 of online application – print & sign)
  - Written Protocol (Nurse Practitioners Only)

If you have any questions on accessing the CAQH ProView, you may contact the CAQH Help Desk at **888-599-1771** for

**Note:** BCBSTX may contact you to supplement, clarify or confirm certain responses on your application. Therefore, you may be required to submit additional documentation in some situations, in addition to the information you submit through CAQH ProView.

**Additional Forms Required by BCBSTX for Credentialing**
If you are a physician or professional provider that requires one of the additional forms, you must complete the form(s) and forward to BCBSTX.

Refer to the list of forms in this manual or under the "Credentialing Process for Office Based Physicians or Professional Providers" on the Network Participation - How to Join page on the provider website.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Getting Started with CAQH, cont’d
Visit the CAQH website for more information about the CAQH ProView and the application process. Or you can view the CAQH Provider Credentialing Application now.

Additional Resources
CAQH Contact Information
Help Desk: 888-599-1771
Online Application System
Help Desk Email
Address: caqh.uphelp@acsgs.com
Help Desk Hours: 6 am – 8 pm, CT, Monday – Thursday
6 am – 6 pm, CT, Friday
Fax Supporting Documentation to: 866-293-0414

Frequently Asked Questions
CAQH Provider and Practice Administrator Quick Reference Guide

*The Council for Affordable Quality Healthcare, Inc. (CAQH) is a not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs.

CAQH is solely responsible for its products and services, including ProView.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Hospitals or Facilities Credentialing Process

Blue Cross and Blue Shield of Texas Hospital/Facility Credentialing Program consists of a fully accredited NCQA MCO Standard based program that requires the credentialing of hospital/facility 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 applications 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 an 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.
Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Hospitals or Facilities

Hospitals or Facilities that wish to participate or continue participation in the HMO credentialing/recredentialing process should complete the Facility Credentialing and Recredentialing application. The Hospital/Facility Network Representative/Specialist can provide you with this application. The HMO credentialing/recredentialing process includes the review of each Hospital/Facility provider’s application or recredentialing packet. Participation in the HMO networks requires a Hospital/Facility 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.

Hospitals or Facilities

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.
Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

### Hospitals or Facilities

#### Initial/Continued Participation Decision Review Process

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

- Submit a written appeal and any supporting documentation or pertinent facts that the Hospital/Facility 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 Consultant/Representative in your service area.

Once the review request has been received by BCBSTX, your Network Management 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 Network Management Representative/Specialist to secure the documentation and submit to the FPCC. *Note: The FPCC recommendation is intended to assist the Medical Director in the Hospital/Facility 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 Network Management Representative/Specialist will forward the final determination in writing to the Hospital/Facility 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.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

Credentialing Process for Hospital or Facility Based Providers

For your convenience, we have outlined the steps necessary for facility based providers to submit a request for contracting/participating in **Blue Essentials, Blue Advantage HMO or Blue**

- Eligible specialties include, but are not limited to, Anesthesia, Emergency Medicine, Radiology, Pathology, Neonatology, and Hospitalist.
- The facility based application *only* applies to providers who practice *exclusively* in a facility, *either a hospital OR a freestanding outpatient facility*.

Hospital or Facility Based Providers must have the following:

- Hospital or Ambulatory Surgical Center privileges
- Type 1 NPI #
- 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# *(applicable to CRNA providers only)*
- NCCAA certificate (applicable to Anesthesia Assistants providers only)

*Note:* Obtaining a BCBSTX Provider Record ID does not automatically activate the **Blue Essentials, Blue Advantage HMO or Blue Premier networks**. Claims will be processed out-of-network until the provider has applied for network participation, been approved, and activated in the network.
### Credentialing Process for Hospital or Facility-Based Providers, cont’d

<table>
<thead>
<tr>
<th>If provider is ....</th>
<th>THEN ....</th>
</tr>
</thead>
<tbody>
<tr>
<td>with a provider group that is <strong>currently</strong> contracted with <strong>Blue Essentials, Blue Advantage HMO or Blue Premier</strong></td>
<td>If a BCBSTX Provider Record ID is not currently set up for the provider in the group, refer to the <a href="#">Request a BCBSTX Provider Record ID</a> section to obtain a Provider Record ID for each provider billing under Tax Identification Number. Once the provider number is set up, complete a <a href="#">Facility-Based Provider Application</a> and fax completed application to the appropriate Network Management Regional office for processing: <a href="#">View email/fax list to send Facility Based Application</a>.</td>
</tr>
<tr>
<td>a solo practitioner or medical group interested in contracting as a facility based provider with <strong>Blue Essentials, Blue Advantage HMO or Blue Premier</strong></td>
<td>If a BCBSTX Provider Record ID is not currently set up for the Provider(s) and/or Group, refer to the <a href="#">Request a BCBSTX Provider Record ID</a> section to obtain a Provider Record ID for each provider billing under Tax Identification Number. Sign BCBSTX Physician or Medical Group Contract/Agreement. To request contract/agreement to be sent to you, complete the <a href="#">BCBSTX Contract/Agreement Network Participation Online Contract Request Form</a> or contact your Provider Relations Servicing Representative. Complete a <a href="#">Facility-Based Provider Application</a> and fax to application to the appropriate Network Management Regional office for processing: <a href="#">View email/fax list to send Facility Based Application</a>.</td>
</tr>
</tbody>
</table>
Facility Based Provider Application for Network Participation

This application is used for providers who practice exclusively in an inpatient or freestanding facility. Eligible specialties include, but are not limited to, Anesthesia, Emergency Medicine, Radiology, Pathology, Neonatology & Hospitalist. Providers must be a Texas resident and be physically located in Texas.

Please complete all blanks below and include appropriate required attachments as indicated.

NOTE: Incomplete or inaccurate applications will be returned resulting in processing delays.

Refer to BCBSTX.com/provider under "Network Participation" for information on where to forward completed applications.

<table>
<thead>
<tr>
<th>BCBSTX Agreements:</th>
<th>Group agreement(s) on file</th>
<th>Individual Agreement(s) attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Name:</td>
<td></td>
<td>Organizational Type 2 NPI #:</td>
</tr>
<tr>
<td>Provider Name:</td>
<td></td>
<td>Professional Provider Type1 NPI #:</td>
</tr>
<tr>
<td>Degree:</td>
<td></td>
<td>Maiden Name, if applicable:</td>
</tr>
<tr>
<td>Social Security #:</td>
<td>Date of Birth:</td>
<td>Gender: Male Female</td>
</tr>
<tr>
<td>Tax Identification # Used for Billing:</td>
<td>Start Date With Group:</td>
<td></td>
</tr>
<tr>
<td>Practice Location – Physical Address/City/State/Zip/Phone/Fax:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing Address/City/State/Zip:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing Phone #:</td>
<td>Fax #:</td>
<td></td>
</tr>
<tr>
<td>Correspondence Address/City/State/Zip:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Hospital/ASC(s) where services are performed</td>
<td>City</td>
<td>If Available, Facility Type II NPI or Tax ID</td>
</tr>
<tr>
<td>Practicing Specialty:</td>
<td>Board Certified</td>
<td>Board Eligible</td>
</tr>
<tr>
<td>Practicing Sub-Specialty:</td>
<td>Board Certified</td>
<td>Board Eligible</td>
</tr>
<tr>
<td>Texas License Number (if temporary, attach copy):</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Anesthesia Assistants &amp; CRNAs Only – Certificate or AANA# (MUST attach copy of certificate)</td>
<td>Date Certified:</td>
<td></td>
</tr>
<tr>
<td>Does applicant have professional liability insurance limits of at least $200,000/600,000?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is applicant currently in Residency Program?</td>
<td>Yes</td>
<td>Is applicant currently in Fellowship Program?</td>
</tr>
<tr>
<td>Is applicant a Medicare Participant?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Add Provider to: Medicaid STAR STAR Kids CHIP</td>
<td>If yes, please indicate TPI numbers below:</td>
<td></td>
</tr>
<tr>
<td>Group TPI:</td>
<td>Individual TPI:</td>
<td></td>
</tr>
<tr>
<td>Application Submitted By:</td>
<td>Title:</td>
<td>Date:</td>
</tr>
<tr>
<td>Email Address:</td>
<td>Phone #:</td>
<td>Fax #:</td>
</tr>
</tbody>
</table>

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Updated 08-27-2018
Refer to the Facility Based Provider Type Contact List below for location of your Network Consultant/Representative and where to send your Facility based application:

**Email/Fax List to send Facility Based Application**

Please forward your completed Facility Based Application to the email/fax number listed below based on county location color shown on map:

**Provider Relations Southeast – Grey Region on Map**

Phone: 713-663-1149  
Fax: 713-663-1227  
Email: [Provider_Relations_Houston@bcbstx.com](mailto:Provider_Relations_Houston@bcbstx.com)

Servicing Counties: Austin, Brazoria, Brazos, Calhoun, Chambers, Colorado, Fort Bend, Galveston, Grimes, Hardin, Harris, Jackson, Jasper, Jefferson, Lavaca, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Victoria, Walker, Waller, Washington, Wharton

**Provider Relations Southwest – Red Region on Map**

Phone: 361-878-1623  
Fax: 361-852-0624  
Email: [Provider_Relations_South_Texas@bcbstx.com](mailto:Provider_Relations_South_Texas@bcbstx.com)


**Provider Relations North – Purple Region on Map**

Phone: 972-766-8900  
Fax: 972-766-2231  
Email: [Provider_Relations_DFW@bcbstx.com](mailto:Provider_Relations_DFW@bcbstx.com)

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Credentialing Updates

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

CAQH ProView

You will be sent automatic reminders to review and attest to the accuracy of your data. Use CAQH ProView to report any changes to your practice.

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

BCBSTX Provider File Updates:

BCBSTX members rely on the accuracy of the provider information in our online Provider Finder®. This is why it’s very important that you also inform BCBSTX of changes to your practice. If you are a participating provider with BCBSTX, you may request most changes online by using the online Demographic Change Form.
Please Note  
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

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 (4) months.

➢ At the time you are scheduled for recredentialing, BCBSTX will send your name, via its roster, to CAQH to determine if you have already completed the CAQH ProView credentialing process and authorized BCBSTX or selected “global authorization”. If so, BCBSTX will be able to obtain current information from the UPD database and complete the recredentialing process without having to contact you.

➢ If your credentialing application (for recredentialing) is not available to BCBSTX through CAQH because
  1. you have not completed the CAQH ProView 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 ProView via the Internet to complete and submit your application.
  2. 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 license(s)
      • Drug Enforcement Administration (DEA) Certificate
      • Controlled and Dangerous Substances (DPS) 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)

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Please Note
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Recredentialing, cont’d

**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.

**Additional Forms Required by BCBSTX for Recredentialing**
If you are a physician or professional provider that requires one of the additional forms, you must complete the form(s) and forward to BCBSTX.

Refer to the list of forms in this manual or under the "Credentialing Process for Office Based Physicians or Professional Providers" on the Network Participation - How to Join page on the provider website.
Please Note
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Credentialing Frequently Asked Questions & Answers

Q1. Who is CAQH?
CAQH is the Council for Affordable Quality Healthcare, Inc., a not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH’s participating organizations provide health care coverage for more than 500 million Americans.

Q2. What is CAQH ProView?
The CAQH ProView service is the industry standard for collecting provider data used in credentialing and member service resource. A single, standard online form—the CAQH application—is the centerpiece of the CAQH ProView service. Providers in all 50 states and the District of Columbia can enter their information free of charge through an interview-style process. Through its streamlined, electronic data collection process, CAQH ProView is helping to reduce unnecessary paperwork while saving millions of dollars in annual administrative costs for more than 800,000 physicians and other health professionals, as well as more than 550 participating health plans, hospitals, and health care organizations.

Q3. Is there a charge for providers to utilize CAQH? No. Providers may utilize CAQH ProView at no cost.

Q4. Are Accrediting Bodies in support of the CAQH application? Yes. The CAQH application meets the data-collection requirements of URAC, the National Committee for Quality Assurance (NCQA) and the Joint Commission standards. Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, New Jersey, New Mexico, Ohio, Rhode Island, Tennessee, Vermont, and the District of Columbia have adopted the CAQH standard form as their mandated or designated provider credentialing application.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Frequently Asked Questions & Answers, cont’d

Q5. Why did Blue Cross and Blue Shield of Texas (BCBSTX) choose to work with CAQH?

BCBSTX chose to work with CAQH because CAQH ProView is a proven solution for simplifying administrative burdens placed on providers during the credentialing/recredentialing process. The easy-to-use online data collection and application process means less paperwork for BCBSTX providers, with built-in auditing tools to help increase efficiency and maintain data security and integrity. BCBSTX also considered independent user studies further assessing the track-record of CAQH Pro.

Based on figures from a Medical Group Management Association (MGMA) cost analysis, CAQH estimates that CAQH ProView has already eliminated more than 2.4 million legacy-credentialing applications resulting in savings of $95 million per year or more than 3.2 million hours (the equivalent of 1,561 full-time employees) of provider and support staff time required to complete and send redundant application forms.

Q6. Am I required by BCBSTX to utilize CAQH ProView?

Yes. All providers, required to submit a credentialing or recredentialing application, must utilize the CAQH database. Exception: Texas physicians and professional providers who do not have a provider type listed in the “CAQH Approved Provider Types” list below 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 to BCBSTX:

<table>
<thead>
<tr>
<th>CAQH Approved Provider Types</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Provider Types</strong></td>
</tr>
<tr>
<td>Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM) Doctor of Chiropractics (DC), Doctor of Osteopathy (DO)</td>
</tr>
<tr>
<td><strong>Allied Provider Types</strong></td>
</tr>
<tr>
<td>Acupuncturist (ACU), Alcohol/Drug Counselor (ADC), Audiologist(AUD), Biofeedback Technician (BT), Certified Registered Nurse Anesthetist (CRNA), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNS), Clinical Psychologist (CP), Clinical Social Worker (CSW), Dietician (DT), Licensed Practical Nurse (LPN), Marriage/Family Therapist (MFT), Massage Therapist (MT), Naturopath (ND), Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN), Occupational Therapist (OT), Optician (OPT), Optometrist (OD), Pharmacist (PHA), Physical Therapist (PT), Physician Assistant (PA), Professional Counselor (PC), Registered Nurse (RN), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP), Hospitalist (HOS), Advanced Practice Nurse (APN), Anesthesia Assistant (AA), Applied Behavioral Analyst (ABA), Athletic Trainers (AT), Genetic Counselor (GC), Surgical Assistant (SA)</td>
</tr>
</tbody>
</table>
Q7. I have been told I must be “rostered” to input my information into CAQH ProView. What does this mean?

When you apply for network participation, BCBSTX will add you to its roster with CAQH. If you do not have a CAQH ID number, CAQH will send you a registration letter with your ID. If you already have a CAQH ID and your information is complete and current and you have authorized BCBSTX, CAQH will provide your information to BCBSTX.

Q8. When will CAQH send my registration letter after I have been “rostered” by BCBSTX?

CAQH will typically send a registration letter within 24 hours of receiving a provider on a roster.

Q9. I am already a BCBSTX network provider and would like to get my information into CAQH. How do I do this?

If you already have a CAQH ID number, you may update your information at any time. BCBSTX will roster you in advance of your next recredentialing due date. If you do not have a CAQH ID number, CAQH will send you a registration letter with your ID.

Q10. How can I access CAQH ProView?

Once you are rostered by BCBSTX, access and registration instructions will be sent to you from CAQH. You will use a personal ID and password to obtain immediate access to the CAQH ProView via the Internet. You may submit your completed application online and fax supporting documents to a specified toll-free fax number 866-293-0414. If you have any questions on accessing the database, you may contact the CAQH Help Desk at 888-599-1771 for assistance or you may send an email to caqh.updhelp@acsgs.com.

Q11. Is the CAQH ProView applicable in states where there is a state-mandated application?

Yes. In states where legislation has passed mandating the use of a standard credentialing application form, the data collected through CAQH ProView and data collection process will include the data elements and/or form as is required by the state. The system will automatically ask the necessary questions to fulfill the requirements for the state in which the provider's primary office address is located.
Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

**Q12. Will I be required to give BCBSTX information to supplement what I entered in CAQH ProView?**

The primary goal of CAQH ProView is to simplify the administrative process with a robust and streamlined data system. While the CAQH credentialing data set is substantially complete, BCBSTX may need to supplement, clarify, or confirm certain responses in the application with individual physicians and other health care providers on a case-by-case basis. Therefore, you may be required to provide supplemental documentation in some situations, in addition to the information you submit through CAQH ProView.

**Q13. Can I use CAQH ProView to report any changes to my practice, such as address, phone numbers, and new providers?**

BCBSTX has selected CAQH ProView as its data collection source for credentialing and recredentialing applications. We will access CAQH ProView for your data at initial credentialing and during your scheduled recredentialing cycle every third year. You must continue to directly notify BCBSTX of any changes to your practice information or status.

**Q14. How will my confidentiality be maintained within CAQH ProView?**

The confidentiality and security of provider information and the privacy of system users are critical priorities for CAQH. The CAQH ProView design is compliant with laws, rules, and regulations relating to the privacy of individually identifiable health information. In addition, CAQH complies with applicable laws and regulations pertaining to confidentiality and security in development of the database and the data collection process. The CAQH ProView is housed in the U.S. within a secure Network Operations Center. You may contact the CAQH Help Desk with additional questions by calling **888-599-1771** or by email [caqh.updhelp@acsgs.com](mailto:caqh.updhelp@acsgs.com).

**Q15. How often must my information be updated?**

You will be sent automatic reminders to review and attest to the accuracy of your data. You must review and authorize data once every four (4) months. This is easily accomplished through a quick online visit to XAQH ProView [https://proview.caqh.org/Login](https://proview.caqh.org/Login) or by calling the CAQH Help Desk at **888-599-1771** for assistance.
Frequently Asked Questions & Answers, cont’d

Q16. Why do I need to review and attest to my information three (3) times a year?

Because BCBSTX will be using this system for credentialing and recredentialing, it is important that CAQH ProView contains the most accurate and up-to-date information. By reviewing and attesting to your data three (3) times a year, you will enable BCBSTX to obtain current information from CAQH ProView database at the time of recredentialing or database updates, without having to contact you repeatedly. This will help you continue to conform to the requirements of your network contract.

Q17. Can any health plan access my data?

No. You control which health plan(s) have access to your CAQH application information. When completing the application, you will have the option of granting global access to your application data, or you may choose to select which participating health plan(s) and health care organization(s) you want to view your data.

Q18. Who will have access to my data?

Only the health plan(s) that you have authorized can access your application data.

Q19. Do I have to give you my Social Security Number?

Your Social Security Number is required to complete the application and will be used to verify your credentials.

Q20. How do I input my data if I do not have Internet access?

If you do not have Internet access, you may call the CAQH Help Desk at 888-599-1771 and complete the application by telephone. Supporting documents may be faxed toll-free to 866-293-0414.

Q21. Are hearing/sight challenged persons able to use the CAQH database?

Yes. Hearing/sight challenged providers may call the CAQH Help Desk at (888) 599-1771 and complete the application by telephone. Supporting documents may be faxed toll-free to 866-293-0414.
Please Note

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Frequently Asked Questions & Answers, cont’d

Q22. Who do I contact for administrative support if I have questions when utilizing the database?

The CAQH Help Desk provides telephone service Monday through Thursday, from 6 a.m. to 8 p.m., CT, and Friday, from 6 a.m. to 6 p.m., CT, to assist with any questions you may have. You may reach the Help Desk by calling 888-599-1771 or by email at caqh updhelp@acsgs.com.
Please Note
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Medical Advisory Committee
The Medical Advisory Committee conducts regularly scheduled meetings, or as needed, to review the physician, professional provider, facility and ancillary provider applicants for credentialing and recredentialing.

The Committee provides peer recommendations for approval or denial of a physician, professional provider, facility and ancillary provider applicant files, reviews regular reports of Blue Essentials, Blue Advantage HMO, and Blue Premier credentialing activities, and reviews/recommends action to resolve physician, professional provider, facility and ancillary provider appeals. The Committee also reviews and resolves quality of care issues.

The BCBSTX credentialing process includes a review of each physician, professional provider, facility and ancillary 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.

To participate in BCBSTX, physician, professional provider, facility and ancillary providers must have a current Texas license, be in good standing with the licensing board, the Provider Network and its hospital affiliates, and Blue Cross and Blue Shield of Texas, plus meet other credentialing criteria established by BCBSTX.

The standard procedure used in processing a completed physician, professional provider, facility and ancillary provider application includes, but is not limited to, the verification of information regarding education and training, hospital privileges at the primary admitting network facility as indicated by the physician, professional provider, facility and ancillary provider on his/her application or recredentialing package, licensure and malpractice history.

All documentation and signatures must meet time frame criteria (i.e., current dates on DEA, practitioners license, liability insurance face sheet, attestation signature, etc.) that are required by all regulatory and/or accreditation agencies. Physicians, professional providers, facility and ancillary providers who have submitted an application for credentialing/recredentialing have the right to review the information submitted in support of these applications to BCBSTX. The right to review does not include references, recommendations, information that is peer review protected or which the health plan is otherwise prohibited from releasing.
Please Note

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Medical Advisory Committee, cont’d

Physicians, professional providers, facility and ancillary 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 physician, professional provider, facility or ancillary provider applications. Physicians, professional providers, facility or ancillary provider also have the right to correct erroneous information submitted by another party. Physicians, professional providers, facility or ancillary 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. Existing BCBSTX network physicians, professional providers, facility and ancillary providers in recredentialing will be notified only if an adverse decision, such as termination, is made.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Credentialing Review Requests

Who can Request Review?
Any physician, professional provider, facility or ancillary provider may seek a review of a decision related to initial credentialing or recredentialing decision on their continued participation in Blue Essentials, Blue Advantage HMO and/or Blue Premier.

When to Request Review
Requests for review must be submitted in writing within 60 calendar days from the date of the denial/termination letter.

Addressing the Request
Written requests should be addressed to the Medical Director for your area. See addresses at the front of this manual.

What to Include
Requests should include any supporting documentation or facts the physician, professional provider, facility or ancillary provider feels would be beneficial for review.

Process
The following table describes the review process:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The physician, professional provider, facility provider or ancillary provider submits an appeal request to the Medical Director.</td>
</tr>
<tr>
<td>2</td>
<td>The Medical Director reviews appeal request.</td>
</tr>
<tr>
<td>3</td>
<td>The Medical Director presents the physician’s, professional provider’s, facility or ancillary provider’s file and appeal request and supporting documentation for a recommendation to the Medical Advisory Committee. If the Medical Advisory Committee review panel is not able to make a recommendation based on the information provided, then the plan will seek the physician’s, professional provider’s, facility’s or ancillary provider’s consent to extend the review period. The extension will include the time necessary for the Medical Advisory Committee to receive additional information from the physician, professional provider, facility or ancillary provider and will provide the required 30 days notification to members. <strong>Note:</strong> The committee recommendation is intended to assist the Medical Director. The committee’s role is advisory only, and, as such, the recommendation of the committee is not binding.</td>
</tr>
</tbody>
</table>

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Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Process, cont’d
The following table describes the review process, cont’d:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The Medical Director forwards the final determination in writing to the physician, professional provider, facility provider or ancillary provider within 60 days of initial notification to the physician, professional provider, facility provider or ancillary provider or the date of the request for additional information for review.</td>
</tr>
</tbody>
</table>

Physician, Professional Provider, Facility or Ancillary Provider Termination Process

- If the physician, professional provider, facility provider or ancillary provider is being considered for BCBSTX network termination for any of the following reasons, BCBSTX will present the proposal for termination to a BCBSTX Advisory Peer Review Panel (Texas Medical Advisory Committee [TMAC] or Texas Peer Review Committee [TPRC]) along with all available supporting documentation:
  - Non-compliance with credentialing criteria; or
  - Loss, restriction or probation of license; or
  - Government action such as debarment from Medicare and Medicaid; or
  - Cost and utilization issues; or
  - Quality of care issues.

- A BCBSTX medical director may immediately terminate a physician, professional provider, facility provider or ancillary provider’s network participation if he/she determines that:
  - Continued network participation by the physician, professional provider, facility provider or ancillary provider poses imminent harm to patient health; or
  - An action by a state licensing board effectively impairs the physician, professional provider, facility provider or ancillary provider of the reason(s) for termination. Physician, professional provider, facility provider or ancillary provider’s ability to provide services; or
  - There has been fraud or malfeasance.

- If network termination is initiated based on advice from TMAC or TPRC, a written explanation shall be provided to the physician, professional provider, facility provider or ancillary provider of the reason(s) for termination.
Physician, Professional Provider, Facility or Ancillary Provider Termination Process, cont’d

- A physician, professional provider, facility provider or ancillary provider may, within thirty (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.

- BCBSTX will not notify Members of the provider’s termination until thirty (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, BCBSTX may notify Members immediately.

- Within sixty (60) days following receipt of the physician’s, professional provider’s, facility provider’s or ancillary provider’s written request for review, BCBSTX will notify the provider of its review decision.

- Upon request, BCBSTX will provide the physician, professional provider, facility provider or ancillary provider with a copy of the recommendation of the Advisory Peer Review Panel. The Panel’s recommendation must be considered by BCBSTX but is non-binding.

Please Note

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**Please Note**
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**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.
5. **Claims** must be billed on CMS-1500
6. Physicians working at the center must be credentialed by BCBSTX
7. Providers must have a specialty in Emergency Medicine, Family Practice, Internal Medicine, OBGyn or Pediatrics and must meet the BCBSTX network credentialing criteria.

**Urgent Care Center Services Billed Using CPT Code S9088**
BCBSTX considers 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.
Please Note

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Room Rate

Numerous HMO group and member benefits only provide for a semi-private room. The room rate on file and loaded in the claims payment system is used to determine the patient’s liability for claims when the difference between the private room and the semi-private room is the patient’s responsibility. Therefore, the accurate information that you provide, assists in adjudicating the claim with the correct patient liability.

For updates, please notify Blue Cross and Blue Shield of Texas (BCBSTX) at least 30 days prior to the planned effective date. The Room Rate Updates Notification form is located on the BCBSTX Provider website at www.bcbstx.com/provider. To locate, click on the Education & Reference tab. Also, a sample of this form is located on the next page. The completed form can be faxed to the applicable fax number listed on the form or mail to your Network Management Representative.

It is also important to notify BCBSTX if your facility becomes private room only or a wing of the hospital is private room only.

Once the information is received, BCBSTX will update their records with the effective date being later of:

- The actual effective date of the new rate, or
- Date received by BCBSTX.
- If you have any questions or concerns, please contact your Network Management Representative.

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Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Roles and Responsibilities, cont’d

Room Rate Update Notification Form

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

<table>
<thead>
<tr>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider City:</td>
</tr>
<tr>
<td>National Provider Identifier (NPI) Number(s):</td>
</tr>
<tr>
<td>Private Room Rate:</td>
</tr>
<tr>
<td>Semi-Private Room Rate:</td>
</tr>
<tr>
<td>Psychiatric Wing (Y/N)?</td>
</tr>
<tr>
<td>Private Room Only (Y/N)?</td>
</tr>
<tr>
<td>Private Room Only Wings?</td>
</tr>
<tr>
<td>Effective Date of Change:</td>
</tr>
<tr>
<td>Information Provided By And Phone #:</td>
</tr>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Date:</td>
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</table>

FAX Completed Form to Your Network Management Office:

<table>
<thead>
<tr>
<th>Network Management Offices:</th>
<th>Fax #:</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 and West Texas</td>
<td>972-766-2231</td>
</tr>
<tr>
<td>Houston, Beaumont, Victoria, Lufkin &amp; Nacogdoches</td>
<td>713-354-1227</td>
</tr>
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</table>

If you have any questions, please contact your Network Management Office.
Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Blue Advantage HMO Only
Routine Vision Benefits
Blue Advantage HMO members will receive their annual eye exam and eyewear from Davis Vision providers through 12/31/16. Effective 1/1/17, Blue Advantage HMO members 19 and younger will have routine vision care through EyeMed Vision Care. For all other Blue Advantage HMO members, providers for vision care could vary. Contact the customer service number on the member’s ID card to verify the member’s vision benefits.

Blue Advantage HMO members will continue to use Blue Advantage HMO contracted providers for medical eye care. Please include all appropriate diagnosis codes on your claims to accurately represent the services provided.

To request network participation with Davis Vision, please call Davis Vision at 800-584-3140 or contact Davis Vision at www.davisvision.com.


Blue Advantage HMO Only
Dental Coverage and Services
Blue Advantage HMO members under age 20 have an included dental benefit. For more information, refer to the member’s Blue Advantage HMO ID card.
Please Note
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Affordable Care Act
The new health care law offers a host of coverage changes and opportunities which began in 2014. Blue Cross and Blue Shield of Texas (BCBSTX) is committed to implementing coverage changes to comply with ACA requirements and to better meet the needs and expectations of you and your patients.

Refer to the ACA section under Standards and Requirements menu on bcbstx.com/provider for additional information.

Risk Adjustment
Risk Adjustment 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
Please Note

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Risk Adjustment

- Submission of risk adjustable diagnoses to CMS 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.

Premium Payments for Individual Plans

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

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

BCBSTX may choose, in its sole discretion, to allow payments from not-for-profit foundations provided those foundations meet nondiscrimination requirement 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.