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Blue Choice PPO Provider Manual - Provider Roles and Responsibilities

Role and Responsibilities

Health care provider's roles and responsibilities will differ among the various specialties; however, certain responsibilities will be shared by all Blue Cross and Blue Shield of Texas (BCBSTX) health care providers.

Role of the Primary Care Physician

Each Primary Care Physician (PCP) is responsible for making his/her own arrangements for patient coverage when out of town or unavailable.

A physician who has contracted with BCBSTX as a PCP will agree to render to the BCBSTX member primary, preventive, acute and chronic health care management and:

- Provide the same level of care to BCBSTX 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. 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 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.
- Be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to subscribers. Such requests must be responded to within one hour.
- Meet required Patient Appointment Access Standards (for more detail refer to Section J - Quality Improvement Program)
Role of the Primary Care Physician, cont.

- Keep a central record of the subscriber’s health and health care that is complete and accurate.
- When applicable, complete inpatient admissions and select outpatient prior authorizations online or by calling the Utilization Management Department at 1-800-441-9188. 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 requesting prior authorizations.
- Provide copies of X-ray and laboratory results and other health records to specialty care health care providers to enhance continuity of care and to preclude duplication of diagnostic procedures.
- Provide BCBSTX, upon request and at no charge, copies of medical records when requested by BCBSTX for the purpose of claims review, quality improvement, risk adjustment or auditing.
- Enter into the subscriber’s health record all reports received from Specialty Care health care providers.
- Assume the responsibility for arranging and prior authorizing hospital admissions in which he/she is the admitting physician or delegate this responsibility to the admitting Specialty Care health care providers or professional provider.
- Assume the responsibility for care management as soon as possible after receiving information that a Blue Choice PPO member has been hospitalized in the local area on an emergency basis.
- Coordinate inpatient care with the Specialty Care health care providers so that unnecessary visits by both providers are avoided.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the BCBSTX patient in accordance with Texas Department of Health standards.
- 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.
Blue Choice PPO Provider Manual - 
Provider Roles and Responsibilities

Role of the Primary Care Physician, cont.

- Only bill members for copayments, cost share (coinsurance) and deductibles, where applicable. The PCP will not offer to waive or accept lower copayments, cost share or otherwise provide financial incentives to members, including lower rates in lieu of the subscriber’s insurance coverage.

- 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.

The role of the Primary Care Physician for Blue Choice PPO network is described below:

<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Specialty Care Health Care Provider</th>
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<tr>
<td>• Primary role is to provide or direct all medical care for the Blue Choice PPO member.</td>
<td>• Provides specialized care and/or services for the Blue Choice PPO members.</td>
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<td>• For the Blue Choice PPO members – to receive in-network benefits, the member must receive care from a participating Blue Choice PPO Primary Care or Specialty Care health care provider.</td>
<td>• For Blue Choice PPO members – to receive in-network benefits, the member must receive care from a participating Blue Choice PPO Specialty Care health care provider.</td>
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<td>• For information on behavioral health services, refer to the “Behavioral Health” section of this manual.</td>
<td>• Blue Choice PPO members have direct access to Blue Choice PPO Specialty Care health care providers - No Referral Required.</td>
</tr>
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<td>• Obtain referral prior authorization for out-of-network referrals by calling 1-800-441-9188.</td>
<td>• OBGyns 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.</td>
</tr>
<tr>
<td>• Important Note: Out-of-network health care providers are providers who do not participate in the Blue Choice PPO network.</td>
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Updated 12-26-2019
Blue Choice PPO members have **direct access** to all participating Blue Choice PPO primary care and specialty care health care providers.

**No referral is required.**

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**Role of the Specialty Care Health Care Providers**

A Blue Choice PPO participating health care provider who provides services as a specialty care health care provider is expected to:

- Provide the same level of care to Blue Choice PPO 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. Specialty care health care providers will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient’s need. Acceptable mechanisms may include: an answering service that offers to call or page the 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 J: Quality Improvement Program**):
  - Meet required Patient Appointment Access Standards (**for more detail refer to Section J - Quality Improvement Program**).
  - Keep a central record of the subscriber’s health and health care that is complete and accurate.
  - Provide inpatient consultation within 24 hours of receipt of the request. Emergency consultation to be provided as soon as possible.
  - Provide BCBSTX, upon request and at no charge, copies of medical records when requested by Blue Choice PPO for the purpose of claims review, quality improvement, risk adjustment or auditing.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities

Role of the Specialty Care Health Care Providers, cont.

- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the Blue Choice PPO patient in accordance with Texas Department of Health standards.
- 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 health care providers agree to file claims with BCBSTX even if the health care provider believes or knows there is a third-party liability.
- Only bill for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty Care health care provider will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to member’s, including lower rates in lieu of the subscriber’s insurance coverage.
- 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.

Role of the OBGyn

A female Blue Choice PPO member has direct access to all Blue Choice PPO participating Blue Choice PPO participating primary care physicians and specialty care physicians including an OBGyn – no referral is required.

The access to health care services of an obstetrician or gynecologist, includes, but is not limited to:

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions
Role of the OBGyn, cont.

- Diagnosis, treatment, and access to a specialist for any disease or condition within the scope of the designated professional practice of a credentialed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts.

- When abnormalities are discovered, the Blue Choice PPO participating OBGyn has the ability to directly manage and coordinate a woman’s care for obstetrical and gynecological conditions.

- Also, any services rendered outside of the OBGyn’s office, such as lab and ultrasound, must be performed by facilities contracted for the Blue Choice PPO network.

- **Note:** Non-prescription contraceptives and associated care vary by employer benefit program. To verify coverage for this type of service, call BCBSTX Provider Customer Service at 1-800-451-0287.

Notification for Obstetrical and Newborn Care

After the first prenatal visit, the Blue Choice PPO participating physician’s office should provide notification of the Blue Choice PPO member’s obstetrical care to BCBSTX. OB ultrasounds may be performed in the physician’s office and do not require prior authorization.

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

**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.
**Notification for Obstetrical and Newborn Care, cont.**

**FIRST OBSTETRIC VISIT**
Please refer to the current edition of the Current Procedural Terminology (CPT®) in the Maternity Care and Delivery section for guidelines for billing. If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, see the antepartum and postpartum care codes **59425-59426 and 59430**. For one to three care visits, refer to the appropriate Evaluation and Management code(s).

**Predetermination Requests**
A predetermination of benefits is a voluntary 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 prior authorization process.*

Predetermination of benefits request can be submitted to BCBSTX by mail or fax using the Predetermination Request Form, available in the Education and Reference Center/Forms section of our website at [www.bcbstx.com/provider/forms/index.html](http://www.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

Fax to: **1-888-579-7935**

For Status call: **1-800-451-0287**
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities

**Predetermination Requests, cont.**

For out-of-area BCBS members, an online “router” tool is available to help you locate Plan-specific precertification/preauthorization and medical policy information. Look for the Medical Policy and Precertification/Preauthorization for Out-of-Area members link under the Standards & Requirements tab on the BCBSTX provider website at https://www.bcbstx.com/provider/standards/mppc.html. When you enter the three-character prefix from the member’s ID card, you will be redirected to the appropriate BCBS Plan’s website for more information.

*For Federal Employee Program members,* a Predetermination of Benefits review is *required* for the following services: Outpatient/Inpatient surgery for Morbid Obesity; Outpatient/Inpatient surgical correction of Congenital Anomalies; and Outpatient/Inpatient Oral/Maxillofacial surgical procedures needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

Please note that 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, or that an RQI number has been issued is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the subscriber’s eligibility and the terms of the subscriber’s certificate of coverage applicable on the date services were rendered.
Blue Choice PPO participating health care providers are urged to contact the Blue Choice PPO Provider Customer Service area when there is an administrative question, problem, complaint or claims issue at 1-800-451-0287.

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

- Call **1-800-441-9188**
- Hours: 6 a.m. – 6 p.m., CST, M-F and non-legal holidays and 9 a.m. to 12 noon CST, 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 Choice PPO participating health care provider may contact the Texas Department of Insurance (TDI) to obtain information on companies, coverage, rights or complaints at **1-800-252-3439** or the health care provider may write the Texas Department of Insurance (TDI) at the following address:

Texas Department of Insurance  
P.O. Box 149091  
Austin, TX 78714-9091  
[tdi.state.tx.us](http://tdi.state.tx.us)

For all other inquiries, please contact your Network Management office.
Reasons a health care provider may terminate his/her professional relationship with a member/patient include, but are not limited to, the following:

- Fraudulent use of services or benefits;
- Threats of physical harm to a health care 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 health care provider, if such refusal is incompatible with the continuation of the health care provider member/patient relationship (health care 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 health care provider member/patient relationship.

Reasons a health care provider may not terminate his/her professional relationship with a member/patient include, but are not limited to, the following:

- Member’s/patient’s medical condition (i.e., catastrophic disease or disabilities);
- Amount, variety, or cost of covered health services required by the member/patient; patterns of over utilization, either known or experienced;
- Patterns of high utilization, either known or experienced.
When the BCBSTX Network Management department receives preliminary information indicating a contracted health care provider has deemed it necessary to terminate a relationship with a member/patient, the BCBSTX Network Management department will:

1. Review with the health care 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/patient.
   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/patient. Exception: 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 health care provider to the subscriber/patient is required and must include:
      • Name of member/patient – if it involves a family, list all patients 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/patient must be sent simultaneously to the applicable BCBSTX Network Management Representative (or Director), via email, or by fax or regular mail to the appropriate BCBSTX Network Management office.

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

Note: A sample health care provider letter is available on further on in this manual.

e. The health care provider must continue to provide medical services for the member/patient until the termination date stated in the provider’s letter.
When the BCBSTX Network Management department receives a copy of the Health Care Provider’s letter to the member/patient, the BCBSTX Network Management department will:

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

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

**If the Health Care Provider Agrees to Continue to See the member/Patient:**

If the member/patient appeals the termination directly with the health care provider and the health care provider agrees to continue to see the member/patient, the health care provider must immediately:

- Notify BCBSTX in writing of his/her approval to reinstate the member/patient to his/her panel (so that BCBSTX Provider Customer Service can re-assign the PCP to the subscriber/patient if the member/patient requests such, and/or to prevent any future miscommunication).
Sample of Letter from Health Care Provider to Member

Current Date

Patient Name*
Address
City/State/Zip

Phone Number
BCBSTX Member Number
Group Number

Dear Patient:

I will no longer be providing services to you as a ____ (insert Primary Care Physician 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.** 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 provider. The BCBSTX Customer Service Department is available to assist you in selecting another physician 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 Provider Relations Department

*If the provider is terminating the relationship with a family, all member names should be listed in this area.
Blue Choice PPO Provider Manual -
Provider Roles and Responsibilities

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 the Affordable Care Act (ACA) requirements and to better meet the needs and expectations of you and your patients.

Refer to the ACA section under the 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

**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.

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