# Blue Choice PPO<sup>SM</sup> Provider Manual - Provider Roles and Responsibilities

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

*Note:* The term “subscriber” is used herein as that term is defined in the provider’s network participation agreement.

### Using the ID Card

Each **Blue Choice PPO** 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 or Ancillary Providers should check to make sure the current group number is included in the subscriber’s records.

To assist in ensuring that your office always has the most current information for your **Blue Choice PPO** subscribers, it is recommended that you copy the subscriber’s ID card (front and back) for your files at each visit.

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

- The subscriber’s unique identification number
- The employer group number through which coverage is obtained
- The current coverage date
- Plan number
- Applicable coinsurance, copayment, deductible and/or cost-sharing to Covered Services

### Definitions:

- **Coinsurance** means, if applicable, the specified percentage of the Allowable Amount for a Covered Service that is payable by the subscriber. The 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 or professional provider, facility or ancillary provider, pharmacy, etc., by or on behalf of a subscriber in connection with the services rendered.

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

- **Covered Services** means those health services specified and defined as Covered Services under the terms of a subscriber’s health plan.
- **Deductible** means, if applicable, the specified annual amount of payment for certain Covered Services, expressed in dollars that the subscriber is required to pay before the subscriber can receive any benefits for the Covered Services to which the Deductible applies.

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

**Note:** The subscriber is not allowed to let any other person use his/her Blue Choice PPO ID card for any purpose.

Other Information

Much of the information you will need is printed on the face and reverse side of your patient’s ID card. Please note the copayment amount is usually indicated on the face of the ID card. Please call BCBSTX Provider Customer Service at 800-451-0287 to verify a subscriber’s applicable coinsurance, copayment, and/or deductible or if you have questions.

Department of Insurance (DOI) Requirements

TDI requires carriers to identify subscribers who are subject to the requirements of prompt pay legislation. ID cards that reflect an indicator “TDI” signify subscribers who are subject to the requirements of prompt pay legislation.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

Blue Choice PPO

**Subscriber Access**

Blue Choice PPO subscribers have direct access to all participating primary care physicians as well as to all participating specialty care physicians or providers. A Blue Choice PPO subscriber does not need to obtain a referral from their primary care physician in order to seek services/care from a participating specialty care physician or provider.

Blue Choice PPO subscribers receive in-network benefits by selecting services/care from participating Blue Choice PPO physicians and professional providers.

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

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**Blue Choice PPO ID Card Sample**

The subscriber’s identification card (ID card) provides information concerning eligibility and contract benefits and is essential for successful claims filing. The alpha prefix is a critical part of the ID number and identifies what group benefits apply or which Blue Cross and Blue Shield plan are responsible for payment. When submitting a claim, the alpha prefix should always be entered as it appears on the ID card. If the correct alpha prefix is not provided, the claim may be unnecessarily delayed or denied.
Blue Choice PPO – Sample Group ID Card

The three (3) alpha characters displayed in the red font will identify the plan/network that a subscriber is enrolled in. **BCA** = Blue Choice PPO Network

Blue Choice PPO With Health Advocacy Solutions (HAS) Plans Sample ID Cards

PPO groups may elect to include Health Advocacy Solutions (HAS) which allows them to take a tailored approach to enriching a member’s health care journey and reducing health care costs. There are 3 HAS plans: Primary, Advanced and Premier. HAS ID cards will indicate on the back of the card:

**Providers: This is a (Primary, Advanced or Premier) package.**
EPO is a network only PPO plan utilizing the Blue Choice PPO network in Texas. This plan provides no coverage for out-of-network services except for medical emergencies or accidents. To receive benefits, subscribers must seek care from network physicians, professional providers, facility and ancillary providers. Primary Care Physician (PCP) selection is not required.

BlueEdge Products

Highlights of the BlueEdge product portfolio:
- The BlueEdge products utilize the Blue Choice PPO network of physicians and professional providers.
- To receive the highest level of benefits, BlueEdge subscribers must receive medical care from network physicians, professional providers, facility and ancillary providers.
- No referrals are required.
- Primary Care Physician (PCP) selection is not required.
- Network physicians and professional providers may only bill BlueEdge subscribers for cost share (coinsurance) and deductibles, where applicable. There are no copayments within the benefit plan.

- A Health Care Account (HCA) is established for each employee enrolled in BlueEdge:
  - The HCA is a specific dollar amount per year for initial health care costs, for example, $750 for an individual and $1500 for a family.
  - First dollars spent are paid from the HCA and applied toward the deductible.
  - Covered services are paid from the HCA until the balance is spent.
  - BlueEdge benefits are applied once the HCA is depleted and the self-pay requirement is satisfied, which equals the deductible.

- A Health Savings Account (HSA) can be funded by an employer, employee or both:
  - Amounts paid for PPO-eligible expenses are applied to meeting the deductible.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

BlueEdge Products, cont’d

- If the subscriber elects, claims are paid by BCBSTX using available HSA account balance until the account is depleted.
- The subscriber may also access their available funds by use of a debit card or checkbook issued by the HSA administrator.

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

The Provider Claim Summary (PCS) will notify you of any patient responsibility. Following receipt of the PCS, the subscriber may be billed for any deductible and coinsurance amount.
Subscriber Eligibility Questions

Should a question arise regarding eligibility of a subscriber for services covered under BCBSTX (e.g., does not have an ID card at time of service), the BCBSTX participating physician, professional provider, facility or ancillary provider may contact BCBSTX Provider Customer Service to check benefits, eligibility and verification by calling the appropriate number listed below. When the subscriber does not present an ID card, a copy of the enrollment confirmation letter may be accepted. BCBSTX also recommends that the subscriber’s identification is verified with a photo ID and that a copy is retained for his/her file.

BCBSTX Provider Customer Service

**Blue Choice PPO, BlueEdge, EPO, and Indemnity**
800-451-0287

**Federal Employee Program — FEP (all areas)**
800-442-4607

**Out-of-State Blues Plan Subscriber**
800-676-BLUE (2583)

*(You must have the alpha prefix from the subscriber’s ID card to utilize this service.)*

Eligibility Statement

BCBSTX complies with the Eligibility Statement Legislation. For additional information on this legislation, please refer to the Texas Department of Insurance (TDI) website at [www.tdi.texas.gov](http://www.tdi.texas.gov).

Premium Payments for Individual Plan

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

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

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

Verification
Under the Prompt Pay Legislation, physicians, professional providers, facility or ancillary providers of services 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 BCBSTX Provider Customer Service at 800-451-0287 and select the prompt for verification.

Note: Please be advised that verification is not applicable for all enrollees or physicians, professional providers, facility or ancillary 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. BCBSTX will respond to the physician’s, professional provider’s, facility or ancillary provider’s request with one of the following letters within the required time frames:

- Request for Additional Information
- Verification Notice
- Declination Notice

Delegated Entity Responsible for Claim Payment
Requests for verification of services will be issued by BCBSTX only if the claim processing will be performed by BCBSTX. If your request is for a service covered under a capitated independent physician association (IPA), medical group or other delegated entity responsible for claim payment, please make your request for verification directly to the appropriate IPA or entity.
Required Elements to Initiate a Verification

The 13 required elements a network physician, professional provider, facility or ancillary provider needs to supply to initiate a verification are as follows:

1) patient name
2) patient ID number
3) patient date of birth
4) name of enrollee or subscriber
5) patient relationship to enrollee or subscriber
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 a place of service is other than physician’s, professional provider’s, facility or ancillary provider’s office or physician’s, professional provider’s, facility or ancillary provider’s 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 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 physician, professional provider, facility or ancillary provider providing the proposed services
13) Physician’s or professional provider’s National Provider Identifier (NPI) number

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

For additional information, refer to Sections C and E of this provider manual.
Declination

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

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

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

A declination is simply a decision that a guarantee cannot be issued in advance, not a determination that a claim will not be paid. Therefore, if a declination is given, physicians, professional providers, facility or ancillary providers cannot bill the subscriber at the time of service except for the applicable copayments, deductibles or coinsurance amounts.
Additional Fees Charged By Participating Physicians and Participating Professional Providers Beyond Copayments and Coinsurance

- **Blue Choice PPO** discourages the practice of participating physicians, professional providers, facility or ancillary providers charging subscribers additional fees beyond required copayments and coinsurance.

- **Blue Choice PPO** participating physician, professional provider, facility or ancillary provider agreements require physicians, professional providers, facilities and ancillary providers to treat subscribers in the same manner as all other patients. These subscribers should be treated in accordance with the same standards, and within the same time availability as such services are provided to other patients, and without regard to the degree or frequency of utilization of such services.

- Notwithstanding the above, if a participating 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 Choice PPO** subscriber 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 subscriber for the service. Non-covered services include personal choice services such as cosmetic surgery for which the subscriber agrees in advance and in writing to pay. Any such additional fee must be voluntary for subscribers.

  **Note:** Services for which **Blue Choice PPO** denies payment based on bundling or other claim edits **cannot** be billed to the subscriber even if the subscriber 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 Choice PPO** claims edits.

- A participating physician, professional provider, facility or ancillary provider cannot require **Blue Choice PPO** subscribers to pay any type of “access fee” as a prerequisite to receiving services that are covered under subscriber benefit plans.

- **Blue Choice PPO** subscribers 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.
Physicians, professional providers, facility and ancillary providers roles and responsibilities will differ among the various specialties; however, certain responsibilities will be shared by all BCBSTX physicians, professional providers, facility and ancillary 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 subscriber 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 G - Quality Improvement Program)
Role of the Primary Care Physician, cont’d

- 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 preauthorizations through the iExchange System or by calling the Utilization Management Department at **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 the iExchange System for preauthorizations.
- Provide copies of X-ray and laboratory results and other health records to specialty care physicians, professional providers, facility or ancillary 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 physicians, professional providers, facility or ancillary 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, professional providers, facility or ancillary providers or professional provider.
- Assume the responsibility for care management as soon as possible after receiving information that a Blue Choice PPO subscriber has been hospitalized in the local area on an emergency basis.
- Coordinate inpatient care with the Specialty Care physician, professional providers, facility or ancillary 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.
### Role of the Primary Care Physician, cont’d

- Only bill subscribers 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 subscribers, 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:

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<td><strong>Specialty Care Physician, Professional Provider, Facility or Ancillary Provider</strong></td>
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<td>• Primary role is to provide or direct all medical care for the <strong>Blue Choice PPO</strong> subscriber.</td>
<td>• Provides specialized care and/or services for the <strong>Blue Choice PPO</strong> subscriber.</td>
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<td>• <strong>For the Blue Choice PPO</strong> subscribers – to receive in-network benefits, the subscriber must receive care from a participating <strong>Blue Choice PPO Primary Care or Specialty Care</strong> physician, professional provider, facility or ancillary provider.</td>
<td>• <strong>For Blue Choice PPO</strong> subscribers – to receive in-network benefits, the subscriber must receive care from a participating <strong>Blue Choice PPO Specialty Care</strong> physician, professional provider, facility or ancillary provider.</td>
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<td>• For information on behavioral health services, refer to the “Behavioral Health” section of this manual.</td>
<td>• <strong>Blue Choice PPO</strong> subscribers have direct access to <strong>Blue Choice PPO</strong> Specialty Care physicians, facility or ancillary providers - <strong>No Referral Required</strong>.</td>
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<td>• Obtain referral authorization for out-of-network referrals by calling <strong>800-441-9188</strong>.</td>
<td>• <strong>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.</strong></td>
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<td>• <strong>Important Note:</strong> Out-of-network physicians, professional providers, facility or ancillary providers are providers who do not participate in the <strong>Blue Choice PPO</strong> network.</td>
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Referrals to Specialty Care Physicians, Professional Providers, and Facility and Ancillary Providers

Blue Choice PPO subscribers have direct access to all participating Blue Choice PPO primary care and specialty care physicians or facility and ancillary providers.

No referral is required.
Role of the Specialty Care Physician or Professional Provider and Facility and Ancillary Providers

A Blue Choice PPO participating physician, professional provider, facility or ancillary provider who provides services as a specialty care physician, professional provider, facility or ancillary 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 physicians, professional providers, or facility and ancillary 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 G: Quality Improvement Program):
  - Meet required Patient Appointment Access Standards (for more detail refer to Section G - Quality Improvement Program).
  - Keep a central record of the subscriber’s health and health care that is complete and accurate.
Role of the Specialty Care Physician or Professional Provider and Facility and Ancillary Providers, cont’d

- 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.
- 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 physicians, professional providers, facility or ancillary providers agree to file claims with BCBSTX even if the physician, professional provider, facility or ancillary provider believes or knows there is a third-party liability.
- Only bill for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty Care physician, professional provider, facility or ancillary provider will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to subscriber’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 subscriber has direct access to all 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
- 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 **800-451-0287**.
Blue Choice PPO Provider Manual -
Provider Roles and Responsibilities, cont’d

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 subscriber’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.

FIRST OBSTETRIC VISIT

Please refer to the current edition of the Current Procedural Terminology 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 preauthorization process.

Predetermination of benefits requests can be submitted electronically to BCBSTX through iExchange®, our online, benefit preauthorization and predetermination of benefits tool.

If you need to submit a paper predetermination of benefits request, you must include the Predetermination Request Form, available in the Education and Reference Center/Forms section of our website at bcbstx.com/provider/forms/index.html.

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

For Urgent Requests Only – Fax to: 888-579-7935
For Status call: 800-451-0287

For out-of-area BCBS subscribers, 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 subscribers link under the Standards & Requirements tab on the BCBSTX provider website at https://www.bcbstx.com/provider/standards/mppc.html. When you enter the Alpha Prefix from the subscriber’s ID card, you will be redirected to the appropriate BCBS Plan’s website for more information.

*For Federal Employee Program subscribers, 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.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

**Predetermination Requests, cont’d**

**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.

**Physician, Professional Provider, Facility or Ancillary Provider Complaint Procedure**

**Blue Choice PPO** participating physicians, professional providers, facility or ancillary 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 **800-451-0287**.

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

- Call **800-441-9188**
- 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 Choice PPO** participating physician, professional provider, facility or ancillary 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, TX 78714-9091  
FAX: (512) 475-1771  
tdi.state.tx.us

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

- Fraudulent use of services or benefits;
- Threats of physical harm to a physician, professional provider, facility or ancillary provider or office staff;
- Non-payment of required copayment for services rendered or applicable coinsurance and/or deductible;
- Evidence of receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or necessary;
- Refusal to accept a treatment or procedure recommended by the physician, professional provider, facility or ancillary provider, if such refusal is incompatible with the continuation of the physician, professional provider, facility or ancillary provider subscriber/patient 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 subscriber/patient relationship.

Reasons a physician, professional provider, facility or ancillary provider may not terminate his/her professional relationship with a subscriber/patient include, but are not limited to, the following:

- Subscriber’s/patient’s medical condition (i.e., catastrophic disease or disabilities);
- Amount, variety, or cost of covered health services required by the subscriber/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 physician, professional provider, facility or ancillary provider has deemed it necessary to terminate a relationship with a subscriber/patient, the BCBSTX Network Management department will:

1. 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 subscriber/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 subscriber/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 physician, professional provider, facility or ancillary provider to the subscriber/patient is required and must include:
      - Name of subscriber/patient – if it involves a family, list all patients affected;
      - Subscriber 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 subscriber/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 physician, professional provider, facility or ancillary provider letter is available on further on in this manual.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

Procedures, cont’d

e. The physician, professional provider, facility or ancillary provider must continue to provide medical services for the subscriber/patient until the termination date stated in the provider’s letter.

When the BCBSTX Network Management department, receives a copy of the Physician, Professional Provider, Facility or Ancillary Provider’s letter to the subscriber/patient, the BCBSTX 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’s, professional provider’s, facility’s or ancillary provider’s letter to the applicable BCBSTX Customer Service area and they will:

   • Send a letter to the subscriber/patient, 30 days prior to the termination date, which will include a new designated PCP or outline steps for the subscriber/patient 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 Subscriber/Patient:

If the subscriber/patient 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 subscriber/patient, the physician, professional provider, facility or ancillary provider must immediately:

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

Current Date

Patient Name*
Address
City/State/Zip

Phone Number
BCBSTX Subscriber 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 subscriber identification card.

Sincerely,

John Doe, M.D.

cc: BCBSTX Provider Relations Department

*If the provider is terminating the relationship with a family, all subscriber names should be listed in this area.
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. 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.
Laboratory Services – Quest Diagnostics, Inc.

Quest Diagnostics, Inc. is the preferred statewide outpatient clinical reference laboratory provider for Blue Choice PPO subscribers. 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 or call 888-277-8772.

- Convenient patient access to over 220 patient service locations.

- 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 set up an account, contact your Quest Diagnostics’ Representative or call 866-MY-QUEST.

To locate other participating labs in the Blue Choice PPO network, visit the Online Provider Directory through the BCBSTX website:

https://www.bcbstx.com/find-a-doctor-or-hospital
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

Radiology Services Overview

BCBSTX is contracted with AIM Specialty Health®, (AIM) to manage a statewide Radiology Quality Initiative (RQI) as well as eviCore healthCare(eviCore) for certain outpatient diagnostic imaging services for Blue Choice PPO subscribers.

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 whether preauthorization through eviCore or an RQI is required through AIM for each Blue Choice PPO member.

For AIM, clinical guidelines can be accessed through AIM’s interactive website at aimspecialtyhealth.com. The guidelines are consistent with the clinical appropriateness criteria developed by the American College of Radiology. This program helps promote:

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

Compliance with obtaining the RQI is required for the outpatient non-emergency diagnostic imaging services listed below when performed in a physician’s, professional provider’s, facility or ancillary provider’s office, outpatient department of a hospital or freestanding imaging center. Ordering physicians (PCPs or Specialists), professional providers, facility or ancillary providers must contact AIM to obtain an RQI for the following services:

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

How to obtain an RQI from AIM is explained in the Quick Reference Guide located further in this section. Ordering physicians (PCPs or Specialists), professional providers, facility or ancillary provider’s must write the RQI on the requisition for the imaging study. Issuance of an RQI is not a guarantee of payment. Payment is subject to eligibility and contract benefits.

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or 23-hour observation are excluded from this requirement.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

For routine radiology services not part of the RQI:
If these services cannot be performed in the physician’s, professional provider’s, facility or ancillary provider’s office, the physician, professional provider, facility or ancillary provider must send the Blue Choice PPO subscriber to one of the contracted network imaging locations in the BCBSTX network. To locate a BCBSTX network facility, visit the Online Provider Directory through the BCBSTX website at: Find a Doctor or Hospital - https://www.bcbstx.com/find-a-doctor-or-hospital

Note: The Physician’s Guide for Radiology Services is located on further in this section.

Provider Transparency and AIM’s OptiNet® Assessment Tool
To help physicians, professional providers, facility and ancillary providers support better-informed decisions about care and services for BCBSTX subscribers, BCBSTX is gathering data about the imaging capabilities of all contracted providers who perform certain diagnostic imaging services. Through AIM’s OptiNet® online assessment tool, we are collecting data including training, imaging equipment, capacity, access and compliance with industry standards such as those established by The Joint Commission (formerly JCAHO) and the American College of Radiology (ACR).

Advanced Diagnostic Imaging
BCBSTX is collecting data on the following advanced diagnostic imaging services:
- Computed Tomography (CT/CTA)
- Magnetic Resonance Imaging (MRI/MRA)
- Nuclear Cardiology
- Positron Emission Tomography (PET)

Upon the completion of the assessment, responses are evaluated and a score for each registered modality (represented by a letter grade) is assigned to the facility based on the following scale:

A = 88 – 100 points
B = 76 – 87 points
C = less than 76 points

Information regarding imaging capabilities and cost values for facilities are available to ordering/referring physicians, professional providers, facility and ancillary providers who submit a request for an advanced diagnostic imaging service online or via telephone. The OptiNet assessment tool will display cost using the National Consumer Cost Tool® (NCCT®) methodology based on the allowed amount of paid claims from the previous calendar year for both facility and professional claims.
Ordering/referring physicians or professional providers have access to the NCCT cost data for each type of advanced imaging service.

Ordering physicians or professional providers can choose a facility from AIM’s online directory based on the modality score, using the National Consumer Cost Tool® (NCCT®) methodology, for transparency purposes for a procedure (based on facility and professional related costs of previously billed services), and distance from the ordering physician’s or professional provider's office. All facilities, including those that are already ACR or Joint Commission accredited, need to complete their data to have their site included in AIM’s online directory. This table is only available in the provider selection portion of the RQI process. In some instances, (i.e., not enough data) cost information will not be available. When this occurs, a dash will be displayed in the “$” column.

As an ordering physician or professional provider, when you submit your high-tech radiology order through the AIM Specialty Health℠ ProviderPortal℠, you will experience a revision to the initial imaging provider suggestion display. The initial suggestions will only include imaging sites that have an “A” score. **Please note:** As an ordering physician or professional provider, you will still be able to search for additional servicing providers in your network.

If you are a servicing/imaging provider and would like to view your completed assessment and/or cost information, please log on to aimspecialtyhealth.com/goweb. Only those providers who have completed their OptiNet assessment will be able to view their cost information for advanced diagnostic imaging services online once they have been scored. Your participation in this online assessment is critical to help support BCBSTX’s quality initiative.

If you are not currently registered for AIM’s ProviderPortal℠, you will need to register online at aimspecialtyhealth.com/goweb.
Low-Tech Imaging

BCBSTX collects information on the capabilities of all Blue Choice PPO contracted providers who provide the technical component of the following low-tech imaging services:

- Ultrasound
- X-ray
- Echocardiography
- Mammography

Upon the completion of the assessment, responses are evaluated and a score for each registered modality (represented by a letter grade) is assigned to the facility based on the following scale:

- A = 88 – 100 points
- B = 76 – 87 points
- C = less than 76 points

Scores and modality cost information will not be made available to ordering physicians and professional providers for low-tech services. A modality score will not be generated for mammography. At this time, this information is strictly informational only for the servicing/imaging provider.

Your participation in this online assessment is critical to help support BCBSTX’s quality initiative.

If you are not currently registered for AIM’s Provider PortalSM, you will need to register online at aimspecialtyhealth.com/goweb.

Important Note

The RQI program does not apply to Medicare primary members with a BCBSTX Medicare supplement. Medicare primary members with BCBSTX commercial Blue Choice PPO coverage are included in the program.

Note: For BlueCard subscribers, please contact Customer Service utilizing the phone number on the back of the subscriber’s ID card to determine if the RQI program applies.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

Physician’s Guide for Radiology Services

RQI Program
Blue Cross and Blue Shield of Texas has implemented a Radiology Quality Initiative (RQI) program through AIM for certain Blue Choice PPO subscribers. The RQI program is designed to promote the most appropriate and efficient use of outpatient high tech diagnostic imaging services.

Note: For BCBSTX and BlueCard members, please contact Customer Service utilizing the phone number on the back of the subscriber’s ID card to determine if the RQI program applies.

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

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

How to Obtain an RQI from AIM

Telephone Requests: Call AIM toll-free at 800-859-5299, Mon – Fri, 6 am - 6 pm CT, and Saturday, Sunday and Legal Holidays, 9 am - 12:00 noon CT.

Web/Internet Requests: Access AIM’s website to set up a login and password for Internet-based RQI requests and other helpful tools at aimspecialtyhealth.com.

Fax Requests: Fax option is available only for physicians or professional providers who are submitting clinical.
FAX to AIM: 800-610-0050
Physician’s Guide for Radiology Services, cont’d

AIM will require the following information for every request. Please have the subscriber’s chart or office notes available.

- Subscriber’s name and date of birth
- Insurance information, such as subscriber’s name, BCBSTX ID number, group number, etc.
- Ordering physician’s, professional provider’s, facility or ancillary provider’s name, address and telephone number
- Name of imaging facility (where the procedure will be performed)
- Type of service and/or CPT code
- Reason (indication) for the imaging procedure and/or ICD-10 CM diagnosis code
- Results of pertinent previous studies (labs, x-rays, etc.) and treatments, including their duration
- Subscriber’s symptoms

1. AIM will use clinical criteria to either immediately issue an RQI or forward the case to a nurse or physician for review.
   a. A physician reviewer may contact the ordering physician, professional provider, facility or ancillary provider to discuss the case in greater detail within two (2) business days of receipt of the request.
   b. Ordering physicians (PCPs or Specialists) and professional providers, facility or ancillary providers may also contact AIM’s physician reviewer at any time during the RQI process.

2. AIM will provide the ordering physician, professional provider, facility or ancillary provider with an RQI, which will be valid for 30 days from the date issued.

3. The ordering physician, professional provider, facility or ancillary provider must write the RQI on the requisition for the imaging study.

4. Issuance of an RQI is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of a subscriber’s health benefit plan.

5. Imaging services will be directed to the most cost-effective outpatient providers to maximize subscribers’ insurance benefits.
Physician’s Guide for Radiology Services, cont’d

How to Access AIM’s OptiNet® Assessment Tool

Through AIM’s OptiNet® online assessment tool, we are collecting data including training, imaging equipment, capacity, access and compliance with industry standards such as those established by The Joint Commission (formerly JCAHO) and the American College of Radiology (ACR). Your participation in this online assessment is critical to help support BCBSTX’s quality initiative.

If you are not currently registered for AIM’s ProviderPortal℠, you will need to register online at aimspecialtyhealth.com/goweb.
The BlueCard Program links participating health care physicians, professional providers, facility and ancillary providers and the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. The program ensures that subscribers can obtain health care services while traveling or living in another Blue Plan’s area. With BlueCard, they receive all the same benefits of their contracting Blue Cross and Blue Shield Plans, and access to BlueCard health care physicians, professional providers, facility and ancillary providers and savings.

Physicians, professional providers, facility and ancillary providers and Hospitals in Texas submit claims for subscribers from other Blue Plans electronically. When a paper claim is submitted, use the following address:

**Blue Cross and Blue Shield of Texas**  
P.O. Box 660044  
Dallas, TX 75266-0044

The BlueCard Program includes both indemnity and PPO health care benefits.

Additionally, the program offers subscribers access to international hospital coverage.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

**Why is BlueCard Important to Physicians or Professional Providers?**

Physicians, professional providers and facility and ancillary providers save significant time and money through efficient and timely payment for services rendered. Savings are passed on to physicians, professional providers through reduced administrative costs for claims processing.

**Look for the BlueCard PPO Logo**

The alpha prefix, at the beginning of the subscriber’s ID number, is the key element used to identify the subscriber’s Blue Plan and correctly route out-of-area claims.

**Here’s How BlueCard PPO Works**

- When a subscriber is outside his or her Blue Cross and Blue Shield Plan area and needs health care, he or she calls BlueCard Access at **800-810-BLUE (2583)** for information on the nearest Blue Cross and Blue Shield health care physicians and professional providers and facilities. BlueCard physicians or professional providers in the area where the subscriber is traveling or living are available through this number.

- The subscriber presents his or her ID card and the physician or professional provider verifies his or her subscribership and coverage with the subscriber’s Blue Plan by calling BlueCard Eligibility at **800-676-BLUE (2583)**.

- After the subscriber receives care, the physician or professional provider files the claim with BCBSTX. The subscriber is only responsible for any non-covered services, deductible, copayment and coinsurance amounts.

- BCBSTX electronically routes the claim to the subscriber’s Blue Cross and Blue Shield Plan for processing. The subscriber’s contract benefits apply.

- The subscriber’s Blue Cross and Blue Shield Plan send the subscriber a detailed Explanation of Benefits report, while BCBSTX reimburses the physician or professional provider.

*A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association*
Here’s how BlueCard PPO Works, cont’d

- Once the subscriber receives care, submit the claim electronically. If you need assistance with electronic claims, call the Availity Health Information Network at 877-334-8446 or 972-766-5480 (Dallas area). If you submit the claim by mail, use the following address:

  Blue Cross and Blue Shield of Texas
  Claims Division
  P.O. Box 660044
  Dallas, TX 75266-0044

- Make sure you include the subscriber’s correct alpha prefix as it appears on the subscriber’s ID card.

- When we (BCBSTX) receive the claim, it is electronically routed to the subscriber’s Blue Cross and Blue Shield Plan. The subscriber’s Plan then processes the claim and approves payment, and we (BCBSTX) pay you according to our contract.

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How to Use the BlueCard 800 # Network

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<tr>
<th>Step</th>
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<tr>
<td>1</td>
<td>Have the subscriber’s ID number, including the alpha prefix, ready before calling.</td>
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| 2    | Call 800-676-BLUE (2583). The 800 number gives you direct access to information on:  
  ● Eligibility and coverage  
  ● Dependents  
  ● Deductibles  
  ● Copayments  
  ● Coinsurance  
  ● Benefit maximums  
  ● Other patient information |
| 3    | You will be asked to voice the subscriber’s three (3) digit alpha prefix. Make sure you voice it exactly as it appears on the ID card. The alpha prefix is the “key” to the BlueCard Program. |
FOUR EASY STEPS!

➢ Step 1* – Get set up.

Before you can join the BCBSTX Provider Networks – Blue Choice PPO – 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: 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

➢ 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
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:
- Residency must be completed prior to requesting a provider record ID and/or contract.
- Obtaining a BCBSTX Provider Record ID does not automatically activate the BlueChoice PPO network. 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
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

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**Change in Status or Changes Affecting Your BCBSTX Provider Record ID**

You may submit changes directly to BCBSTX by email to bcbstx.com/provider. 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. 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

*Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d*
Change in Status or Changes Affecting Your BCBSTX Provider Record ID - cont’d

**Note:** If requesting termination from a Network, please contact your Network Management office. Go to Section A for a list of the Network Management offices and telephone 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 ID.

**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.

- 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 Choice PPO Provider Directory with current and accurate information.

For 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.

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**Request Contract/Agreement/Network Participation**

- 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”.

- 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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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.
- **Optometrist Supplemental Questionnaire – Prescribing Authority** - required for Therapeutic Optometrist and Optometric Glaucoma Specialist who plan to prescribe controlled substances and hold a current DEA.
- **Ophthalmologist Treatment Expertise** – required for Ophthalmologists to indicate if their practice includes retinal surgery.
- **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 for a PA who plans to prescribe controlled substances and holds a current DEA.

Forward completed application packet to BCBSTX:

**Fax to:** 972-996-8230 (preferred method) or

**Mail to:**
Blue Cross and Blue Shield of Texas
Attn: Provider Administration
P.O. Box 65067
Dallas, TX 75265-0267

BCBSTX requires full credentialing of all the following office-based physicians and professional 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
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

Credentialing Process for Office-Based Physicians or Professional Providers, cont'

- 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

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.

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.
Initial Credentialing and Recredentialing Process
BCBSTX require physicians and professional providers to use the Council for Affordable Quality Healthcare's (CAQH®) ProView for initial credentialing and recredentialing. CAQH ProView, a free online service, allows physicians and professional providers to fill out one application to meet the credentialing data needs of multiple organizations. This solution helps to ensure the accuracy and integrity of our provider database.

Texas physicians and professional providers who have a provider type listed in the CAQH Approved Provider Types list below must apply for initial or continuing participation with BCBSTX through the ProView database 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>Standard Provider Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD),</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Osteopathy</td>
</tr>
<tr>
<td>(DO)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allied Provider Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncturist (ACU), Alcohol/Drug Counselor (ADC), Audiologist (AUD), Biofeedback</td>
</tr>
<tr>
<td>Technician (BT), Certified Registered Nurse Anesthetist (CRNA), Christian Science</td>
</tr>
<tr>
<td>Practitioner (CSP), Clinical Nurse Specialist (CNS), Clinical Psychologist (CP),</td>
</tr>
<tr>
<td>Clinical Social Worker (CSW), Dietician (DT), Licensed Practical Nurse (LPN), Marriage/</td>
</tr>
<tr>
<td>Family Therapist (MFT), Massage Therapist (MT), Naturopath (ND), Neuropsychologist (NEU)</td>
</tr>
<tr>
<td>Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN),</td>
</tr>
<tr>
<td>Occupational Therapist (OT), Optician (OPT), Optometrist (OD), Pharmacist (PHA),</td>
</tr>
<tr>
<td>Physical Therapist (PT), Physician Assistant (PA), Professional Counselor (PC),</td>
</tr>
<tr>
<td>Registered Nurse (RN), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT)</td>
</tr>
<tr>
<td>Speech Pathologist (SLP), Hospitalist (HOS), Advanced Practice Nurse (APN), Anesthesia</td>
</tr>
<tr>
<td>Assistant (AA), Applied Behavioral Analyst (ABA), Athletic Trainers (AT), Genetic</td>
</tr>
<tr>
<td>Counselor (GC), Surgical Assistant (SA)</td>
</tr>
</tbody>
</table>
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

Exceptions:

1. Providers who have a Provider Type listed in the CAQH Approved Provider Types list above: Go to the next step below – “Activating Your ProView Registration with CAQH”.

2. Providers who do not have a Provider Type listed in the CAQH Approved Provider Types list above: 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
   - 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.
Activating your CAQH ProView Registration

Blue Choice PPO participating physicians and professional 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 the CAQH ProView database via the Internet.

3. When you receive your CAQH Provider ID:
   a. go to the CAQH website to register or
   b. physicians and professional 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.

5. Once registration is completed, you may use your CAQH ProView user name and password to log in at any time.
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 the CAQH ProView database 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 [www.cagh.org/solutions/caqh-proview/](http://www.cagh.org/solutions/caqh-proview/). Select Providers, 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 CAQH ProView service is maintained by CAQH in a secure, state-of-the-art data center.
Getting Started with CAQH, cont’d

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, 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 the CAQH ProView database with your user name and password.

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 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)**

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Updated 09-04-2018
If you have any questions accessing the [CAQH ProView database](#), you may contact the CAQH Help Desk at [888-599-1771](#) for assistance.

**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 the CAQH ProView database.

### 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 [Network Participation](#) page on the [provider website](#).
Getting Started with CAQH, cont’d

Visit the CAQH website for more information about the CAQH ProView database and the application process.

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 a.m. – 8 p.m., CT, Mon – Thurs
6 a.m. – 6 p.m., 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 the CAQH ProView database
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 the Blue Choice PPO network.

- 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.

<table>
<thead>
<tr>
<th>Hospital or Facility Based Providers must have the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Hospital privileges</td>
</tr>
<tr>
<td>➢ Type 1 NPI #</td>
</tr>
<tr>
<td>➢ Texas State Board of Medical Examiners license (temporary</td>
</tr>
<tr>
<td>permit is acceptable) or appropriate Texas licensure</td>
</tr>
<tr>
<td>➢ Provider must be physically located in the state of Texas</td>
</tr>
<tr>
<td>➢ Certificate/AANA# (applicable to CRNA providers only)</td>
</tr>
<tr>
<td>➢ NCCAA certificate (applicable to Anesthesia Assistants</td>
</tr>
<tr>
<td>providers only)</td>
</tr>
</tbody>
</table>

**Note:** Obtaining a BCBSTX Provider Record ID does not automatically activate the Blue Choice PPO network. 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 Blue Choice PPO</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: <strong>View email/fax list to send Facility-Based Application</strong></td>
</tr>
<tr>
<td>a solo practitioner or medical group interested in contracting as a facility based provider with Blue Choice PPO</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 application to the appropriate Network Management Regional office for processing: <strong>View email/fax list to send Facility Based Application</strong></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.

#### BCBSTX Agreements:

<table>
<thead>
<tr>
<th>Group Name:</th>
<th>Organizational Type 2 NPI #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
<td>Professional Provider Type 1 NPI #:</td>
</tr>
<tr>
<td>Degree:</td>
<td>Maiden Name, if applicable:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security #:</th>
<th>Date of Birth:</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tax Identification # Used for Billing:</th>
<th>Start Date With Group:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Practice Location – Physical Address/City/State/Zip/Phone/Fax:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Billing Address/City/State/Zip:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Billing Phone #:</th>
<th>Fax #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Correspondence Address/City/State/Zip:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Hospital/ASC(s) where services are performed</th>
<th>City</th>
<th>If Available, Facility Type II NPI or Tax ID</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Practicing Specialty:</th>
<th>Board Certified</th>
<th>Board Eligible</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Practicing Sub-Specialty:</th>
<th>Board Certified</th>
<th>Board Eligible</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Texas License Number (if temporary, attach copy):</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Anesthesia Assistants &amp; CRNAs Only – Certificate or AANA# (MUST attach copy of certificate):</th>
<th>Date Certified:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does applicant have professional liability insurance limits of at least $200,000/600,000?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is applicant currently in Residency Program?</th>
<th>Yes</th>
<th>Is applicant currently in Fellowship Program?</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is applicant a Medicare Participant?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Add Provider to:</th>
<th>Medicaid STAR</th>
<th>STAR Kids</th>
<th>CHIP</th>
<th>If yes, please indicate TPI numbers below:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Group TPI:</th>
<th>Individual TPI:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Application Submitted By:</th>
<th>Title:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email Address:</th>
<th>Phone #:</th>
<th>Fax #:</th>
</tr>
</thead>
</table>
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

**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


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

- **Phone:** 972-766-8900
- **Fax:** 972-766-2231
- **Email:** Provider_Relations_DFW@bcbstx.com

Credentialing Updates

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

**CAQH ProView Database**

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

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

**BCBSTX Provider File Updates**

BCBSTX subscribers 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 provider Demographic Change Form.
Recredentialing

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

- **If you are an existing user of CAQH,** you are required to review and attest to your data once every four (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 ProView credentialing process and authorized BCBSTX or selected “global authorization”. If so, BCBSTX will be able to obtain current information from the ProView 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 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 the ProView database via the Internet to complete and submit your application, or

  2. **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
   - 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*)
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 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 Network Participation page on the provider website.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities,

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 the 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 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, 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 the CAQH ProView at no cost.

Q4. Are Accrediting Bodies in support of the CAQH application?
Yes. The CAQH application (ProView form) 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.

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

Based on figures from a Medical Group Management Association (MGMA) cost analysis, CAQH estimates that the 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 the CAQH database?**

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 Chiropractic (DC), Doctor of Osteopathy (DO)</td>
</tr>
<tr>
<td><strong>Allied Provider Types</strong></td>
</tr>
<tr>
<td>Acupuncturist (ACU), Audiologist (AUD), Biofeedback Technician (BT), Alcohol/Drug Counselor (ADC), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNS), Clinical Psychologist (CP), Clinical Social Worker (CSW), Professional Counselor (PC), Licensed Practical Nurse (LPN), Massage Therapist (MT), Marriage/Family Therapist (MFT), Naturopath (ND), Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN), Occupational Therapist (OT), Optometrist (OD), Optician (DT), Registered Dietitian (RD), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP)</td>
</tr>
</tbody>
</table>

**Required Supporting Documents:**

- 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 (located in online application – print & sign)

**Forward completed application packet to BCBSTX:**

**Fax to:** 972-996-8230 (preferred method)

**or**

**Mail to:**
Blue Cross and Blue Shield of Texas
Attn: Provider Administration
P.O. Box 65067
Dallas, TX 75265-0267
Frequently Asked Questions, cont’d

Q7. I have been told I must be “rostered” in order to input my information into the 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 the CAQH database?

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 Universal Provider Datasource 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.
Frequently Asked Questions, cont’d

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 the CAQH database 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 the CAQH database?

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 database 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.

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 upd.caqh.org/oas/ or by calling the CAQH Help Desk at 888-599-1771 for assistance.

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 the CAQH ProView database 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 the 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.

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 caqh updhelp@acsgs.com.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

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

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

The BCBSTX credentialing process includes a review of each physician or professional 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, physicians or professional 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 or professional 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 or professional 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 or professional 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. Physicians or professional 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 or professional provider applications. Physicians or professional providers also have the right to correct erroneous information submitted by another party. Physicians or professional 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 or professional providers in recredentialing will be notified only if an adverse decision, such as termination, is made.
Blue Choice PPO Provider Manual - Provider Roles and Responsibilities, cont’d

Credentialing Review Requests

<table>
<thead>
<tr>
<th>Who can Request Review?</th>
<th>Any physician or professional provider may seek a review of a decision related to initial credentialing or continued participation in the Blue Choice PPO Network.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When to Request Review</td>
<td>Requests for review must be submitted in writing within 60 calendar days from the date of the denial/termination letter.</td>
</tr>
<tr>
<td>Addressing the Request</td>
<td>Written requests should be addressed to the Medical Director for your area. See addresses at the front of this manual.</td>
</tr>
<tr>
<td>What to Include</td>
<td>Requests should include any supporting documentation or facts the physician or professional provider feels would be beneficial for review.</td>
</tr>
</tbody>
</table>

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 or professional provider submit 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 or professional provider’s file, 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 or professional 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 or professional provider and will provide the required 30 days notification to subscribers.</td>
</tr>
<tr>
<td></td>
<td><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>
<tr>
<td>4</td>
<td>The Medical Director forwards the final determination in writing to the physician or professional provider within 60 days of initial notification to the physician or professional provider or the date of the request for additional information for review.</td>
</tr>
</tbody>
</table>
Physician, Professional Provider, Facility and Ancillary Provider Termination Process

- If a physician, professional provider, facility 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’s, professional provider’s, facility or ancillary provider’s network participation if he/she determines that:
  - Continued network participation by the physician, professional provider, facility or ancillary provider poses imminent harm to patient health; or
  - An action by a state licensing board effectively impairs the physician, professional provider, facility or ancillary provider of the reason(s) for termination. Physician’s, professional provider’s, facility 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 or ancillary provider of the reason(s) for termination.
- A physician, professional provider, facility 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 subscribers 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 subscribers immediately.
Physician, Professional Provider, Facility and Ancillary Provider Termination Process, cont’d

- Within sixty (60) days following receipt of physician’s or professional provider’s written request for review, BCBSTX will notify the provider of its review decision.
- Upon request, BCBSTX will provide physician or professional 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.
Urgent Care Center (UCC) Criteria

An Urgent Care Center must meet the following requirements:

- Extended hours – UCC must be open weekday evenings until at least 7:00 p.m. Weekend hours preferred but not required.
- Defibrillator - If not physically adjacent to an Emergency Room, UCC must have a defibrillator in their office.
- Tax ID Number - Urgent Care Center must have its own group BCBSTX record number and Tax ID number.

UCC Summary – UCC must complete the Urgent Care Center Summary (included in the application packet) and return it along with their application.

- Claims must be billed on CMS - 1500
- Physicians working at the center must be credentialed by BCBSTX
- 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.

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 the Standards and Requirements menu on bcbstx.com/provider for additional information.
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.