Physician/Professional Provider Roles and Responsibilities: Overview

In this Section

This section covers the roles and responsibilities of HMO Blue® Texas Physicians/Professional Providers.

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</table>

Note:

Physicians/Professional Providers who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group for instructions regarding referral and precertification process, contracting and claims related questions. Additionally, Physicians/Professional Providers who are not part of a capitated IPA/Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated IPA/Medical Group must also contact the applicable IPA/Medical Group for instructions. Physicians/Professional Providers who are contracted/affiliated with a capitated IPA/Medical Group are subject to that entity’s procedures and requirements for Physician/Professional Provider complaint resolution.
HMO Blue Texas ID Card

Using the ID Card

Each member 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 should check to make sure the current group number is included in the member’s records. A copy of the front and back of the ID card is also suggested.

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

- The member’s unique identification number
- The employer group number through which coverage is obtained
- The current coverage date
- Plan number
- The name, provider number, and telephone number of the Primary Care Physician selected by the member
- The PORG of the Primary Care Physician’s Provider Network, if applicable
- Some (most common) applicable copayments.

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

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

Department of Insurance (DOI) Requirements

TDI requires carriers to identify members who are subject to the requirements of SB418. ID cards that reflect an indicator, “TDI”, signify members who are subject to the requirements of SB418.

Continued on next page
The HMO Blue Texas ID Card, Continued

Pictured below is a sample of the HMO Blue Texas Member ID card.
### Eligibility and Benefits

#### Eligibility Questions
To confirm eligibility and benefits, the HMO Blue Texas participating Physician/Professional Provider may contact HMO Blue Texas Customer Service by calling the appropriate number listed below. When the member does not present an ID card, a copy of the enrollment application or a temporary card may be accepted. HMO Blue Texas also recommends that the member's identification be verified with a photo ID and that a copy be retained for his/her file. The Primary Care Physician may also reference their member PCP eligibility list distributed by HMO Blue Texas monthly.

<table>
<thead>
<tr>
<th></th>
<th>HMO Blue Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-877-299-2377</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Employees of BCBSTX and dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-888-662-2395</td>
</tr>
</tbody>
</table>

#### Eligibility Statement
HMO Blue Texas complies with the Eligibility Statement Legislation, Senate Bill 1149. For additional information on Senate Bill 1149, please refer to the Texas Department of Insurance (TDI) Web site at [www.tdi.state.tx.us](http://www.tdi.state.tx.us).

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

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

The member is required to pay a copayment, if applicable, at the time services are rendered.
Verification Procedure

Introduction

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

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

Verification Procedure

To initiate a request for verification, please contact HMO Blue Texas Provider Customer Service Department at 1-800-299-2377 and select the prompt for verification.

Note: Please be advised that verification is not applicable for all enrollees or providers. Routine eligibility check and benefit information may still be obtained when verification is not applicable.

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

- Request for Additional Information
- Verification Notice
- Declination Notice

Delegated Entity Responsible for Claim Payment

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

Continued on next page
Verification Procedure, Continued

<table>
<thead>
<tr>
<th>Required Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 13 required elements a Physician/Professional Provider needs to supply in order to initiate a Verification are as follows:</td>
</tr>
<tr>
<td>1. patient name</td>
</tr>
<tr>
<td>2. patient ID number</td>
</tr>
<tr>
<td>3. patient date of birth</td>
</tr>
<tr>
<td>4. name of enrollee or member</td>
</tr>
<tr>
<td>5. patient relationship to enrollee or member</td>
</tr>
<tr>
<td>6. presumptive diagnosis, if known, otherwise presenting symptoms</td>
</tr>
<tr>
<td>7. description of proposed procedure(s) or procedure code(s)</td>
</tr>
<tr>
<td>8. place of service code where services will be provided and if place of service is other than Physician’s/Professional Provider’s office or Physician’s/Professional Provider’s location, name of hospital or facility where proposed service will be provided</td>
</tr>
<tr>
<td>9. proposed date of service</td>
</tr>
<tr>
<td>10. group number</td>
</tr>
<tr>
<td>11. if known to the Physician/Professional Provider, name and contact information of any other carrier, including</td>
</tr>
<tr>
<td>a. other carrier’s name</td>
</tr>
<tr>
<td>b. address</td>
</tr>
<tr>
<td>c. telephone number</td>
</tr>
<tr>
<td>d. name of enrollee</td>
</tr>
<tr>
<td>e. plan or ID number</td>
</tr>
<tr>
<td>f. group number (if applicable)</td>
</tr>
<tr>
<td>g. group name (if applicable)</td>
</tr>
<tr>
<td>12. name of the Physician/Professional Provider providing the proposed services</td>
</tr>
<tr>
<td>13. Physician’s/Professional Provider’s federal tax ID number</td>
</tr>
</tbody>
</table>

**Note:** In addition to the required elements, be prepared to provide a referral or precertification number for those services which require an authorization. Please also provide your office fax number for your written confirmation. This will expedite HMO Blue Texas’ response.

*Continued on next page*
Verification Procedure, Continued

Declination

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

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

1. policy or contract limitations:
   a. premium payment timeframes that prevent verifying eligibility for 30-day period
   b. policy deductible, specific benefit limitations or annual benefit maximum
   c. benefit exclusions
   d. no coverage or change in membership eligibility, including individuals not eligible, not yet effective or membership cancelled.

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

| Pass Through Billing | Pass through billing is not permitted by BCBSTX. Pass through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider. The performing provider should bill for these services unless approved by BCBSTX.  

BCBSTX does not consider the following scenarios to be pass through billing:

1) The service of the performing provider is performed at the place of service of the ordering provider and is billed by the ordering provider, or

2) The service is provided by an employee of a physician/professional provider. e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered First Assistant, who is under the direct supervision of the ordering provider and the service is billed by the ordering provider. |
|---|---|
Lab Services Information and Reimbursable Lab Services List

Exclusive Lab Provider & County Listing

Laboratory Corporation of America (LabCorp) is the exclusive provider for HMO Blue Texas for all outpatient clinical reference laboratory services. **Exception:** Members whose PCP is associated with a capitated IPA/Medical Group must receive outpatient laboratory services from their applicable IPA's/Medical Group's designated outpatient laboratory. Contact the IPA/Medical Group for direction, if necessary.

For Physicians and Professional Providers located in the following counties, the services that will be reimbursed on a fee-for-service basis *if performed in the Physician's/Professional Provider's office* for HMO Blue Texas members are included on the Reimbursable Lab Services list that follows below. *All other lab services must be referred to HMO Blue Texas’ exclusive provider LabCorp.*

**County Listing:**


*Note: Effective January 1, 2008, the following counties will be removed from the HMO Blue Texas Outpatient Clinical Reference Lab Services County Listing: Atascosa, Medina and Wilson.*

Continued on next page
Lab Services Information and Reimbursable Lab Services List, continued

Reimbursable Lab Services

Note: For the County Listing and Reimbursable Lab Services prior to 1/01/2008, visit the BCBSTX Web site @ www.bcbstx.com/provider (under General Reimbursement Information, select ...and more, enter password – manual, under HMO Blue Texas News, refer to the applicable bullet offerings).

<table>
<thead>
<tr>
<th>Reimbursable Lab Services - Effective 1/01/08</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection of venous blood by venipuncture</td>
<td>36415</td>
</tr>
<tr>
<td>Collection of capillary blood specimen</td>
<td>36416</td>
</tr>
<tr>
<td>Venipuncture, cutdown; under age 1 year</td>
<td>36420</td>
</tr>
<tr>
<td>Basic metabolic panel</td>
<td></td>
</tr>
<tr>
<td>Electrolyte panel</td>
<td></td>
</tr>
<tr>
<td>Urinalysis, dipstick</td>
<td>81000</td>
</tr>
<tr>
<td>Urinalysis, with microscopy, automated</td>
<td>81001</td>
</tr>
<tr>
<td>Urinalysis, without microscopy, non-automated</td>
<td>81002</td>
</tr>
<tr>
<td>Urinalysis, without microscopy, automated</td>
<td>81003</td>
</tr>
<tr>
<td>Urinalysis, bacteriuria screen, except by culture or dipstick</td>
<td>81007</td>
</tr>
<tr>
<td>Pregnancy test, urine</td>
<td>81025</td>
</tr>
<tr>
<td>Stool for occult blood (Hemoccult)</td>
<td>82270</td>
</tr>
<tr>
<td>Stool for occult blood (Hemoccult single)</td>
<td>82272</td>
</tr>
<tr>
<td>Stool for occult blood</td>
<td>82274</td>
</tr>
<tr>
<td>Glucose, blood, quantitative</td>
<td>82947</td>
</tr>
<tr>
<td>Glucose, blood, reagent strip</td>
<td>82948</td>
</tr>
<tr>
<td>Glucose, blood, monitoring device</td>
<td>82962</td>
</tr>
<tr>
<td>H. pylori; breath test analysis for urease activity, drug administration</td>
<td>83014</td>
</tr>
<tr>
<td>Bleeding time</td>
<td>85002</td>
</tr>
<tr>
<td>Blood count, differential WBC, automated</td>
<td>85004</td>
</tr>
</tbody>
</table>

Note: All other outpatient clinical reference lab services not listed above must be referred to HMO Blue Texas' exclusive provider - Laboratory Corporation of America (LabCorp).

Continued on next page
Lab Services Information and Reimbursable Lab Services List, Continued

<table>
<thead>
<tr>
<th>Reimbursable Lab Services – Effective 1/01/2008</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood count, smear, WBC differential, manual</td>
<td>85007</td>
</tr>
<tr>
<td>Blood count, smear, no WBC differential</td>
<td>85008</td>
</tr>
<tr>
<td>Blood count, spun microhematocrit</td>
<td>85013</td>
</tr>
<tr>
<td>Blood count, hematocrit</td>
<td>85014</td>
</tr>
<tr>
<td>Blood count, hemoglobin</td>
<td>85018</td>
</tr>
<tr>
<td>Blood count, complete CBC &amp; WBC differential, automated</td>
<td>85025</td>
</tr>
<tr>
<td>Blood count, complete CBC, automated</td>
<td>85027</td>
</tr>
<tr>
<td>Blood count, manual, each</td>
<td>85032</td>
</tr>
<tr>
<td>Blood count, platelet, automated</td>
<td>85049</td>
</tr>
<tr>
<td>Coagulation time, Lee and White</td>
<td>85345</td>
</tr>
<tr>
<td>Coagulation time, Lee and White, activated</td>
<td>85347</td>
</tr>
<tr>
<td>Coagulation time, Lee and White, other methods</td>
<td>85348</td>
</tr>
<tr>
<td>Prothrombin time</td>
<td>85610</td>
</tr>
<tr>
<td>Heterophile antibody screen for mononucleosis</td>
<td>86308</td>
</tr>
<tr>
<td>Skin test, coccidioidmycosis</td>
<td>86490</td>
</tr>
<tr>
<td>Skin test, histoplasmosis</td>
<td>86510</td>
</tr>
<tr>
<td>Skin test, tuberculosis, intradermal</td>
<td>86580</td>
</tr>
<tr>
<td>Wet mount for infectious agents</td>
<td>87210</td>
</tr>
<tr>
<td>Tissue exam by KOH slide</td>
<td>87220</td>
</tr>
<tr>
<td>Influenza</td>
<td>87400</td>
</tr>
<tr>
<td>Strep screening, qualitative</td>
<td>87430</td>
</tr>
<tr>
<td>Influenza, rapid</td>
<td>87804</td>
</tr>
<tr>
<td>RSV, rapid</td>
<td>87807</td>
</tr>
<tr>
<td>Strep screening, rapid</td>
<td>87880</td>
</tr>
<tr>
<td>Sperm evaluation, cervical mucus penetration test – New – Effective 1/1/2008</td>
<td>89330</td>
</tr>
</tbody>
</table>

Note: All other outpatient clinical reference lab services not listed above must be referred to HMO Blue Texas’ exclusive provider - Laboratory Corporation of America (LabCorp).

Additional information regarding LabCorp is included on the following pages.
Lab Services Information and Reimbursable Lab Services List, Continued

How to Access LabCorp Services

- **Supply Orders** – To order supply order forms or place your order, please call LabCorp at:

  **Houston/San Antonio/ Austin/ South Texas**
  - (800) 800-2387, option 7
  - (713) 856-8288, option 7
  - FAX: (713) 856-4348

  **Dallas/Ft. Worth/ El Paso/West Texas**
  - (800) 788-9892, option 7
  - (972) 566-7500, option 7
  - FAX: (800) 788-9338
  - FAX: (972) 661-5762

- **Patient Service Center Locations** - To find the closest LabCorp Patient Service Center, please access LabCorp’s phone system at 1-888-LABCORP, or their Web site at [www.labcorp.com](http://www.labcorp.com). Both of these systems will prompt you for your zip code and will provide those service centers nearest the zip code location.

- **Specimen Pick-up** – For pick-up of specimens, please contact LabCorp’s Logistics Department:

  **Houston/San Antonio/ Austin/ South Texas**
  - (800) 326-8478, option 4
  - (713) 856-4327, option 4

  **Dallas/Ft. Worth/ El Paso/West Texas**
  - (800) 788-9980, option 4
  - (972) 566-3251, option 4

- **Billing Guidelines** – Please complete the following information on the lab requisition:
  a) Patient’s Full Name
  b) Patient Address
  c) Sex
  d) Patient Date of Birth
  e) Diagnosis Code (ICD-9)
  f) Patient/Insured ID Number

*Continued on next page*
### How to Access LabCorp Services, continued

#### Receiving Test Results

- to provide your practice the flexibility and time saving convenience in ordering and receiving test results in an electronic manner, LabCorp offers a number of multiple result delivery systems including the Laboratory Communication Manager Computer (LCM) and high-speed remote report teleprinters. Interfaces with Practice Management Systems are an option as well. Laboratory test results are also available from LabCorp via e-Results over the internet and through various portals such as WebMD and ProxyMed.

- **Questions** – If you have any specific questions regarding your LabCorp account or need to set-up an account with LabCorp, please contact LabCorp’s Client Services Department:

<table>
<thead>
<tr>
<th>Houston/San Antonio/ Austin/ South Texas</th>
<th>Dallas/Ft. Worth/ El Paso/West Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>(800) 800-2387, dial 1 then ext. 3999</td>
<td>(800) 788-9892, dial 1 then ext. 6202</td>
</tr>
<tr>
<td>(713) 856-8288, dial 1 then ext. 3999</td>
<td>(972) 566-7500, dial 1 then ext. 6202</td>
</tr>
</tbody>
</table>
# Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers

## Introduction

Physician/Professional Provider roles and responsibilities will differ among the various specialties, however, certain responsibilities will be shared by all HMO Blue Texas Physicians/Professional Providers.

## Role of the Primary Care Physician

The member must contact his/her Primary Care Physician (family practice, general physician, internal medicine or pediatrician) for all of his/her health care needs, other than obstetrics and gynecology. For information on behavioral health services, refer to Section I, Behavioral Health Services of the HMO Blue Texas Provider Manual, for more detail.

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

A physician who has contracted with HMO Blue Texas as a Primary Care Physician will agree to render to the HMO Blue Texas member primary, preventive, acute and chronic health care management and:

- Provide the same level of care to HMO Blue Texas patients as provided to all other patients.
- Provide emergency care or coverage for care 24 hours a day, seven days a week.
- Be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to members. Such requests must be responded to within one hour.
- Keep a central record of the member’s health and health care that is complete and accurate.
- Refer the member to Specialty Care Physicians/Professional Providers within the same Provider Network.
- Complete referrals and precertifications through the IEXCHANGE System at http://www.bcbstx.com/provider or by calling 1-800-413-0869 unless otherwise instructed to call the Utilization Management Department. Department phone numbers and addresses are listed in Section C of this guide. Refer to the detailed information and instructions in Sections C & E for more information on the IEXCHANGE System for referrals and precertifications.

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

- Provide copies of X-ray and laboratory results and other health records to Specialty Care Physicians/Professional Providers to enhance continuity of care and to preclude duplication of diagnostic procedures.

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

- Enter into the member’s health record all reports received from Specialty Care Physicians/Professional Providers.

- Assume the responsibility for arranging and preauthorizing hospital admissions in which he/she is the admitting physician or delegate this responsibility to the admitting Specialty Care Physician/Professional Provider.

- Assume the responsibility for care management as soon as possible after receiving information that a member on his/her Primary Care Physician list has been hospitalized in the local area on an emergency basis.

- Coordinate inpatient care with the Specialty Care Physician/Professional Provider so that unnecessary visits by both physicians are avoided.

- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the HMO Blue Texas patient in accordance with Texas Department of Health standards.

- Cooperate with HMO Blue Texas for the proper coordination of benefits involving covered services and in the collection of third party payments including workers’ compensation, third party liens and other third party liability. HMO Blue Texas contracted physicians agree to file claims and encounter information with HMO Blue Texas even if the physician believes or knows there is a third party liability.

- Only bill HMO Blue Texas member for copayments, cost share (coinsurance) and deductibles, where applicable.

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Primary Care Physician Backups

The Primary Care Physician designates backup (covering) Primary Care Physicians during the network application process.

**Note:** If the Primary Care Physician is capitated, then the backup physician should seek reimbursement directly from that PCP. The covering physician is responsible for filing a claim for any member seen on behalf of the PCP. **The Primary Care Physician’s staff must report any upcoming changes in covering Primary Care Physicians to their local Professional Provider Network Representative.**

*Continued on next page*
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Referrals to Specialty Care Physicians/Professional Providers, except OB/Gyns, must be initiated by the Primary Care Physician. It is essential that the Primary Care Physician refer HMO Blue Texas members requiring specialty care to HMO Blue Texas participating Physicians/Professional Providers within the same Provider Network, if applicable.

A Primary Care Physician may not refer to himself/herself as a Specialty Care Physician/Professional Provider when treating the member who is already on his/her Primary Care Physician list.

Refer to the detailed information and instructions in Section D that discusses the iEXCHANGE system for referrals.

Once the iEXCHANGE system issues a confirmation number to the Primary Care Physician for the referral to the Specialty Care Physician/Professional Provider, the system will automatically generate notification letters to the Specialty Care Physician/Professional Provider and to the HMO Blue Texas member.

The Primary Care Physician may provide the HMO Blue Texas member with the iEXCHANGE referral confirmation number to take to appointments with the Specialty Care Physician/Professional Provider or the Specialty Care Physician/Professional Provider can access the iEXCHANGE system to obtain the referral confirmation number.

If the Specialty Care Physician/Professional Provider determines that an HMO Blue Texas member needs to be seen by another Specialty Care Physician/Professional Provider, the HMO Blue Texas member must be referred back to the member's Primary Care Physician.

Note: The Specialty Care Physician/Professional Provider cannot refer to other Specialty Care Physicians/Professional Providers.

(Exception: OB/Gyn physicians have the ability to directly manage and coordinate a woman’s care for obstetrical and gynecological conditions, including obtaining referrals through iEXCHANGE for obstetrical/gynecological related specialty care and testing to other HMO Blue Texas participating Physicians/Professional Providers who participate in the same Provider Network as the member’s Primary Care Physician, if applicable.)
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Role of the Specialty Care Physician/Professional Provider

An HMO Blue Texas participating Physician/Professional Provider who provides services as a Specialty Care Physician/Professional Provider is expected to:

- Provide the same level of care to HMO Blue Texas patients as provided to all other patients.

- Provide emergency care or coverage for care 24 hours a day, seven days a week.

- Make his/her own arrangements for patient coverage when out of town or unavailable.

- Keep a central record of the member’s health and health care that is complete and accurate.

- Accept referrals for HMO Blue Texas members in accordance with the services and number of visits requested by the Primary Care Physician in the same Provider Network, if applicable.

- Report back to the Primary Care Physician upon completion of the consultation/treatment.

- Provide copies of X-ray and laboratory results and other health record information to the member’s Primary Care Physician as appropriate.

Additionally,

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

- If authorized by the Primary Care Physician, arrange for hospital admission of the HMO Blue Texas member into a participating facility through the Utilization Management Department and assume responsibility for completion of steps required by HMO Blue Texas to preauthorize the admission.

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Role of the Specialty Care Physician/Professional Provider, Continued

- Coordinate inpatient care with the Primary Care Physician so that unnecessary visits by both Physicians/Professional Providers are avoided.
- Provide inpatient consultation within 24 hours of receipt of request. Emergency consultation to be provided as soon as possible.
- Provide copies of medical records when requested by HMO Blue Texas for the purpose of claims review or auditing.
- Return the member to the care of the referring HMO Blue Texas Primary Care Physician as soon as medically feasible.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the HMO Blue Texas patient in accordance with Texas Department of Health standards.
- Only bill HMO Blue Texas member for copayments, cost share (coinsurance) and deductibles, where applicable.

Specialist as a Primary Care Physician

Any HMO Blue Texas member with chronic, disabling or life-threatening illnesses may apply to the HMO Blue Texas Medical Director to utilize a Specialty Care Physician/Professional Provider as a Primary Care Physician (PCP), provided that:

- The request for the Specialty Care Physician/Professional Provider includes certification of medical need, along with all applicable supporting documentation, and is signed by the HMO Blue Texas member and the Specialty Care Physician/Professional Provider interested in serving as the Primary Care Physician.
- The Specialty Care Physician/Professional Provider must meet HMO Blue Texas requirements for Primary Care Physician participation. Refer to Section B, page 12, Role of the Primary Care Physician. The Specialty Care Physician/Professional Provider is willing to coordinate all the HMO Blue Texas member’s health care needs and accept HMO Blue Texas reimbursement.

All Physicians/Professional Providers participating in HMO Blue Texas 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 HMO Blue Texas.

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Specialist as a Primary Care Physician, continued

- If the request for special consideration is approved by HMO Blue Texas, the local Professional Provider Network Representative contacts the specialist within 30 days of receiving the request to educate them on the role and responsibilities of the PCP, preventive care guidelines, claim filing instructions and discuss reimbursement. They will also provide a current directory of participating specialists and professional providers.
- If the request for special consideration is denied by HMO Blue Texas, the HMO Blue Texas medical director sends a denial letter within 30 days of receiving the request explaining the denial and the member’s right to appeal the decision through the HMO Blue Texas Complaint Process.
- The effective date of the new designation of the non-primary care specialist will not be retroactive and may not reduce the amount of the compensation owed to the original Primary Care Physician for services provided before the date of the new designation.

For further details, contact HMO Blue Texas Customer Service at: 1-877-299-2377
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

**Role of OB/Gyn**

A female HMO Blue Texas member has direct access to an HMO Blue Texas participating OB/Gyn participating in the same Provider Network as her Primary Care Physician. The access to health care services of an obstetrician or gynecologist, includes, but is not limited to:

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions
- Diagnosis, treatment and referral to a specialist who participates in the same Provider Network as the member’s Primary Care Physician, 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.

Any female HMO Blue Texas member may access an HMO Blue Texas participating OB/Gyn physician participating in the same Provider Network as her Primary Care Physician without obtaining a referral from her Primary Care Physician or calling HMO Blue Texas.

When abnormalities are discovered, the HMO Blue Texas participating OB/Gyn has the ability to directly manage and coordinate a woman’s care for obstetrical and gynecological conditions including issuing referrals for obstetrical/gynecological related specialty care and testing to other HMO Blue Texas participating Physicians/Professional Providers who participate in the same Provider Network as the member’s Primary Care Physician.

Services for all other conditions must be coordinated through the HMO Blue Texas member’s Primary Care Physician. Also, any services rendered outside of the OB/Gyn’s office, such as ultrasound and mammograms, must be performed by facilities in the same Provider Network as the member’s Primary Care Physician.

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

*Continued on next page*
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

**Notification for Obstetrical and Newborn Care**

After the first prenatal visit, the HMO Blue Texas network participating Physician/Professional Provider office should provide notification of the HMO Blue Texas member’s obstetrical care. OB ultrasounds may be performed in the physician’s office and do not require precertification.

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

**Note:** The initial OB office visit is excluded from the “global maternity care” reimbursement. Physicians will be reimbursed separately for the initial OB visit for HMO Blue Texas members and should submit a claim for this service at the time of the initial visit. Global maternity care is subject to a one-time office visit copayment from the member. This copayment should be collected at the time of the initial OB office visit.

**Physician/Professional Provider Complaint Procedure**

HMO Blue Texas participating Physicians/Professional Providers are urged to contact Customer Service when there is an administrative question, problem, complaint or claims issue. To appeal a Utilization Management medical necessity determination, contact the Utilization Management Department.

Utilization Management decisions may be formally appealed by phone, fax, or in writing. For appeals of denied claims, refer to the Claims Information section in this Manual.

An HMO Blue Texas participating Physician/Professional Provider may contact the Texas Department of Insurance (TDI) to obtain information on companies, coverage, rights or complaints at 1-800-252-3439 or the Physician/Professional 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  
[www.tdi.state.tx.us](http://www.tdi.state.tx.us)

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

*Continued on next page*
Changes Affecting Your Provider Number

Every Physician and Professional Provider contracted with HMO Blue Texas receives a provider number. A minimum of 30 days advance notice is required when making changes affecting a Physician/Professional Provider's status, especially in the following areas:

- Physical address (primary, secondary, tertiary),
- Billing address,
- National Provider Identifier (NPI) Number(s) changes
- Tax Identification/Social Security number changes,
- Moving from a Group to Solo practice,
- Moving from Solo to a Group practice,
- Moving from Group to Group practice, and
- Backup/Covering Physicians/Professional Providers

Note the following information regarding provider numbers.

- All provider number effective dates will be established as of the date that complete applications are received in the corporate office. This will apply to all additions, changes and cancellations.
- HMO Blue Texas will not add, change or cancel information related to the provider number on a retroactive basis.
- Retroactive provider number effective dates will not be established.
- Retroactive network participation effective dates will not be established.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new provider number.
- If the Physician/Professional Provider files claims electronically and their provider number changes, the Physician/Professional Provider must contact THIN at 1-877-EDITIN or 1-877-334-8446 or (972) 766-5480 (Dallas) to obtain a new EDI Agreement.
- For provider number questions or to obtain a provider number application, please contact the Professional Provider Services department at (972) 996-9610, press 3.

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Reminders:

- An application for a provider number does not constitute a request for participation in the HMO Blue Texas network.
- A separate network application must be completed and sent to the Professional Provider Network department.
- Also, report changes immediately to your local Professional Provider Network Representative.

Keeping HMO Blue Texas informed of any changes you make allows appropriate claims processing, as well as maintaining the HMO Blue Texas Provider Directory with current and accurate information.

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Failure to Establish Physician/Professional Provider Patient Relationship

A Physician/Professional Provider may terminate his/her professional relationship with a member if one or more of the following have occurred:

- Fraudulent use of services or benefits;
- Threats of physical harm to a Physician/Professional Provider or office staff;
- Non-payment of required copayment for services rendered or applicable coinsurance and/or deductible;
- 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, if such refusal is incompatible with the continuation of the Physician/Professional Provider patient relationship (Physician/Professional 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/patient relationship.

The following are not grounds for a Physician/Professional Provider terminating his/her professional relationship with a member:

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

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Procedures

When information is provided to the Professional Provider Network Department or Medical Director indicating that a contracted Physician/Professional Provider has deemed it necessary to terminate a relationship with a member, the following will occur:

1. The department receiving the information that a Physician/Professional Provider wishes to terminate a physician/patient relationship will notify your local Professional Provider Network Representative and the Medical Director.

2. Professional Provider Network Department will:
   - Inform the Physician/Professional Provider that he/she may not terminate his/her relationship with a member because of such member’s medical condition or the amount, variety, or cost of covered health services that are required by the member, and
   - Forward the information to Quality Improvement Programs for tracking and trending and recommendation.

3. After review, the Medical Director, or designee, will notify the Physician/Professional Provider of the decision regarding the request for termination within three business days after receipt of the request for termination. If the termination is appropriate, the Physician/Professional Provider and the Medical Director agree on an effective date of termination which will be no less than 30 days from the date the Physician/Professional Provider notifies the patient.

4. The Medical Director will instruct the Physician/Professional Provider that the termination requires a letter to the member with a copy to the Medical Director. The letter must include:
   - Name of patient(s) - if it involves family, list all patients affected
   - HMO Blue Texas member identification number
   - Group number
   - Effective date of termination

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

5. Upon receipt of the Physician’s/Professional Provider’s letter to the member, the Medical Director will forward a copy to the Customer Service Manager or National Accounts, as applicable.

6. Customer Service will send a letter to the member 30 days prior to the date of the termination that will outline all of the procedures/steps required of the member in the selection of an alternative PCP or SCP, if applicable.

7. After review, the Medical Director, or designee, will notify the Physician/Professional Provider of the decision regarding the request for termination within three business days after receipt of the request for termination. If the termination is appropriate, the Physician/Professional Provider and the Medical Director agree on an effective date of termination which will be no less than 30 days from the date the Physician/Professional Provider notifies the patient.

8. The Medical Director will instruct the Physician/Professional Provider that the termination requires a letter to the member with a copy to the Medical Director. The letter must include:
   - Name of patient(s) - if it involves family, list all patients affected
   - HMO Blue Texas member identification number
   - Group number
   - Effective date of termination

9. Upon receipt of the Physician’s/Professional Provider’s letter to the member, the Medical Director will forward a copy to the Customer Service Manager or National Accounts, as applicable.

10. Customer Service will send a letter to the member 30 days prior to the date of the termination that will outline all of the procedures/steps required of the member in the selection of an alternative PCP or SCP, if applicable.

11. Customer Services will follow-up with the patient to make sure the patient selects a new PCP or SCP or obtains a referral to a new SCP, as applicable.

12. Customer Service will notify the local Professional Provider Network Department and Medical Director via memo of any feedback obtained from the patient regarding the circumstances that precipitated the termination.
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

Procedures, Continued

13. Physician/Professional Provider must continue to provide medical services to the member until the end date stated in the Physician’s/Professional Provider’s letter to the member.

14. If the Physician/Professional Provider initiating the physician/patient termination is a PCP, the Physician/Professional Provider may refer the patient to another Network Physician/Professional Provider. If the PCP is a member of a large group or IPA, he/she may refer patient to a Physician/Professional Provider within the large group or IPA. Having the referral on file will assure the patient continues to receive covered benefits until a new PCP is selected.

Continued on next page
Responsibilities of All HMO Blue Texas Participating Physicians/Professional Providers, Continued

The letter to the HMO Blue Texas Medical Director should be sent to the appropriate address or fax number listed below.

<table>
<thead>
<tr>
<th>Physician/Professional Provider Letter</th>
<th>In Houston, Beaumont or East Texas areas:</th>
<th>In the Dallas/Fort Worth and Tyler areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HMO Blue Texas</td>
<td>HMO Blue Texas</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 272169</td>
<td>P.O. Box 834105</td>
</tr>
<tr>
<td></td>
<td>Houston, TX 77277-2169</td>
<td>Richardson, TX 75083-4105</td>
</tr>
<tr>
<td></td>
<td>Fax (713) 663-1250</td>
<td>Fax (972) 766-8942</td>
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</table>

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</table>

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<tr>
<th>In the Austin, Corpus Christi, and San Antonio areas:</th>
<th>In the Lubbock and Amarillo areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Blue Texas</td>
<td>HMO Blue Texas</td>
</tr>
<tr>
<td>P. O. Box 272169</td>
<td>5225 S. Loop 289 Suite 207</td>
</tr>
<tr>
<td>Houston, TX 77277-2169</td>
<td>Lubbock, TX 79424</td>
</tr>
<tr>
<td>Fax (713) 663-1250</td>
<td>Fax (806) 798-6329</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the El Paso area:</th>
<th>In the San Angelo, Abilene and Midland/Odessa areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Blue Texas</td>
<td>HMO Blue Texas</td>
</tr>
<tr>
<td>118 Mesa Park Drive</td>
<td>3300 North A St., Bldg 8, Ste 120</td>
</tr>
<tr>
<td>El Paso, TX 79912</td>
<td>Midland, TX 79705</td>
</tr>
<tr>
<td>Fax (915) 496-6611</td>
<td>Fax (915) 620-1431</td>
</tr>
</tbody>
</table>

A sample letter is shown on the following page.
Sample of Letter from Physician/Professional Provider to Member

Current Date        Certified Mail Number        Returned Receipt Requested

Patient Name*       
Address             
City/State/Zip      

Phone Number       
HMO Blue Texas Member Number
Group Number        

Dear Patient:

I will no longer be providing services to you as a (Primary Care Physician/Specialty Care Physician/Professional Provider). I will continue to be available to you for your health care until
_____________________ (end date - no less than 30 days from the date of the 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 Physician/Professional Provider. The Customer Service Department of HMO Blue Texas is available to assist you in selecting another Physician/Professional Provider to provide your care.

Sincerely,

John Doe, M.D.

cc: Medical Director
HMO Blue Texas

**Note:** LETTER IS TO BE SENT VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

*If the Physician/Professional Provider is terminating the relationship with a family, all member names should be listed in this area.
**Credentialing**

**Committee Meetings**

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

The Committee provides peer recommendations for approval or denial of Physician/Professional Provider applicant files, reviews regular reports of HMO Blue Texas credentialing activities, and reviews/recommends action to resolve Physician/Professional Provider appeals. The Committee also reviews and resolves quality of care issues.

The HMO Blue Texas credentialing process includes a review of each Physician/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 HMO Blue Texas, Physicians/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 HMO Blue Texas.

The standard procedure used in processing a completed Physician/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/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, DPS, practitioners license, liability insurance face sheet, attestation signature, etc.) that is required by all regulatory and/or accreditation agencies. Physicians/Professional Providers who have submitted an application for credentialing/credentialing have the right to review the information submitted in support of these applications to HMO Blue Texas. 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/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/professional provider applications. Physicians/Professional Providers also have the right to correct erroneous information submitted by another party. Physicians/Professional Providers, upon request, have the right to be informed of the status of their credentialing or recredentialing application.

*Continued on next page*
Physicians/Professional Providers should use the “TDI Texas Standard Credentialing Application” when initially applying for participation in HMO Blue Texas. This application can be downloaded from the TDI Web site at www.tdi.state.tx.us or by calling TDI at 1-800-599-7467. However a plan specific cover sheet must be obtained from your local Professional Provider Network Representative.

**Reminder:** Credentialing is an intense and timely process that can take up to six months to complete. Please make a note of this when hiring a new associate or bringing on a new partner.

*Continued on next page*
Credentialing Review Requests

Who can Request Review? Any Physician/Professional Provider may seek a review of a decision related to initial credentialing or continued participation in the HMO Blue Texas Network.

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

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

What to Include Requests should include any supporting documentation or facts the Physician/Professional Provider feels would be beneficial for review.

Process The following table describes the review process:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Physician/Professional Provider submits an appeal request to the Medical Director.</td>
</tr>
<tr>
<td>2</td>
<td>The Medical Director reviews appeal request</td>
</tr>
<tr>
<td>3</td>
<td>The Medical Director presents the Physician’s/Professional Provider’s file, appeal request and supporting documentation for a recommendation to the Medical Advisory Committee.</td>
</tr>
<tr>
<td></td>
<td>If the Medical Advisory Committee review panel is not able to make a recommendation based on the information provided, then the plan will seek the Physician’s/Professional Provider’s consent to extend the review period. The extension will include the time necessary for the Medical Advisory Committee to receive additional information from the Physician/Professional Provider, and will provide the required 30 days notification to members.</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/Professional Provider within 60 days of initial notification to the Physician/Professional Provider or the date of request for additional information for review.</td>
</tr>
</tbody>
</table>
Physician/Professional Provider Termination Process

- If a Physician/Professional Provider is being considered for BCBSTX network termination for any of the following reasons, BCBSTX will present the proposal for termination to a BCBSTX Advisory Peer Review Panel (Texas Medical Advisory Committee [TMAC] or Texas Peer Review Committee [TPRC]) along with all available supporting documentation:
  - Non-compliance with credentialing criteria; or
  - Loss, restriction or probation of license; or
  - Government action such as debarment from Medicare and Medicaid; or
  - Cost and utilization issues; or
  - Quality of care issues.
- A BCBSTX medical director may immediately terminate a Physician/Professional Provider’s network participation if he/she determines that:
  - Continued network participation by the Physician/Professional Provider poses imminent harm to patient health; or
  - An action by a state licensing board effectively impairs the Physician/Professional Provider of the reason(s) for termination. Physician’s/Professional 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 of the reason(s) for termination.
- A Physician/Professional 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 Subscriber’s 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.
- Within sixty (60) days following receipt of Physician’s/Professional Provider’s written request for review, BCBSTX will notify provider of its review decision.
- Upon request, BCBSTX will provide Physician/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.