BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual -Provider Roles and Responsibilities

Important Information

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "**Plan**" is referenced, the information will apply to **all PPO** products

In this Section

The following topics are covered in this section:

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Role and Responsi-bilities

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

Role of the Primary Care Physician

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

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

- Provide the same level of care to BCBSTX patients as provided to all other patients.
- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. PCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- Be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to subscribers. Such requests must be responded to within one hour.
- Meet required Patient Appointment Access Standards ***(for more detail refer to Section J - Quality Improvement Program)***

Role of the Primary Care Physician, cont.

- Keep a central record of the subscriber's health and health care that is complete and accurate.
- When applicable, complete prior authorizations for inpatient admissions and outpatient services online using the Availity® Authorizations & Referrals tool, Blue ApprovR℠ or by calling the Utilization Management Department at **1-800-441-9188** when prior authorization is managed by BCBSTX or contacting Carelon when managed by them. UM contact phone numbers and addresses are listed in Section C of this provider manual. Refer to the detailed information and instructions in Sections C & E for more information on requesting prior authorizations.
- Provide copies of X-ray and laboratory results and other health records to specialty care health care providers to enhance continuity of care and to preclude duplication of diagnostic procedures.
- Provide BCBSTX, upon request and at no charge, copies of medical records when requested by BCBSTX for the purpose of claims review, quality improvement, risk adjustment or auditing.
- Enter into the subscriber's health record all reports received from Specialty Care health care providers.
- Assume the responsibility for arranging and prior authorizing hospital admissions in which he/she is the admitting physician or delegate this responsibility to the admitting Specialty Care health care providers or professional provider.
- Assume the responsibility for care management as soon as possible after receiving information that a **Plan** member has been hospitalized in the local area on an emergency basis.
- Coordinate inpatient care with the Specialty Care health care providers so that unnecessary visits by both providers are avoided.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the BCBSTX patient in accordance with Texas Department of Health standards.
- Cooperate with BCBSTX for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, third-party liens, and other third-party liability. BCBSTX contracted Physicians agree to file claims and encounter information with BCBSTX even if the Physician believes or knows there is a third-party liability.

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Role of the Primary Care Physician, cont.

- Only bill members for copayments, cost share (coinsurance) and deductibles, where applicable. The PCP will not offer to waive or accept lower copayments, cost share or otherwise provide financial incentives to members, including lower rates in lieu of the subscriber's insurance coverage.
- Agrees to use his/her best efforts to participate with BCBSTX's Plan's Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.

Role of the PCP for Blue Choice PPO Members

The role of the Primary Care Physician for **Plan** network is described below:

Primary Care Physician	Specialty Care Health Care Provider
• Primary role is to provide or direct all medical care for the **Plan** member. • For the **Plan** members to receive in-network benefits, the member must receive care from a participating **Plan Primary Care or Specialty Care** health care provider. • For information on behavioral health services, refer to the "Behavioral Health" section of this manual. • Obtain referral prior authorization for out-of-network referrals by calling **1-800-441-9188**. • **Important Note:** Out-of-network health care providers are providers who do not participate in the **Plan** network.	• Provides specialized care and/or services for the **Plan** members. • For **Plan** members to receive in-network benefits, the member must receive care from a participating **Plan** Specialty Care health care provider. • **Plan** members have direct access to **Plan** Specialty Care health care providers - **No Referral Required.** • 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.

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Referrals to Specialty Care Health Care Providers

Plan members have **direct access** to all participating **Plan** primary care and specialty care health care providers.

No referral is required.

Prior to referring a Plan enrollee to an out-of-network provider for non-emergency services, if such services are also available through an in-network Plan Provider, as a participating network provider you must contact BCBSTX Medical Management for authorization and also complete the appropriate "Out-of-Network Enrollee Notification" form. Refer to Section D Referral Notification Program of this provider manual for more information

Referrals to Specialty Care Health Care Providers

Role of the Specialty Care Health Care Providers

A **Plan** participating health care provider who provides services as a specialty care health care provider is expected to:

- Provide the same level of care to **Plan** patients as provided to all other patients.
- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. Specialty care health care providers will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Meet required Patient Appointment Access Standards ***(for more detail refer to Section J: Quality Improvement Program)***:
- Meet required Patient Appointment Access Standards ***(for more detail refer to Section J - Quality Improvement Program)***.
- Keep a central record of the subscriber's health and health care that is complete and accurate.
- Provide inpatient consultation within 24 hours of receipt of the request. Emergency consultation to be provided as soon as possible.
- Provide BCBSTX, upon request and at no charge, copies of medical records when requested by the **Plan** for the purpose of claims review, quality improvement, risk adjustment or auditing.

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Role of the Specialty Care Health Care Providers, cont.

- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the **Plan** patient in accordance with Texas Department of Health standards.
- Cooperate with BCBSTX for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, third-party liens, and other third-party liability. BCBSTX contracted health care providers agree to file claims with BCBSTX even if the health care provider believes or knows there is a third-party liability.
- Only bill for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty Care health care provider will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to member's, including lower rates in lieu of the subscriber's insurance coverage.
- Agrees to use his/her best efforts to participate with BCBSTX's Plan's Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.

Role of the OBGyn

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

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

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions

Role of the OBGyn, cont.

- Diagnosis, treatment, and access to a specialist for any disease or condition within the scope of the designated professional practice of a credentialed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts.
- When abnormalities are discovered, the **Plan** 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 **Plan** network.
- **Note:** Non-prescription contraceptives and associated care vary by employer benefit program. To verify coverage for this type of service, call BCBSTX Provider Customer Service at **1-800-451-0287.**

Notification for Obstetrical and Newborn Care

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

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

Note:

- Maternity care is subject to a one-time office visit copayment. This copayment should be collected at the time of the initial OB office visit.
- Physicians will be reimbursed for the initial OB visit separately from the "global maternity care" and should submit a claim for this service at the time of the initial OB visit.
- All subsequent office visits for maternity care and delivery are considered as part of the "global maternity care" reimbursement. Submit claim upon delivery.

Notification for Obstetrical and Newborn Care, cont.

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

Recommended Clinical Review Requests

Recommended Clinical Review are optional reviews for medical necessity submitted before services are completed for a Covered Service that does not require prior authorization and helps limit the situations where a service may be denied based upon medical necessity retrospectively.

**Prior to submitting a recommended clinical review request, you should always check eligibility and benefits first to determine any pre-service requirements. A recommended clinical review is not a substitute for the prior authorization process.* Recommended clinical review requests, can be submitted via:

- Availity® Attachments tool
- Recommended Clinical Review Form, available in the Education and Reference Center/Forms section of the BCBSTX provider website.

  Mail completed form to:
  Blue Cross and Blue Shield of Texas
  Attn: Recommended Clinical Review Department
  P.O. Box 660044
  Dallas, TX 75266-0044
  Fax to: **1-888-579-7935**
  For Status call: **1-800-451-0287**

Recommended Clinical Review Requests, cont.

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

***For **Federal Employee Program** members, refer to the FEP page and go to **Policies and Guidelines** at the bottom of the page or the FEP section of this provider manual.

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.

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Health Care Provider Complaint Procedure

Plan participating health care providers are urged to contact the **Plan** Provider Customer Service area when there is an administrative question, problem, complaint or claims issue at **1-800-451-0287**.

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

- Call **1-800-441-9188**
- Hours: 6 a.m. – 6 p.m., CST, M-F and non-legal holidays and 9 a.m. to 12 noon CST, Saturday, Sunday and legal holidays
- Messages may be left in a confidential voice mailbox after business hours.

Medical 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 **Plan** participating health care provider may contact the Texas Department of Insurance (TDI to obtain information on companies, coverage, rights or complaints at **1-800-252-3439** or utilize their online complaint system.

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

Failure to Establish, Health Care Provider-Patient Relationship – Performance Standard

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

- Fraudulent use of services or benefits;
- Threats of physical harm to a health care provider or office staff;
- Non-payment of required copayment for services rendered or applicable coinsurance and/or deductible;
- Evidence of receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or necessary;
- Refusal to accept a treatment or procedure recommended by the health care provider, if such refusal is incompatible with the continuation of the health care provider member/patient relationship (health care provider should also indicate if he/she believes that no professionally acceptable alternative treatment or procedure exists);
- Repeated refusal to comply with office procedure in accordance with acceptable community standards;
- Other behavior resulting in serious disruption of the health care provider member/patient relationship.

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

- Member's/patient's medical condition (i.e., catastrophic disease or disabilities);
- Amount, variety, or cost of covered health services required by the member/patient; patterns of over utilization, either known or experienced;
- Patterns of high utilization, either known or experienced.

Failure to Establish, Health Care Provider-Patient Relationship - Procedures

When the BCBSTX Network Management department, receives preliminary information indicating a contracted health care provider has deemed it necessary to terminate a relationship with a member/patient, the BCBSTX Network Management department will:

1. Review with the health care provider the following important points:
   a. Refer to the Performance Standard section above – and if necessary explain why he/she may not terminate his/her relationship with a member/patient.
   b. Determine the effective date of termination based on the following: The effective date must be no less than 30 calendar days from the date of the provider's notification letter to the member/patient. Exception: Immediate termination may be considered if a safety issue or gross misconduct is involved – must be reviewed and approved by BCBSTX.
   c. A notification letter from the health care provider to the subscriber/patient is required and must include:
      - Name of member/patient– if it involves a family, list all patients affected;
      - Member identification number(s);
      - Group number; and
      - The effective date of termination (as determined based on the above).
   d. A copy of the letter to the member/patient must be sent simultaneously to the applicable BCBSTX Network Management Representative (or Director), via email, or by fax or regular mail to the appropriate BCBSTX Network Management office.
      A list of the BCBSTX "Network Management Office Locations" including fax numbers and addresses is available by accessing the "Contact Us" area on the BCBSTX provider website.

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

   e. The health care provider must continue to provide medical services for the member/patient until the termination date stated in the provider's letter.

Failure to Establish, Health Care Provider-Patient Relationship -Procedures, cont.

When the BCBSTX Network Management department, receives a copy of the Health Care Provider's letter to the member/patient, the BCBSTX Network Management department will:

1. Contact the health care provider to confirm receipt of the letter, review important points outlined above, and address any outstanding issues, if applicable.
2. Forward the health care provider's letter to the applicable BCBSTX Customer Service area and they will:
   - Send a letter to the member/patient, 30 days prior to the termination date, which will include a new designated PCP or outline steps for the member/patient to select a new PCP (or SCP if applicable).
   - Send a follow-up resolution letter to the health care provider (or IPA/Medical Group if applicable).

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

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

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

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Sample of Letter from Health Care Provider to Member

Current Date

Patient Name*****
Address
City/State/Zip

Phone Number
BCBSTX Member Number
Group Number

Dear Patient:

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

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

Sincerely,

John Doe, M.D.

cc: BCBSTX Provider Relations Department

*****If the provider is terminating the relationship with a family, all member names should be listed in this area.

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Affordable Care Act

The Affordable Care Act offers a host of coverage changes and opportunities. BCBSTX is committed to implementing coverage changes to comply with the Affordable Care Act (ACA) requirements and to better meet the needs and expectations of you and your patients.

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

Risk Adjustment

Risk Adjustment seeks to level the playing field by discouraging adverse selection of members 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.
    If you have specific questions about Risk Adjustment, Risk Adjustment Validation Audits, medical record retrieval or other related topics, please email us at **risk adjustment@bcbstx.com.**