BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual - Roles and Responsibilities

Important Note:

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health**. 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** HMO products.

In this Section

The following topics are covered in this section:

BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual - Roles and Responsibilities

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Roles and Responsibilities Overview

The Blue Cross and Blue Shield of Texas health care provider roles and responsibilities will differ among the various specialties; however, certain responsibilities will be shared by all **Plan** health care providers.

Important Notes

* **Capitated Medical Groups:**
  Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral, prior authorization and recommended clinical review processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

* **Use of In-Network Providers:**
  The Primary Care Physician/Provider must utilize participating facilities in the member's Plan networks for all care that is rendered to these members.

Definition of PCP

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

Role of the PCP

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

Role of the Primary Care Physician/ Provider cont.

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

  Each PCP is responsible for making his/her own arrangement for patient coverage when out of town or unavailable. A physician/provider who has contracted with the Plans as a PCP will agree to render to these members primary, preventive, acute and chronic health care management and:

- 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. PCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the PCP or on-call physician/provider; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the PCP or on-call physician/provider and the phone number is provided.
- Be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to members. Such requests must be responded to within one hour.
- Meet required Patient Appointment Access Standards (for more detail refer to **Section G - Quality Improvement Program**).
- Keep a central record of the member's health and health care that is complete and accurate.
- Refer the member to specialty care physicians or professional providers within the member's same Provider Network.

Role of the Primary Care Physician/ Provider, cont.

Blue Advantage HMO Only Important Note:
PCP and Pediatricians will assist with referrals to dental care providers for members under the age of 20.

- For **Dental** – Dental Networks of America – call **1-800-972-7565**

PCP and Pediatricians will assist with referrals to vision care providers for members under the age of 19.

- For **Vision** for members under the age of 19 – call **EyeMed Vision Care** at **1-866-939-3633**

- When applicable, complete prior authorizations or recommended clinical reviews for inpatient admissions and outpatient services online using the Availity® Authorizations & Referrals tool, Blue ApprovR℠ or by calling the Medical Management Department at 1-800-441-9188 when prior authorization or recommended clinical review 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 or RCR.
- Provide copies of X-ray and laboratory results and other health records to specialty care physicians or professional providers to enhance continuity of care and to preclude duplication of diagnostic procedures. Provide copies of X- ray and laboratory results and other health records to specialty care physicians or professional providers to enhance continuity of care and to preclude duplication of diagnostic procedures.
- Provide copies of medical records when requested by BCBSTX for the purpose of claims review, quality improvement, risk adjustment or auditing.
- Enter into the member's health record all reports received from specialty care physicians or professional 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 physician or professional provider

Role of the Primary Care Physician/ Provider, cont.

- Assume the responsibility for care management as soon as possible after receiving information that a member on his/her PCP list has been hospitalized in the local area on an emergency basis.
- Coordinate inpatient care with the specialty care physician or professional provider so that unnecessary visits by both physicians are avoided.
- Maintain and operate his/her office or facility in a manner protective of the health and safety of his/her personnel and the patient in accordance with Texas Department of Health standards.
- Only bill *(or collect from)* members Copayments, Cost Share (Coinsurance) and Deductibles, where applicable. PCP will not offer to waive or accept lower copayments, cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member's insurance coverage. ***Note**: **Blue Essentials** copayment (s) for basic services shall not exceed fifty percent (50%) of the cost (contract allowable) for covered services.*
- Agrees to use his/her best efforts to participate with BCBSTX's Plan's Electronic Funds Transfer and Electronic Remittance Advise under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.
- Assume the responsibility for care management as soon as possible after receiving information that a member, on his/her PCP list, has been hospitalized in the local area on an emergency basis.
- Coordinate inpatient care with the specialty care physician or professional provider so that unnecessary visits by both physicians/providers are avoided.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the patient in accordance with Texas Department of Health standards.
- Cooperate with the plan for the proper coordination of benefits involving covered services and in the collection of third- party payments including workers' compensation, third-party liens and other third-party liability. Blue Essentials, Blue Advantage HMO, Blue Premier or MyBlue Health contracted physicians or professional providers agree to file claims and encounter information with BCBSTX even if the physician or professional provider believes or knows there is a third-party liability.

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Back up PCPs

The PCP designates backup (covering) primary care physicians/ providers during the network application process.

The covering physician is responsible for filing a claim for any member seen on behalf of the PCP. **The primary care physician/provider's staff must report any upcoming changes in covering PCP to their Network Management office.**

Referrals to Specialty Care Physicians or Professional Providers

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

Referrals to specialty care physicians or professional providers, except OBGyns, must be initiated by the PCP. It is essential that the PCP refer members requiring specialty care to participating physicians or professional providers within the member's same **Blue Essentials, Blue Advantage HMO, Blue Premier** or **MyBlue Health** provider network, if applicable.

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

Once Availity Authorizations & Referrals tool issues a confirmation number to the PCP for the referral to the specialty care physician or professional provider, the system will automatically generate notification letters to the specialty care physician or professional provider and to the member.

The PCP may provide the member with the Availity referral confirmation number to take to appointments with the specialty care physician or professional provider or the specialty care physician or professional provider can access Availity Authorizations & Referrals tool to obtain the referral confirmation number.

If the specialty care physician or professional provider determines that a member needs to be seen by another specialty care physician or professional provider, the member must be referred back to the member's PCP.

Note:

- The specialty care physician or professional provider cannot refer to other specialty care physicians or professional providers.
- **Blue Premier Access** allows "open access" within the Blue Premier provider network where PCP selection and referrals are NOT required

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Referrals to Specialty Care Physicians or Professional Providers, cont.

EXCEPTION: Primary Care or Specialty Care OBGyn physicians can directly manage and coordinate a woman's care for obstetrical and gynecological conditions, including obtaining referrals through Availity Authorizations & Referrals tool for obstetrical/ gynecological related specialty care and testing to other **Plan** participating physicians that participate in the same Provider Network as the member's PCP, if applicable.

Obstetrical and Newborn Care: beyond the normal length of stay (48 hours for a vaginal delivery and 96 hours for a C-Section) may require prior authorization or is available for a recommended clinical review through Availity Authorizations & Referrals tool.

Important Note:

Specialty Care Physicians/Providers must utilize Blue Essentials, Blue Advantage HMO, Blue Premier or MyBlue Health facilities within the member's same Provider Network for all care that is rendered to these members.

Request for Out-of-Network Referrals When No In-Network Provider is Available or for Continuity of Care

The Plan's Medical Management may require review all requests for Out-of-Plan or Out-of-Network referrals before a Plan member receives care. The PCP must contact the Medical Management Department at the applicable number listed on the next page to request consideration of an Out-of-Plan or Out-of-Network referral. The request will be reviewed and the Plan Medical Management Department will forward a determination letter to the Out-of-Plan or Out-of-Network physician, professional provider or facility provider.

If the provider needs to perform or refer a patient for a certain service that requires prior authorization or being performed at an Out-of-Network Facility, they must get a approval from medical Management. The referral for the out-of-network services does not apply to the services requiring prior authorization. The Out-of-Network referral must be obtained prior to requesting prior authorization for services from Medical Management.

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Blue Advantage Plus HMO (Point of Service benefit plan) Out-Of-Network Referral When an In-Network Provider Is Available

Before referring a **Blue Advantage Plus HMO** (Point of Service benefit plan) enrollee to an out-of-network provider for non-emergency services, if such services are also available through an in-network Blue Advantage HMO provider, as a participating network provider, you must complete the appropriate form. Refer to Section D Referral Notifications for more information.

If the out-of-network provider needs to perform a service that requires prior authorization or needs to refer a patient to another physician professional provider or facility for services, a separate referral is required to that provider. If that service also requires prior authorization, they must get an approval from Medical Management. The initial out-of-network provider referral does not apply to services requiring prior authorization. An Out-of-Network referral must be obtained prior to requesting prior authorization for services from Medical Management.

Role of the Specialty Care Physician or Professional Provider

A **Plan** participating physician or professional provider who provides services as a specialty care physician or professional 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. SCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Meet required Patient Appointment Access Standards (for more detail refer to Section G - Quality Improvement Program).

Role of the Specialty Care Physician or Professional Provider

- 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. SCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Meet required Patient Appointment Access Standards *(for more detail refer to **Section G - Quality Improvement Program**).*
- Keep a central record of the member's health and health care that is complete and accurate.
- Specialty Care Physicians must utilize **Blue Essentials, Blue Advantage HMO, Blue Premier** or **MyBlue Health** participating facilities within the member's same Provider Network for all care that is rendered to members.
- Accept referrals for members in accordance with the services and number of visits requested by the PCP in the same Provider Network, if applicable.
- Report back to the PCP upon completion of the consultation/ treatment.
- Provide copies of X-ray and laboratory results and other health record information to the member's PCP as appropriate.
- Coordinate inpatient care with the PCP so that unnecessary visits by other physicians or professional providers are avoided.
- The Medical Care Management IQMP staff will send written notification of the approval, to include the effective date [first (1st) day of the month following the approved decision] to the member within 30 calendar days of receiving the request for special consideration.

Role of the Specialty Care Physician or Professional Provider, cont.

- If the request for special consideration is denied by the plan, the 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 plan's Complaint Process.
- The effective date of the new designation of the non-primary care specialist will not be retroactive and may not reduce the amount of the compensation owed to the original PCP for services provided before the date of the new designation. For further details, contact Provider Customer Service:
  Blue Essentials & **Blue Premier: 1-877-299-2377**
  Blue Advantage HMO & **MyBlue Health**: **1-800-451-0287**
- Provide inpatient consultation within 24 hours of receipt of the request. Emergency consultation to be provided as soon as possible.
- Provide copies of medical records when requested by **BCBSTX** for the purpose of claims review, quality improvement, risk adjustment or auditing.
- Return the member to the care of the referring PCP as soon as medically feasible.
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the patient in accordance with Texas Department of Health standards.
- Cooperate with the plan for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, third- party liens and other third-party liability. BCBSTX contracted physicians agree to file claims and encounter information with BCBSTX even if the physician believes or knows there is a third-party liability.
- Only bill members for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty care physician or professional provider will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member's insurance coverage.
  Note: Blue Essentials copayment(s) for basic services shall not exceed fifty percent (50%) of the cost (contract allowable) for covered services.
- Agrees to use his/her best efforts to participate with the BCBSTX Plan's Electronic Funds Transfer and Electronic Remittance Advise under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form.

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Role of the Specialty Care Physician or Professional Provider, cont.

Additionally,

- If additional services and/or visits are needed, beyond those authorized by the PCP through the Availity Authorizations & Referrals tool or the Utilization Management Department, a new referral authorization must be obtained from the PCP
- If authorized by the PCP, arrange for hospital admission of the member into a participating Facility through the Utilization Management Department and assume responsibility for completion of steps required by the plan to prior authorize or submit an RCR for the admission.

Specialist as a Primary Care Physician/ Provider

Any member with chronic, disabling or life-threatening illnesses may apply to the plan's Medical Director to utilize a specialty care professional provider as a PCP provided that:

- The request for the specialty care physician or professional provider includes certification of medical need, along with all applicable supporting documentation, and is signed by the member or the specialty care physician or professional provider interested in serving as the PCP.
- The specialty care physician or professional provider must meet the plan's requirements for PCP participation. Refer to above pages titled, Role of the Primary Care Physician/Provider. The specialty care physician or professional provider is willing to coordinate all the member’s health care needs and accept the plan's reimbursement.All physicians or professional providers participating in the plan must have a current Texas license, be in good standing with the licensing board, the Provider Network and its hospital affiliates and BCBSTX plus meet other credentialing criteria established by the plan.
- If the request for special consideration is approved by the plan, the Network Management Representative contacts the specialist within 30 days of receiving the request to educate them on the role and responsibilities of the PCP, preventive care guidelines, claim filing instructions and discuss reimbursement. The representative will provide instructions on how to view on the BCBSTX provider website a current directory of participating specialists and professional providers.

Specialist as a Primary Care Physician/ Provider, cont

- If the request for special consideration is approved by the plan, the Network Management Representative contacts the specialist within 30 days of receiving the request to educate them on the role and responsibilities of the PCP, preventive care guidelines, claim filing instructions and discuss reimbursement. The representative will provide instructions on how to view on the BCBSTX provider website a current directory of participating specialists and professional providers.

Role of OBGyn as a Specialty Care Physician

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

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

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions
- Diagnosis, treatment, and referral to a specialist who participates in the same provider network as the member's PCP, for any disease or condition within the scope of the designated professional practice of a credentialed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts.

A female member may access a **Plan** participating OBGyn physician *participating in the same Provider Network as her PCP* without obtaining a referral from her PCP **or** calling the plan.

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

If the OBGyn physician has issued a referral to another specialty care physician or professional provider and additional follow-up visits are necessary for the member to see the specialty care physician or professional provider, the OBGyn physician is responsible for issuing a new referral or extending the original referral and obtaining referral authorization through the Availity Authorizations & Referrals tool.

Role of OBGyn as a Specialty Care Physician. cont.

Services for all other conditions must be coordinated through the member's PCP. Also, any services rendered outside of the OBGyn's office, such as ultrasound and mammograms, must be performed by Facilities contracted in the same Provider Network as the member's PCP.

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

Notification of Obstetrical and Newborn Care

After the first prenatal visit, the participating physician's office should provide notification of the member's obstetrical care through the Availity Authorizations & Referrals tool. 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 through the Availity Authorizations & Referrals tool.

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 (CPT®) Codebook 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, refer to the antepartum and postpartum care codes 59400-59426 and 59430. For one to three care visits, refer to the appropriate Evaluation and Management code(s).

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Provider Complaint Process

The **Plan** participating health care providers are urged to contact Provider Customer Service when there is an administrative question, problem, complaint or claims issue.

- **Blue Essentials** - call **1-877-299-2377**
- **Blue Advantage HMO** - call **1-800-451-0287**
- **Blue Premier** – call **1-877-299-2377**
- **MyBlue Health** - call **1-800-451-0287**

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

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

Utilization Management decisions may be formally appealed by phone, fax or in writing. For appeals of denied claims, refer to **Section F – Filing Claims** in this Provider Manual.

A **Plan** participating physician or professional provider may contact the Texas Department of Insurance to obtain information on companies, coverage, rights or complaints at **1-800-252-3439** or utilize the TDI 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 include, but are not limited to, the following:

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

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

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

Failure to Establish Health Care Provider-Patient Relationship - Procedures

When the our Network Management Department receives preliminary information indicating a contracted **Plan** health care provider has deemed it necessary to terminate a relationship with a member, the Network Management Department will:

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.
b. Determine the effective date of termination based on the following: The effective date must be no less than 30 calendar days from the date of the provider's notification letter to the member. Exceptions: 1) If the provider is a plan PCP, the term date must be the last day of the month following the initial 30 calendar days timeframe (due to monthly capitation arrangement with some PCPs); 2) Immediate termination may be considered if a safety issue or gross misconduct is involved – must be reviewed and approved by BCBSTX.
c. A notification letter from the physician to the member is required and must include:
    - Name of the member(s) – if it involves a family, list all members affected;
    - Member identification number(s);
    - Group number; and
    - The effective date of termination (as determined based on the above).
d. A copy of the letter to the member must be sent simultaneously to the applicable 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 Contracting 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 can be found further in this manual.*

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

e. The health care provider must continue to provide medical services for the member until the termination date stated in the provider's letter. If the health care provider is a PCP, he/she may refer the member to another Network health care provider. If the PCP is affiliated with an IPA/Medical Group, he/she may refer the member to a Physician within the IPA/Medical Group. Having a referral on file, if required, will assure the member continues to receive covered benefits until a new PCP is selected and effective.

When the BCBSTX Network Management Department receives a copy of the Health Care Provider letter to the member, the 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 letter to the applicable BCBSTX Customer Service area and they will:
    - Send a letter to the member, 30 days prior to the termination date, which will include a new designated PCP or outline steps for the member to select a new PCP (or SCP if applicable).
    - Send a follow-up resolution letter to the health care provider (or IPA/Medical Group if applicable).

If the health care provider agrees to continue to see the member:

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

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

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Sample of Letter from Provider to Member

Current Date

Patient Name*
Address
City/State/Zip
Phone Number
[Member/Subscriber Number]
Group Number

Dear Patient:

I will no longer be providing services to you as a_____*(insert Primary Care Physician/ Provider or Specialty Care Physician)*. I will continue to be available to you for your health care until_____*(date)*. *(**Note**: end date must be no less than 30 calendar days from the date of this letter, and if the physician is a **plan** PCP the end date must be the last day of the month following the initial 30 days).* After this date, I will no longer be responsible for your medical care.

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

John Doe, M.D.

cc: BCBSTX Network Management Department

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

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Panel Closure

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

Notwithstanding practice closure, Individual PCP, Medical Group or Medical Group PCP agrees to accept all existing patients who are or become plan members. Individual PCP, Medical Group or Medical Group PCP agrees that the plan shall have no obligation to guarantee any minimum number of **Plan** members to Individual PCP, Medical Group or Medical Group PCP and that Individual PCP, Medical Group or Medical Group PCP shall accept all patients enrolling as plan members.

Key Points:

- 90 days prior written notice to close practice is required.
- PCP may only close his/her practice to **Plan** members if he/she closes his/her practice to all other patients, or if he/she has at least 300 or more **Plan** members.

Thus, if the PCP has less than 300 **Plan** members, he/she can only close his/her practice to those members if he/she closes his/her practice to **Blue Choice PPO** members **AND** patients from all other health plans.

If a **Plan** PCP has at least 300 plan members, he/she can close his/her practice for **Plan** members and leave his/her practice open for all other patients.

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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 ACA requirements and to better meet the needs and expectations of you and your patients.

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

Risk Adjustment

Risk Adjustment seeks to level the playing field by discouraging adverse selection of members andis 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
- Submission of risk adjustable diagnoses to CMS via claim submission.
  - 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 riskadjustment@bcbstx.com.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Roles and Responsibilities

Premium Payments for Individual Plans

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

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

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