BlueCross BlueShield of Texas

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

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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Eligibility and Benefits Overview

This section of the manual provides an insight into importance of a Blue Cross and Blue Shield of Texas (BCBSTX) member's eligibility and benefits and how to make sure the services you are providing are covered.

Checking Eligibility and Benefits

Providers are responsible for checking eligibility and benefits prior to rendering services on every member for every visit. Eligibility and benefit quotes include membership and coverage status, prior authorization requirements and determination that the provider is in-network for the patient's policy. It also includes other important information, such as applicable copayment, coinsurance and deductible amounts. Providers can check eligibility and benefits:

- Online via Availity® Essentials
- By phone contacting BCBSTX Provider Customer Service at the numbers listed below or on the back of the member's ID card.

BCBSTX members are provided an identification card when they become eligible for our plans. At times, the member may not have a card prior to needing services. Providers can obtain the member's information by:

- The Patient ID Finder tool via Availity
- Accepting a copy of the enrollment confirmation letter
- Contacting BCBSTX Provider Customer Service at the numbers listed below.

BCBSTX also recommends that the member's identification is verified with a photo ID and that a copy is retained for his/her file.

BCBSTX Provider Customer Service:

- **1-800-451-0287 - Blue Choice PPO, BlueEdge, Blue High Performance Network, EPO,** and **Indemnity**
- **1-800-442-4607 - Federal Employee Program — FEP (all areas)**
- **1-800-676-BLUE (2583) - Out-of-State Blues Plan Members** (You must have the three-character prefix from the member's ID card to utilize this service.)

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Eligibility Statement

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

Premium Payments for Individual Plan

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, 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 requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSTX directly for any or all of an enrollee's premium.

Verification

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

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

Verification Procedure

To initiate a request for verification, please contact BCBSTX Provider Customer Service at **1-800-451-0287** and select the prompt for verification.

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

The verification process includes researching eligibility, benefits, and authorizations. BCBSTX will respond to the health care provider's request with one of the following letters within the required time frames:

- Request for Additional Information
- Verification Notice
- Declination Notice

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Delegated Entity Responsible for Claim Payment

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

Required Elements to Initiate a Verification

The 13 required elements a network health care provider needs to supply to initiate a verification are as follows:

1) patient name
2) patient ID number
3) patient date of birth
4) name of enrollee or subscriber
5) patient relationship to enrollee or subscriber
6) presumptive diagnosis, if known, otherwise presenting symptoms
7) description of proposed procedure(s) or procedure code(s)
8) place of service code where services will be provided and if a place of service is other than health care provider's office or health care provider's location need name of hospital or facility where proposed service will be provided
9) proposed date of service
10) group number
11) if known to the health care provider, name and contact information of any other carrier, including
    a) other carrier's name
    b) address
    c) telephone number
    d) name of enrollee
    e) plan or ID number
    f) group number (if applicable)
    g) group name (if applicable)
12) name of the health care provider providing the proposed services
13) physician's or professional provider's National Provider Identifier (NPI) number

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

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

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Declination

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

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

Policy or contract limitations:

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

A declination is simply a decision that a guarantee cannot be issued in advance, not a determination that a claim will not be paid. Therefore, if a declination is given, health care providers cannot bill the member at the time of service except for the applicable copayments, deductibles or coinsurance amounts.

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Additional Fees Charged By Participating Health Care Providers Beyond Copayments and Coinsurance

- **The Plan** discourages the practice of participating health care providers charging members additional fees beyond required copayments and coinsurance.
- **Plan** participating health care provider agreements require health care providers to treat subscribers in the same manner as all other patients. These subscribers should be treated in accordance with the same standards, and within the same time availability as such services are provided to other patients, and without regard to the degree or frequency of utilization of such services.
- Notwithstanding the above, if a participating health care charges additional fees to its entire population of patients in the same manner for **non-covered services** and the **Plan** member agrees in advance and in writing to accept payment responsibility for the **non-covered service** prior to receiving that service, then it would be acceptable to charge the member for the service. Non-covered services include personal choice services such as cosmetic surgery for which the member agrees in advance and in writing to pay. **Any such additional fee must be voluntary for members**. **Note:** Services for which **the Plan** denies payment based on bundling or other claim edits ***cannot*** be billed to the member even if the member has agreed in writing to be responsible for non-covered services. The services referenced in this note are Covered Services but are not payable under **Plan** claims edits.
- A participating health care provider cannot require **Plan** members to pay any type of "access fee" as a prerequisite to receiving services that are covered under member benefit plans.
- **Plan** members who do not pay the "access fee" must not be treated differently from patients who pay the "access fee" with regard to quality, comprehensiveness of care services, reasonable access to appointments, or after-hours coverage.

Recommended Clinical Review Requests

Recommended Clinical Review is an optional review 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. For more information refer to the Recommended Clinical Review page on the provider website.

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Recommended Clinical Review Requests

Recommended Clinical Review requests, can be submitted via:

- Availity Attachments tool
- Recommended Clinical Review Request form is 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
  P.O. Box 660044 Dallas, TX 75266-0044
  For Urgent Requests Only – Fax to: **1-888-579-7935**

Note: *The fact that a guideline is available for any given treatment, or that a service or treatment has an approved prior authorization or recommended clinical review is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.*

Room Rate Notification

Numerous plan group and member benefits only provide for a semi-private room. The room rate on file and loaded in the claims payment system is used to determine the patient's liability for claims when the difference between the private room and the semi-private room is the patient's responsibility. Therefore, the accurate information that you provide, assists in adjudicating the claim with the correct patient liability.

For updates, please notify BCBSTX at least 30 days prior to the planned effective date.

The **Room Rates Notification Form** is located on the BCBSTX Provider website under Education & Reference then Forms. The completed form can be faxed to the applicable fax number listed on the form or mail to your Network Management Representative.

It is also important to notify BCBSTX if your facility becomes private room only or a wing of the hospital is private room only. Once the information is received, BCBSTX will update their records with the effective date being later of:

- The actual effective date of the new rate, or
- Date it was received by BCBSTX

Contact your local Network Management Office with any questions.

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BlueCard Program

The BlueCard Program links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. The program ensures that subscribers can obtain health care services while traveling or living in another Blue Plan's area. With BlueCard, they receive all the same benefits of their contracting Blue Cross and Blue Shield Plans, and access to BlueCard health care health care providers and savings.

Health care providers and hospitals in Texas submit claims for subscribers from other Blue Plans electronically. When a paper claim is submitted, use the following address:

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

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

Additionally, the program offers members access to international hospital coverage.

For detailed information on BlueCard, refer to the BlueCard Provider Manual on the BlueCard page of the provider website.

Why is BlueCard Program Important To Health Care Providers

Health care providers save significant time and money through efficient and timely payment for services rendered. Savings are passed on to health care providers through reduced administrative costs for claims processing.

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Look for the BlueCard PPO Logo

The three-character prefix, at the beginning of the member's ID number, is the key element used to identify the member's Blue Plan and correctly route out-of-area claims.

How BlueCard Works

- When a member is outside his or her Blue Cross and Blue Shield Plan area and needs health care, he or she calls BlueCard Access at **1-800-810-BLUE (2583)** for information on the nearest Blue Cross and Blue Shield health care physicians and professional providers and facilities. BlueCard physicians or professional providers in the area where the member is traveling or living are available through this number.
- The member presents his or her ID card and the physician or professional provider verifies his or her membership and coverage with the member's Blue Plan by calling BlueCard Eligibility at **1-800-676-BLUE (2583)**.
- After the member receives care, the physician or professional provider files the claim with BCBSTX. The member is only responsible for any non-covered services, deductible, copayment and coinsurance amounts.
- BCBSTX electronically routes the claim to the member's Blue Cross and Blue Shield Plan for processing. The member's contract benefits apply.
- The member's Blue Cross and Blue Shield Plan send the member a detailed Explanation of Benefits report, while BCBSTX reimburses the physician or professional provider.
- Once the member receives care, submit the claim electronically. If you need assistance with electronic claims, call Availity® at **1-877-334-8446**. If you submit the claim by mail, use the following address:

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

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How BlueCard Works, cont.

- Make sure you include the member's correct three-character prefix as it appears on the member's ID card.
- When we (BCBSTX) receive the claim, it is electronically routed to the member's Blue Cross and Blue Shield Plan. The member's Plan then processes the claim and approves payment, and we (BCBSTX) pay you according to our contract.

How to Use the BlueCard 800 # Network

Step	Action
1	Have the member's ID number, including the three-character prefix, ready before calling.
2	Call **1-800-676-BLUE (2583)**. The 800 number gives you direct access to information on: ● Eligibility and coverage ● Dependents ● Deductibles ● Copayments ● Coinsurance ● Benefit maximums ● Other patient information
3	You will be asked to voice the member's three (3) character prefix. Make sure you voice it exactly as it appears on the ID card. The prefix is the "key" to the BlueCard Program.