BlueCross BlueShield of Texas

Blue Advantage HMO℠ Quick Reference Guide

Major Characteristics	Benefits, Eligibility, Claims Status or Verification	Claim Reviews, All Correspondence	Preauthorization, Online Approval of Benefits for Select Outpatient Services and Inpatient Admissions	Laboratory Services	Behavioral Health Services (Mental Health and Chemical Dependency)
• **Blue Advantage HMO** members must select a **Blue Advantage HMO** Primary Care Physician (PCP). • Blue Advantage providers may only bill for copayments, cost share (coinsurance) and deductibles, where applicable. • **Some services may be self-referred to aBlue Advantage HMO** physician or professional provider (i.e. annual well woman exam, annual routine eye exam) as indicated by the member's benefit plan. • To receive benefits, all medical care must be directed by the selected **Blue Advantage HMO** PCP. A PCP referral is required to all **Blue Advantage HMO** Specialist Physicians, Professional Providers, Facility or Ancillary Providers. • To receive benefits, referrals to out-of-network physicians, professional providers, facility or ancillay providers must be authorized by the Utilization Management Dept. • As of 1/1/17, Blue Advantage HMO members 19 and younger will receive their annual eye exam and eye wear from **EyeMed Vision Care** providers. **Blue Advantage HMO** members will continue to use **Blue Advantage HMO** contracted providers for medical eye care. Please include all appropriate diagnosis codes on your claims in order to accurately represent the services provided. To request network participation with **EyeMed Vision Care**, please call (888) 581-3648. For all other **Blue Advantage HMO** members, providers for vision care could vary. Contact the customer service number on the member's ID card to verify the member's vision benefits. • **Blue Advantage HMO** members under age 20 have an included dental benefit. For more information, refer to the member's **Blue Advantage HMO** ID card or call **Dental Network of America** at **800-820-9994**.	• Eligibility and benefit information may be obtained through availity.com or a web vendor of your choice or call **Blue Advantage HMO** Provider Customer Service: **800-451-0287*** • Claim Status may be obtained through the Availity Claim Research tool or a web vendor of your choice. • To adjust a claim, call **Blue Advantage HMO** Provider Customer Service: **800-451-0287*** • **Verification does not apply to administrative services only (ASO) plans.** • **All claims should be submitted electronically. Blue Advantage HMO** Electronic Payor ID: **84980** • If the physician, professional provider, facility or ancillary provider must file a paper claim, mail claim to: **Blue Advantage HMO** P.O. Box 660044 Dallas, TX 75266-0044 • Claims must be submitted within **180** days of the date of service. Claims that are not submitted within **180** days from the date of service are not eligible for reimbursement. Physicians, professional providers, facility or ancillary providers must submit a complete claim for any services provided to a member. **Blue Advantage HMO** physicians, professional providers, facility or ancillary providers may not seek payment from the member for claims submitted after the **180** day filing deadline. ** To access eligibility and benefits, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc.* *** To adjust a claim, you must have a document control number (claim number).*	• Claim Reviews and Correspondence should be sent to: **Blue Advantage HMO** P.O. Box 660044 Dallas, TX 75266-0044 • The Claim Review form with instructions is located on the BCBSTX website: bcbstx.com/ provider click on the Education and Reference tab, then click on Forms	• Access the iExchange Web application through the BCBSTX website at http://www.bcbstx.com/provider/tools/iexchange.html **or** call the iExchange Interactive Voice Response (IVR) System at **800-451-0287**. • Current listings of providers and their NPI numbers are available online through the iExchange Web application or Provider Finder®. • For questions or problems, call the iExchange Support Desk at **800-746-4614**. • For case management or to contact the Medical Care Management Dept., call **855-896-2701**. • For referrals, approval of benefits for select outpatient preauthorizations and inpatient admissions, refer to the iExchange webpage at http://www.bcbstx.com/provider/tools/iexchange.html *(Note: A link to the Preauthorization/ Notification/Referral Requirements List is located in the left-side navigation under Related Resources)* **or** refer to the Blue Essentials (formerly HMO Blue Texas℠), Blue Advantage HMO and Blue Premier Provider Manual sections D and E. • For preauthorization for outpatient molecular and genome testing and outpatient radiation therapy, contact eviCore at www.evicore.com or 1(855)252-1117.	**Laboratory Services** • Quest Diagnostics, Inc. is the **exclusive** lab for **Blue Advantage HMO** for all outpatient clinical reference laboratory services. For locations or questions, contact Quest at **888-277-8772, or** visit Quest's website at: QuestDiagnostics.com/patient	• Magellan Behavioral Health Providers of Texas, Inc. (Magellan) coordinates all behavioral health (mental health and chemical dependency) services for **Blue Advantage HMO** members. • To obtain preauthorization, check benefits, eligibility, claims status/problems or verification, call Magellan at **800-729-2422.** • The patient, Primary Care Physician (PCP) or behavioral health professional must contact Magellan to preauthorize all inpatient, partial hospitalization and outpatient behavioral health services. • Preauthorization must be obtained ***prior*** to the delivery of care for behavioral health services. • The physician or professional provider is responsible for filing claims. Mail claims to: Magellan Behavioral Health Providers of Texas, Inc. Attn: Claims P.O. Box 1659 Maryland Heights, MO 63043 ***Note**: Claim Status may be obtained through the Availity Claim Research tool or a web vendor of your choice.*

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the HMO Blue Texas℠ and Blue Advantage HMO℠ Physician and Professional Provider – Provider Manual online at bcbstx.com/provider.

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Blue Advantage HMO Quick Reference Guide Additional Information Page, cont'd

For Blue Advantage HMO, BCBSTX encourages the provider's office to:

- Ask for the member's ID card at the time of a visit;
- Copy both sides of the member's ID card and keep the copy with the patient's file;
- Eligibility, benefits and/or verification requests, contact availity.com, or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.
- Utilize the iExchange Web application at http://www.bcbstx.com/provider/tools/iexchange.html to obtain approval of: referrals, select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. For case management, call the Medical Care Management Department at **855-896-2701**.

Claims Submission:

- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is **84980**.
  - For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at **800-AVAILITY (282-4546)**.
  - For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at **800-AVAILITY (282-4546).**
  - For information on electronic filing, access the Availity website at availity.com.
- Paper claims must be submitted on the Standard CMS-1500 (02/12) or UB-04 claim form.
- All claims must be filed with the insured's complete unique ID number including any letter or 3-digit alpha prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. **Note**: This does not apply to services provided by an employee of a physician or professional provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing physician or professional provider.

Provider Record ID and Network Effective Dates:

- A minimum of 30 days advance notice is required when making changes affecting the provider's BCBSTX status, especially in the following areas:
  (1) Physical address (primary, secondary, tertiary); (2) Billing address; (3) NPI and Provider Record ID changes; (4) Moving from Group to Solo practice; (5) Moving from Solo to Group practice; (6) Moving from Group to Group practice; and (7) Backup/covering providers.
- ***New*** Provider Record ID effective dates will be established as of the date the completed application is received in the BCBSTX corporate office. This applies to all additions, changes and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files claims electronically and their Provider Record ID changes, the provider must contact the Availity Health Information Network at **800-AVAILITY (282-4546)** to obtain a new EDI Agreement.
- For Provider Record ID questions or to obtain a Provider Record ID application, please contact the Provider Services department at **972-996-9610**, *press 3*.

BlueCard (Out-of-State Claims):

- To check benefits or eligibility, call **800-676-BLUE** (2583);
- File all that include a 3-digit alpha prefix on the member's ID card to BCBSTX ***(Note**: The member's unique ID number may contain alpha characters which may or may not directly follow the 3-digit alpha prefix);*
- File all other claims directly to the Home Plan's address as it appears on the back of the member's ID card;
- For status of claims filed to BCBSTX, contact availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.

Blue Advantage HMO – Outpatient Clinical Reference Lab Services

All outpatient clinical reference lab services must be referred to **Blue Advantage HMO**'s exclusive lab provider - **Quest Diagnostics, Inc**.

The **Affordable Care Act (ACA)** includes a provision that gives Health Insurance Marketplace members who receive **advanced premium tax credits (APTC)** also known as subsidies, a three-month grace period to pay their premium.

- **Grace Period Overview:**
  - The three-month grace period is only required for enrollees who have made one full premium payment during the benefit year and who are receiving the **APTC**.
  - The health plan is responsible for adjudicating claims during the first month after a member enters the grace period. The claims adjudicated are for dates of service rendered within the first month of this grace period.
  - During the second and third months of the grace period, issuers have the choice of either pending the claims or adjudicating the claims and seeking a refund if the member doesn't pay all outstanding premium payments.
  - If a member fails to pay all outstanding premiums by the end of the three-month grace period, the health plan must terminate the member's coverage.
  - For additional details, go to www.Healthcare.gov.
- **How will BCBSTX make providers aware?**
  - Eligibility and Benefits Determination will include a paid through date and be provided by:
    - Electronic and/or clearinghouse compliant with the HIPAA 270/271
    - Interactive Voice Response (IVR) / automated telephone system
    - Provider Customer Service
  - Reminders to check for grace period status will be included on correspondence related to:
    - Pre-determinations
    - Preauthorizations
    - Referrals

** To access eligibility and benefits, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc.*
*** To adjust a claim, you must have a document control number (claim number).*