# Consumer Directed HealthSelect℠ (CDHS) Quick Reference Guide

## MAIN CHARACTERISTICS

**Employee Retirement System of Texas (ERS)** offers a **Consumer Directed HealthSelect (CDHS)** Plan to its participants. The **Consumer Directed HealthSelect (CDHS) Plan** offers:

- A Point of Service (POS) plan utilizing the Blue Essentials℠ providers for in network benefits and also
- A high deductible – which is offset by the HSA.
- An account established from which the first of any services incurred may be paid on a 100% basis.
- Preventive/Wellness services from in-network professional providers, facility, and ancillary providers paid at 100% of the allowable fee, separate from the HSA (services may include: physicals, diagnostic tests including lab, radiology and mammograms, and well child care and immunizations).
- If HSA funds are depleted, the participant would be responsible out of pocket for any remaining deductible or coinsurance.
- The Provider Claim Summary (PCS) will notify you of any patient responsibility. The participant may be billed for any deductible and coinsurance amount.
- To receive network benefits, CDHS participants must receive medical care from a physician, professionalprovider, facility, or ancillary provider within their applicable network. Network physicians, professional providers, facility and ancillary providers may only bill CDHS participants for deductibles, coinsurance and non-covered services.

If the participant has **CDHS HSA (Health Savings Account),** here are some important features:

- HSA can be funded from ERS, participant or both. Amounts for eligible POS expenses are applied to meeting the deductible.
- If participant elects, claims are paid by BCBSTX using available HSA account balance until the account is depleted.
- The participant may also access their available funds by use of a debit card issued by the HSA administrator.

## BENEFITS AND ELIGIBILITY

- Eligibility and benefit information may be obtainedthrough availity.com or a web vendor of your choice or call **HealthSelect of Texas Provider Customer Service** at **1-800-451-0287.**
  Note: *To access eligibility and benefits, you must have full participant's information, i.e.,. participant's ID, patient date of birth, etc.*
- Verification does not apply to **Consumer Directed HealthSelect** participants.
- Patient eligibility and benefits should be verified prior to every scheduled appointment.

## CLAIM SUBMISSIONS

- All claims should be submitted electronically. **BCBSTX Payor ID: 84980**
- If the provider must submit a paper claim, mail claim to:

  **Consumer Directed HealthSelect of Texas**, P.O. Box 660044 Dallas, TX 75266-0044

- **CDHS** 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. Providers must submit a complete claim for any services provided to a participant. **Blue Essential** providers may not seek payment from the participant for claims submitted after the 180 day filing deadline.

## CLAIMS STATUS AND PROCESSING

- Claim Status may be obtained through the Availity® Claim Status Tool or a web vendor of your choice.
- To adjust a claim, you must have a document control number (claim number) then submit:
  - Electronically via the Claim Inquiry Resolution Tool when available
  - Mail the **Claim Review** form which is located on the BCBSTX provider website. Select **Education & Reference** then select **Forms.**
  - Call **BCBSTX Provider Customer Service** at **1-800-451-0287**.
- Claim Reviews and Correspondence should be sent to: BCBSTX, P.O. Box 660044 Dallas, TX 75266-0044



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BlueCross BlueShield of Texas

## UTILIZATION MANAGEMENT - Prior Authorization and Referrals

- Providers should verify through Availity® or their preferred vendor if prior authorization or referrals are required for select outpatient or inpatient services and determine if they are managed by BCBSTX Medical Care Management or Carelon Medical Benefit Management (Carelon).
- Some services may be subject to a Prior Authorization Exemption.
- Refer to Utilization Management on the provider website for additional information.
- To submit referrals for specialty care and prior authorizations requests for inpatient and outpatients services managed by:
    - **BCBSTX Medical Management:**

      (1) Submit online using Availity Authorizations & Referrals Tool
        - ✓ Log in to Availity
        - ✓ Select **Patient Registration** menu option, choose **Authorizations & Referrals**, then **Authorizations** (choose **Referrals** instead of **Authorizations** if you are submitting a referral request)
        - ✓ Select **Payer BCBSTX**, then choose your organization
        - ✓ Select I**npatient Authorization** or **Outpatient Authorization**
        - ✓ Review and submit your authorization
        - ✓ For more information, refer to Availity Authorizations & Referrals under Provider Tools on the provider website.

      (2) By Phone: **1-855-896-2701**
    - **Carelon Medical Benefit Management:**

      (1) Submit online using Carelon Provider Portal

      (2) By Phone: **1-800-859-5299**
- Current listings of providers and their NPI numbers are available online through Provider Finder®.
- For case management or to contact the Utilization Management Dept., call **1-800-441-9188**

## LABORATORY SERVICES

- All Plan providers should refer participants to in-network lab providers for outpatient lab services. To locate participating labs in the Plan network, visit Provider Finder.
- The following are participating statewide outpatient clinical labs for **Consumer Direct HealthSelect** participants
    - Quest Diagnostics, Inc. - For locations and questions contact Quest at **1-888-277-8772** or visit Quest's website at www.questdiagnostics.com.
    - Clinical Pathology Laboratory (CPL) – For locations or questions,contact CPL at**1-800-595-1275** or visit CPL's website at www.cpllabs.com.
    - LabCorp for locations and questions, contact **1-888-LabCorp** or visit LabCorp's website at www.labcorp.com.
- For additional information, refer to the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual.

BlueCross BlueShield of Texas

## MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

- Prior authorization must be obtained prior to the delivery of care including all inpatient, partial hospitalization and outpatient mental health and substance use disorder services.
- To obtain prior authorization, check benefits, eligibility, claims status/problems or check benefits, use Availity Authorizations & Referrals or call **1-800-528- 7264.**
- The patient, PCP or servicing health professional must prior authorize all inpatient, partial hospitalization and outpatient mental health and substance use disorder services.
- The health care provider is responsible for filing claims electronically using BCBSTX Electronic Payor ID: 84980 or mailing paper claims to BCBSTX, P.O. Box 660044 Dallas, TX 75266-0044.
- Note: Claim Status may be obtained through the Availity Claim Status Tool or a web vendor of your choice.

## ADDITIONAL INFORMATION

**Claims Submission:**

- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is 84980.
  - 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 1-800-282-4548.
  - For information on electronic filing, access the Availity website at availity.com/essentials.
  - 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 the 3-character 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.

**ParPlan** is a Blue Cross and Blue Shield of Texas (BCBSTX) payment plan under which health care professionals agree to:

- File all claims electronically for BCBSTX patients;
- Accept the BCBSTX allowable amount;
- Bill subscribers only for deductibles, cost-share (coinsurance) and medically necessary services which are limited or not covered; either at the time of service or after BCBSTX has reimbursed the provider;
- Not bill BCBSTX for experimental, investigative or otherwise unproven or excluded services; and
- Not bill either BCBSTX or subscribers for covered services which are not medically necessary.

**BCBSTX encourages the provider's office to:**

- Ask for the subscriber's ID card at the time of a visit;
- Copy both sides of the participant 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 subscriber's ID card.
- Claim Status may be obtained through the Availity Claim Status Tool or a web vendor of your choice.
- Utilize Availity Authorization & Referrals at www.availity.com or call **1-855-896-2701** to obtain: approval of referrals, approval of benefits for 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 **1-800-344-2354.**

**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:
  Physical address (primary, secondary, tertiary); Billing address; NPI and Provider Record ID changes; Moving from Group to Solo practice or vice versa; Moving from Group to Group practice; and (7) Backup/covering providers. Utilize the Demographic Change Form to submit changes.
- 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.

## ADDITIONAL INFORMATION - continued

**Provider Record ID and Network Effective Dates (cont.):**

- 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 **1-800-282-4548** to obtain a new EDI Agreement.
- Submit a Provider Onboarding Form to obtain a Provider Record ID. Please visit the Network Participation page on our website for more information.

**BlueCard® (Out-of-State Claims):**

- To check benefits or eligibility, call **1-800-676-BLUE (2583)***;
- File all claims that include a 3-character prefix on the subscriber's ID card to BCBSTX (Note: The subscriber's unique ID number may contain alpha characters which may or may not directly follow the character prefix);
- File all other claims directly to the Home Plan's address as it appears on the back of the participant ID card;
- For status of claims filed to BCBSTX, contact Availity® Essentials or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the subscriber's ID card.

  *Interactive Voice Response (IVR) system. To access, you must have full member's information, i.e., member's ID, patient date of birth, etc.)

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 **Blue Essentials®, Blue Advantage HMO℠, Blue Premier® and MyBlue Health® Provider Manual** online at https://www.bcbstx.com/provider/standards/standards-requirements/manuals/hmo-manual.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for participants with coverage through BCBSTX.

BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Please note that verification of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the participant's eligibility and the terms of the participant's certificate of coverage applicable on the date services were rendered.