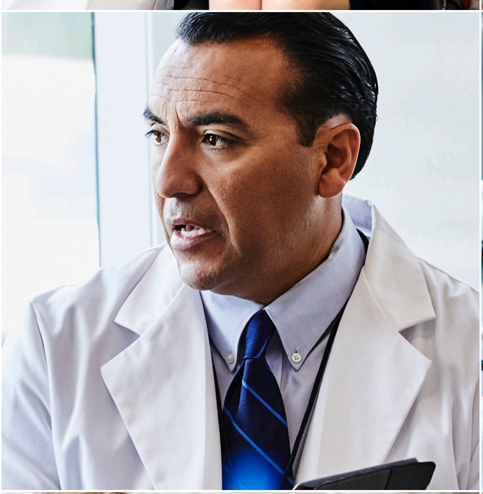
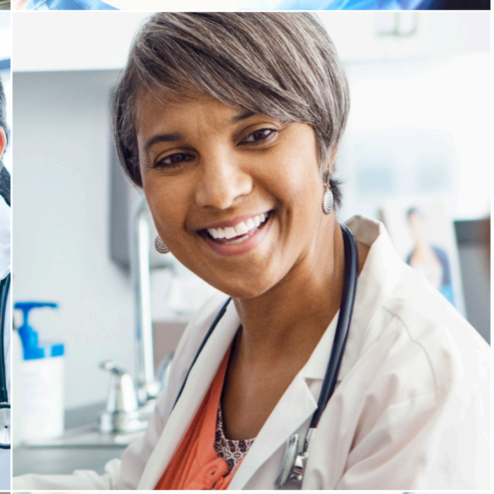
BlueCross BlueShield of Oklahoma

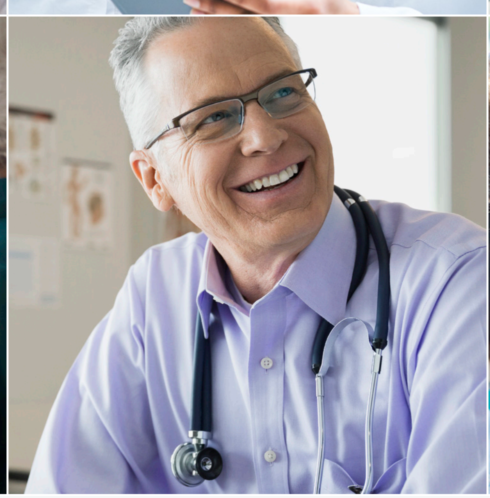
Commercial Provider Reference Manual

Updated April 2026








Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Contents

1 INTRODUCTION

This manual is updated and reviewed periodically. It contains information to assist your office with day-to-day business operations involving Blue Cross and Blue Shield of Oklahoma and our members.

This manual provides links to information posted on the provider site. Stay updated on the latest information by visiting our News & Updates page and signing up for our Blue Review email.

In the event of a conflict between the terms of a provider agreement and the terms of the provider manual, the terms of the agreement will govern.

A covered person is any person entitled to receive covered services pursuant to the terms of a coverage agreement at the time health care services are rendered. Covered persons are referred to as members for the purposes of this manual.

2 NETWORKS AND PRODUCTS

Providers have a direct impact on the satisfaction of our members and the quality of our health benefit plans. One of our goals is to establish and maintain long-lasting, mutually beneficial relationships with providers. Refer to our Network Participation page to join our networks. Our provider networks form the foundation of this relationship. Below is information on our provider networks:

- **Blue Traditional℠**
  More than 11,000 providers representing a wide variety of specialties participate in the Blue Traditional network. Almost every acute care facility in the state participates in the Blue Traditional network. The Blue Traditional provider agreement is the base participation agreement and contains most of the terms and conditions common to our PPO networks.

- **Blue Choice PPO℠**
  Blue Choice PPO is Oklahoma's largest and most comprehensive preferred provider organization network. Most of our benefit plans utilize the Blue Choice network.

- **Blue Preferred PPO℠**
  Blue Preferred PPO is offered on and off the exchange and is a quality and cost-effective network.

- **Blue Plan65 Select℠**
  Blue Plan65 Select is a Medicare Supplement PPO network offered to eligible enrollees in select areas.

- **Blue Advantage PPO℠**
  Blue Advantage PPO is a network that is offered on and off the Health Insurance Marketplace® and allows for lower costs when members use in-network providers.

- **NativeBlue℠**
  Under federal law, eligible businesses have the right to access Medicare-like reimbursements for health care services rendered to employees who are citizens of a federally recognized native nation. NativeBlue was created to help alleviate the administrative burdens and revenue cycle issues providers encounter by removing the need for additional external third-party administrators. Under this network product, employees and family members covered by the NativeBlue health plan can access the benefits, regardless of their tribal citizenship.

- **Blue Options**
  Blue Options is a PPO plan with a tiered network using participating providers in Blue Advantage and Blue Preferred. Each tier may be subject to different benefit level deductibles, coinsurance or copayments depending on the coverage level and providers.

- **Blue Solutions**
  Blue Solutions is a tiered network using participating providers in Blue Advantage and Blue Preferred. Each tier may be subject to different benefit level deductibles, coinsurance or copayments, depending on the coverage level and providers.

- **BlueLincs HMO℠**
  BlueLincs HMO is fully licensed by the Oklahoma Insurance Department as a health maintenance organization. Members must select a primary care physician who coordinates all care.

- **MyBlue HMO℠**
  MyBlue, an HMO, is a managed care plan requiring members to select a primary care physician who coordinates all care, manages specialist referrals, and mandates the use of the MyBlue provider network to keep premiums and out-of-pocket costs low.

ADMINISTRATIVE SERVICES ONLY

Administrative Services Only plans are employer-funded health benefit plans that contract with us for claims processing services, provider network access, clerical services or other administrative responsibilities. Backed by our strength and stability, ASO accounts are given the flexibility to meet the unique requirements of a self-funded employer group.

HEALTH REIMBURSEMENT ACCOUNTS AND HEALTH SAVINGS ACCOUNTS

- **Health Reimbursement Account**
  Consumer-driven health care plans combine a high-deductible health plan with an HRA and decision support tools. This combination allows members greater freedom to choose their providers and the ability to spend their HRA in a manner that meets their needs.

- **Health Savings Account**
  Our HSA is coupled with a federally qualified, PPO high-deductible health plan — an affordable option with lower premiums. This combination allows members the freedom to choose their providers and the ability to spend their HSA funds in a manner that meets their needs. With an HSA, members can draw from their health savings account to cover medical expenses.

FEDERAL EMPLOYEE PROGRAM®

The Blue Cross and Blue Shield Association contracts with the Office of Personnel Management to provide health benefits to eligible federal employees and retirees as authorized by the Federal Employees Health Benefits Act. This contractual arrangement with the federal government is known as the Federal Employee Program. The Blue Cross and Blue Shield Association is the carrier, and health benefits are administered by independent participating PPO Blue Cross and Blue Shield Plans. We administer the health benefit plan for eligible federal employees and retirees in the state.

Verifying FEP Membership and Benefit Coverage

To verify membership and benefit coverage for an FEP member, use Availity® Essentials or call the FEP Customer Service number on the member's ID card.

FEP Member ID Card Information

FEP member ID numbers have an "R" prefix followed by eight numeric digits. Make a copy of the member's ID card and record the exact member ID number on all claims and documentation. Federal form 2809 is proof of enrollment when a member has not yet received an ID card.

Refer to the FEP site for more information.

BLUECARD PROGRAM

The BlueCard Program is a national program that enables members to obtain health care services while traveling or living in another Blue Cross and Blue Shield Plan's area. Member eligibility and benefits are governed by the Plan that issues or administers the member's coverage. The program links participating providers and independent Blue Plans across the country through a single electronic network for claims processing and reimbursement. If you are unsure about your participation status, please contact our Provider Relations via email or phone **800-722-3730, option 2**.

The program lets you submit claims for members from other BCBS Plans, domestic and international, to your local BCBS Plan. Your local BCBS Plan is your sole contact for claims payment, adjustments and issue resolution.

- **Identifying BlueCard Members**
  The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route out-of-area claims. The prefix identifies the Blue Cross and Blue Shield Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage. Some identification cards may not have a prefix or may not be included in the BlueCard program. Contact BlueCard at **800-676-BLUE (2583)** for more information.

  Also check for instructions or a telephone number on the member's ID card for how to file BlueCard claims. If that information is not available, call BCBSOK.

- **BlueCard Manual**
  For more detailed information, refer to the **BlueCard Manual** on the BlueCard page.

3 ELIGIBILITY AND BENEFITS

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

MEMBER IDENTIFICATION CARD

Before treating our members, ask to see their member ID card, along with their photo ID. Our member ID cards have important information for billing and determining benefits, including the member ID number and group number.

Most members have a three-character prefix at the beginning of their unique ID number. When recording the member's ID number, include the three-character prefix. This prefix is used to:

- Confirm the member's eligibility and benefit information.
- Identify and correctly route claims to the appropriate Blue Cross and Blue Shield Plan for processing.

There are two types of prefixes:

- **Plan-specific prefixes:** These are assigned to every Blue Cross and Blue Shield Plan. The first two positions indicate the Plan to which the member belongs, and the third position identifies the product in which the member is enrolled.

- **Account-specific prefixes:** These are assigned to employer groups that may have offices across multiple states and offer uniform coverage benefits to their employees. The prefix assigned to the account is tied to the employer's name.

Please note the following items about the **BlueLincs** member identification card:

- The patient seen must be the person listed on the card.
- The physician listed on the card is the member's primary care provider.

Identify the member's network: The three-character network value appears on ID cards to indicate which network benefits may apply. Check for:

PPO – Blue Choice PPO
EPP – Blue Preferred PPO
BVP – Blue Advantage PPO
NTV – NativeBlue
HMO – BlueLincs
BAV - MyBlue

If the member does not have their ID card, you can access the Patient ID Finder tool to obtain the member ID number and group number by entering member-specific data elements. This tool is available in our Payer Spaces section via Availity Essentials.

Verify member eligibility and benefits before every scheduled appointment. Use Availity or your preferred vendor to check eligibility and benefits before rendering services. This step will also help you determine if services require prior authorization. If you have questions, call the number on the member's ID card.

VERIFYING ELIGIBILITY AND BENEFITS

Member benefits are subject to the member's contract limitations and exclusions. You will need the following information to verify coverage:

- Member name
- Member ID number
- Member date of birth
- National Provider Identifier number

You are responsible for checking eligibility and benefits prior to rendering services for every member 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.

You can check eligibility and benefits:

- Online via Availity or other applicable vendors
- By calling our Provider Inquiry Unit at **800-496-5774** or as listed on the member's ID card
- For BlueCard out-of-state members, call **800-676-2583** to receive benefit and eligibility information

Refer to our Eligibility and Benefits page for information.

BLUE DISTINCTION®

Some member benefit plans include a requirement to utilize our **Blue Distinction Centers** when providing specialty care.

- **Blue Distinction Centers** are providers recognized for their expertise in delivering specialty care.
- **Blue Distinction Centers+** are providers recognized for their expertise and cost-efficiency in delivering specialty care and meeting nationally established quality measures.

Blue Distinction Specialty Care currently has the following areas of specialty care:

- Bariatric surgery
- Cancer care
- Cardiac care
- Knee and hip replacement
- Maternity care
- Spine surgery
- Substance use treatment and recovery
- Transplants
- Fertility care
- Cellular immunotherapy
- Gene therapy

To determine if a member's plan includes using Blue Distinction providers, check Availity or call the number on the member's ID card. Learn more on the Blue Distinction page on the Blue Cross and Blue Shield Association site.

4 NETWORK PARTICIPATION

To participate in our networks, you will need to complete a Provider Onboarding form and provide information to be verified and/or credentialed. In addition, you must adhere to information in this manual, pertinent policy and procedures adopted by us that relate to, without limitation, the credentialing and recredentialing processes, and their participating agreements.

HOW TO JOIN

Our contracts with physicians, facilities and other health care professionals ensure that our members receive accessible, cost-effective and quality health care services.

- **Provider onboarding process**
  Before you can join our networks or send claims electronically as an out-of-network provider, you'll need to be assigned a provider record ID. A provider record ID does not activate network participation. Claims will be processed out-of-network until the provider who has requested network participation on the provider onboarding form has been approved and activated in the network.

  Providers must complete and submit the appropriate form or information to us and indicate whether they choose to be an in-network or out-of-network provider. If you indicate that you want to be an in-network participating provider and meet criteria to have a record ID assigned, we will send the appropriate agreements to complete. If you indicate that you want to participate out-of-network, your application will generate a provider record ID only.

  The provider record ID is needed to submit claims as an out-of-network or in-network provider.

  Refer to the provider onboarding process on the Network Participation page.

- **Credentialing**
  Providers who participate in our networks are required to successfully complete the credentialing process prior to acceptance, subject to the requirements of Oklahoma law. New providers who are not being added to an existing group agreement are not sent to credentialing until we receive the executed agreement. For providers added to an existing group agreement, credentialing will be initiated after submitting the Provider Onboarding form. Providers will be notified when the credentialing decision has been made.

  Refer to the Credentialing Requirements section on the Network Participation page for credentialing criteria, information to maintain credentialing and recredentialing, and appeal processes for determining the eligibility of providers to participate in our networks. We require providers to recredential at least every three years. We may update our credentialing and recredentialing policies and procedures at any time, at our discretion and upon notice to providers. We retain the right to approve, deny, suspend or terminate any provider's participation based on its credentialing and recredentialing review.

PARTICIPATING PROVIDER INFORMATION

Once you are part of our networks, we strongly encourage participation in all electronic options available, including electronic data interchange. EDI transactions help to ensure timeliness, accuracy and security of claims-related information. Please visit the Electronic Commerce page on how to sign up for these electronic solutions.

For more information about being a participating provider with us, refer to the following:

- Provider Orientation – available upon request
- News & Updates
- Blue Review

UPDATING PROVIDER INFORMATION

It is important for providers to keep their practice information up to date as found on Provider Finder®. This is required by law and will help our members locate you for services.

To update provider records, review our Verify and Update Your Information page for options.

Note: The Consolidated Appropriations Act (CAA) of 2021 requires that certain provider directory information be verified every 90 days.

Under Oklahoma law, a provider must be removed from a network if the provider has not submitted claims or otherwise communicated intent to continue participation in the network within a 12-month period.

PROVIDER FORMS

Refer to our Forms page for available forms.

PROVIDER RELATIONS

Provider Relations is responsible for developing and supporting relationships with providers by providing:

- Valuable information on plans and contracts
- Education on claims enhancement programs (e.g., Clear Claims Connection™, Cotiviti)
- Continuing education
- Accessibility to our staff through visits, telephone communication and email
- Continuous enhancements to our various communication technologies
- Guidance for your office staff on policies and procedures
- Accurate information in claims payment systems (e.g., taxpayer identification number, national provider identifier number, address, panel status)
- Compliance with state and federal regulatory requirements

Provider Relations is available to provide information, answer questions, address concerns and assist in resolving any issues you or your staff may have. You may contact them by email, telephone or mail. Please provide the TIN, NPI and, if applicable, Medicare numbers for your provider when contacting provider relations. For contact information, refer to the Contact Us page. You may also email or call **800-722-3730, option 2**.

FRAUD, WASTE AND ABUSE

It is important if you become aware of health care fraud, waste or abuse to report it to our Special Investigations Department. Refer to our Fraud, Waste and Abuse page for more information.

Suspicions of fraud may be reported anonymously as follows:

- Provider Fraud Hotline: **800-543-0867**
- Online: Providers can report fraud 24 hours per day, seven days per week using a fraud reporting form, which is sent to the Special Investigations Department electronically.
- U.S. Mail:
  BCBSOK Special Investigations Department
  1400 S. Boston Ave.
  Tulsa, OK 74119

See our Health Care Fraud Prevention and Reporting page for additional information.

In addition, you can report prescription fraud to the **Oklahoma Bureau of Narcotics** Prescription Monitoring Program. If you receive suspicious communication from someone claiming to be with the OBN, or to report criminal drug activity, you can contact the agency directly at **405-521-2885** or via email. Refer to the Prescription Monitoring Program page on the OBN website for information on reporting controlled substances dispensed in Oklahoma.

5 ELECTRONIC TOOLS

We are committed to providing support to physician practices. We've designed useful tools for providers. In addition to the information below, refer to our Provider Tools and Training pages for detailed information.

AVAILITY ESSENTIALS

Availity offers a web portal for our providers. Availity is a leading provider of electronic health care transactions and provides health care professionals with access to a wide range of web-based products and services.

Availity is a secure, web-based, full-service information exchange that offers a claims clearinghouse and real-time transactions at no charge to our providers. Transactions include eligibility and benefits, claim status, claims submission, electronic remittance and authorizations and referrals. The HIPPA-compliant portal encompasses administrative, financial and clinical services, and supports both real-time and batch transactions.

Go to Availity to sign up or get more information.

TYPES OF ELECTRONIC TOOLS

- Eligibility and Benefits
- Electronic Claim Submission
- Electronic Funds Transfer and Electronic Remittance Advice
- Remittance Viewer
- Provider Claim Summary
- Claim Status Tool
- Electronic Refund Management (eRM)
- Authorization & Referrals

If you have questions about electronic tools, refer to the Provider Tools page or email us. Also refer to the Training page for available webinars.

6 AUTHORIZATIONS

Utilization management is how we help our members access the right care, at the right place and at the right time.

PRIOR AUTHORIZATIONS

We conduct utilization management reviews to determine whether a benefit is covered under the health plan using evidence-based clinical standards of care. It can also assist in determining the appropriate site of care for certain services. Some services may require prior authorization or a post-service review.

Prior authorization is a preservice medical necessity review. If a prior authorization is not required, a post-service review may determine that health care services that a physician or other provider prescribes or orders may not have been medically necessary or is not a covered service for the member's benefit plan. Certain prescription drugs are also subject to prior authorization requirements or post-service review.

A designated vendor may manage prior authorizations for certain services.

You are responsible for obtaining required prior authorization, requesting extensions when necessary and cooperating with case management. Failure to obtain prior authorization may affect claim payment, subject to the terms and conditions of the applicable benefit Plan.

Note: Prior authorization is not a guarantee of benefits or payment.

Timeframes and Information Needed for Requesting Prior Authorization

Refer to the following regarding when to notify us or the designated vendor for prior authorization:

- **Hospital admissions (emergency and obstetric)** – Request prior authorization for all emergency and obstetric admissions within two business days of the admission.

- **Hospital admissions (nonemergency and nonobstetric) and outpatient hospital services** – Obtain prior authorization for all nonemergency and nonobstetric hospital admissions and outpatient hospital services. To the extent practical, obtain prior authorization at least five days in advance of, but not less than one business day prior to, the admission or outpatient hospital service.

- **Extensions** – Request prior authorization for an extension on or before the last day of the length of stay for which prior authorization was previously obtained from us.

- **BlueCard program** – For members participating in the BlueCard program, you may refer to the member's ID card for information regarding authorization requirements.

- **Medicare supplements** – If a member exhausts benefits under Medicare or is otherwise eligible for benefits under a Medicare supplement coverage agreement, follow the prior authorization requirements for such member as set forth herein.

- **Other settings** – Health care services rendered in an office or other outpatient setting must be medically necessary and appropriate for the diagnosis and treatment of the covered person's medical condition. We have designated certain covered services which require prior authorization for the member to receive the maximum benefits possible under their coverage agreement. You may request prior authorization for services on behalf of the member.

- Obtain authorization prior to services being rendered for the following:
    - Genetic testing
    - Home health services
    - Home hospice
    - Home infusion therapy
    - Home hemodialysis
    - Dialysis obtained from an out-of-network provider
    - Skilled nursing facilities
    - Partial hospitalization services
    - Intensive outpatient services
    - Psychiatric hospital nonemergent admissions

BCBSOK Responsibilities for Prior Authorization

Notification of prior authorization determination: We respond to your requests for prior authorization by providing a determination within the timeframes provided by law or accreditation requirements if applicable after receipt of all necessary information. We provide notification of prior authorization determinations to the admitting or ordering provider, the provider rendering health care services as applicable and the member.

Reimbursement for services: If prior authorization is obtained and the information given at that time is accurate, no adjustment to the prior medical necessity determination will be made because of a subsequent medical necessity determination on that specific case, so long as the provider adheres to these requirements. Health care services are reimbursed in accordance with the terms of the provider's agreement.

Note: Prior authorization is not a guarantee of benefits or payment.

Refer to the Utilization Management page for more information and a current list of services that require prior authorization, review or postservice review, and to determine whether medical management at BCBSOK or a designated vendor handles the reviews.

OUT-OF-STATE WAIVERS FOR CERTAIN PLANS

Coverage for **nonurgent** and **nonemergent** out-of-service area care will only be available if the service is not available in the service area of certain member's **Blue Advantage PPO** and **Blue Preferred PPO** plan. If nonurgent or nonemergency care is not available in the service area of the plan, a member may request approval of a waiver for out-of-state coverage beyond border counties by calling the customer service number on their ID card. Members must have requested and received an approved waiver in advance of receiving care for their benefits to apply.

If no waiver is on file, the services are not covered. The member or member's provider must contact us to request authorization for out-of-state services via a waiver.

Prior authorization is a separate process, and you will need to prior authorize services as required.

MYBLUE REFERRALS

MyBlue plans require a PCP and require in-network referral authorization from the PCP for the following services:

- Any service the PCP does not provide or bill, including lab and x-ray services
- Referrals to specialists
- Referrals for all outpatient services
- All hospital inpatient admissions

If a member needs medically necessary services unavailable within their network, the treating provider should request authorization for an out-of-network referral.

Remember:

- Referrals must be authorized prior to the date of service.
- If a member insists on a referral that the PCP believes is inappropriate, the PCP is not obligated to authorize the referral.

Prior authorization is a separate process. The PCP needs to request prior authorization for medical services as required**.**

AUTHORIZATION PROCESS

Submit prior authorizations electronically. For MyBlue members, referrals to specialists should also be submitted electronically. When eligibility and benefits are checked via Availity, it will also indicate if prior authorization or a referral (for MyBlue members) is required and who manages it (our medical management or a designated vendor).

Refer to the Utilization Management page for prior authorization lists. Refer to How to Request a Prior Authorization for details.

Please have the following information available when requesting prior authorization:

- Referring or admitting physician name, address and telephone number
- Patient name, address, age, sex and birth date
- Subscriber name and address if different from the patient
- Subscriber group number or employer name if the group number is not available
- Subscriber Blue Cross and Blue Shield ID number
- Rendering provider/facility name, address or telephone number
- Requested dates of services
- Primary diagnosis, proposed procedure(s), patient history, lab and test results pertinent to the hospitalization/procedure

Refer to the **Timeframes and Information Needed for Requesting Prior Authorization** section above for more details.

Requests for extending a prior authorization follow the same process.

We will assign an authorization confirmation number. You should provide the confirmation number and authorized treatment plan to the specialist or facility.

7 CLAIMS AND REIMBURSEMENTS

We provide the following information to assist providers with filing claims, including timely filing, checking status, reimbursements and contacts for questions.

GENERAL CLAIM INFORMATION

Submit member claims electronically utilizing Availity or other electronic claim submission vendors. If unable to submit electronically, you may use the CMS-1500 or the UB-04 claim forms. All information necessary to adjudicate the claim, including appropriate diagnosis codes, CPT® codes or Healthcare Common Procedure Coding System codes must be provided.

Adhere to the following policies and guidelines with respect to filing clean claims for covered services to our members:

- A provider performing covered services for our member shall be fully and completely responsible for all statements made on any claim form submitted to us by or on behalf of you. A provider is responsible for the actions of staff members or agents.

- We consider fraudulent billing to include, but not be limited to, the following:
  - Deliberate misrepresentation of the services provided to receive payment for a noncovered service
  - Deliberately billing in a manner which results in a reimbursement greater than what would have been received if the claim was properly filed
  - Billing for services that were not rendered

- Provider shall not bill or collect from a member, or from us, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead, facility or concierge fees, or fees for completing claim forms or submitting additional information to BCBSOK.

- A provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for referring our member to another provider or in return for furnishing services to a member referred to provider.

  BCBSOK benefits are not available for services rendered by providers to a member of their immediate family, and claims should not be submitted for processing.

- When a provider refers a member to another provider or supplier, provider shall explain to the member the benefit of treating in-network, including lower out-of-pocket costs for the member and protections against balance billing. If a member chooses to be referred to an out-of-network provider after being informed of the potential financial impact, the provider must obtain an acknowledgement of referral from the member that shows written consent.

- Also, a provider who refers a member to a facility or other provider in which the referring physician has an ownership interest must disclose that interest in writing to the member.

- We do not permit pass-through billing, billing for nonpatients, splitting claims, under arrangements billing or billing practices where a provider or entity submits claims by or for another provider not otherwise provided for in their agreement with us.

- You must maintain accurate financial books and records, including electronic records, concerning covered services provided to each member, including any charges to, and payments received from, the member by provider.

- We use reimbursement policies and medical policies in processing our claims.

  Reimbursement policies are based on criteria developed by specialized professional societies, national guidelines (e.g., MCG care guidelines) and the Centers for Medicare & Medicaid Services Provider Reimbursement Manual. Additional sources are used and can be provided upon request. The reimbursement policies are not intended to provide billing or coding advice but to serve as a reference.

  Medical policies are based on research that provides evidence of scientific merit for a particular medical technology. Technology determinations used in Medical Policies are based in part on criteria found in the Blue Cross Blue Shield Association's Medical Policy Reference Manual. They are also based on data from peer-reviewed scientific literature, from criteria developed by specialty societies and from guidelines adopted by other health care organizations. These may include, but are not limited to:
    - Unaffiliated nonprofit professional associations for the relevant clinical specialty (for example, the American Society of Addiction Medicine)
    - Third-party entities that develop and regularly update clinical guidelines consistent with generally accepted standards of care (for example, MCG care guidelines)
    - Other federal or state governmental agencies involved in review of clinical standards for the industry (for example, CMS NCDs or LCDs)

TIMELINESS

Claims will not be payable if they are not filed within 180 days of the date of discharge or date of service. Claims will be accepted beyond the 180-day period if our member’s coverage agreement allows for a longer timely filing period.
Provide Timely Compensation

Unless otherwise permitted by law, we agree to adjudicate all clean claims for covered services provided to members within 30 days of the date of our receipt. If upon receipt of a claim, we determine it is not a clean claim, you will be notified within 30 days of receipt of the claim. Upon receipt of the additional information or corrections to make the claim a clean claim, the claim shall be processed by us within 30 days, unless otherwise permitted by law. Payment shall be considered made when it is placed in the United States mail or on the date the electronic payment is sent. If payment is due but not made within the time required by law from receipt of a clean claim, it shall bear simple interest at the rate of 10% per year. We shall pay interest only on claims for services rendered to members whose coverage agreements are underwritten by us.

SUBMITTING CLAIMS

We strongly encourage the electronic submission of claims. Since editing begins prior to an electronic claim entering our processing system, electronic claims are less likely to be returned for additional information and are usually adjudicated more quickly than claims submitted via paper. Electronic submission also enables users to have same day access to their batch reports, which allows for quicker error resolution and expedites the overall revenue management cycle process.

You may submit claims directly through Availity or your preferred electronic vendor using payer ID **00840**.

If you are unable to submit claims electronically, refer to the Claim Tips page for instructions on completing the paper CMS 1500 or UB-04 forms. Mail paper claims to:

Blue Cross and Blue Shield of Oklahoma
PO Box 655924
Dallas, TX 75265-5924

Claims will be returned if information is invalid, incomplete or missing. **Review the Helpful Tips for Preventing Claims Delays** on the Claim Tips page.

CLAIM STATUS

Provider Claims Summary

A Provider Claims Summary is an explanation of the processed claims listed in the summary. You can use the PCS to determine how a claim was processed, including nonallowed amounts or adjustments. It will note any appropriate deductible, copayment or coinsurance amounts that are the responsibility of the member, in addition to any nonallowed amounts that are the responsibility of the member or the provider. The PCS will also list and explain ineligible reason codes applied to the claim.

If claim reports are separated for billing or accounting purposes, it is important to make sure the individuals responsible for both purposes receive a copy of the PCS. The PCS application is available in the BCBSOK-branded payer spaces section on Availity Essentials. This tool permits registered Availity users to readily view, download, save or print the PCS online. For additional details, refer to the Provider Claim Summary User Guide on Availity.

Checking Claims Status

You or your billing agent can obtain real-time results by checking claim status through the Availity Essentials Claim Status tool. The claim status tool provides the PCS, which includes line-item breakdowns and detailed denial descriptions. All results are printable and can be used as a duplicate EOB for another insurance carrier when requested. For more additional instructions, refer to the Claim Status page.

CLAIM REFUNDS

We strive to pay claims accurately the first time; however, when payment errors occur, we need your cooperation in correcting the error and recovering any overpayments. When you identify an overpayment, you may submit via:

- Electronic Refund Management through Availity
- Complete the Provider Refund form and mail to:
  Blue Cross and Blue Shield of Oklahoma
  Refund and Recovery Dept. 065
  PO Box 120695
  Dallas, TX 75312-0695

RIGHT OF RECOVERY

We contractually have the right to retract overpayment amounts from your future payments. The following is a summary of these types of overpayments

- When a member's coverage is subject to waiting periods, waivers, exclusion of coverage riders, preexisting condition limitations and/or exclusions and other benefit or membership stipulations, or is subject to cancellation retroactive to the effective date (e.g., in the event of fraud, misrepresentation, or non-payment of dues), we may determine that benefits were paid for noncovered services or when the member was not eligible for coverage. You agree that, if it is determined the patient or member is not entitled to benefits based on the facts pertaining to such benefit exclusion or membership termination, claims may be denied, and any amounts previously reimbursed may be offset against future payments due to you from us.

- In accordance with Oklahoma law, when we have approved a request for prior authorization for a health care service and you have verified the member's or patient's eligibility within four days of the health care service, we will not deny benefits or offset against future payments any amounts previously reimbursed unless:
    - The claim or payment was made because of fraud or intentional misrepresentation
    - The member is subject to a preexisting condition limitation and/or exclusion
    - The member, employer or group failed to pay the applicable premium and membership is retroactively canceled

  This provision is subject to change or may be rendered null and void if Oklahoma law is otherwise amended or repealed.

We will initiate recovery efforts within six months after the payment to you by sending a written notice setting forth the member's name, service date, payment amount and an explanation of the adjustment to be made. You will be given 30 days to refund the amount requested before we exercise our right to offset. In such an event, you can, at your option, pursue payment from the member or other responsible third party.

When amounts have been reimbursed in error, other than as described in this section, such amounts may also be offset by us against future payments due to you. We will initiate recovery efforts within 12 months after the payment to you (or such other time period required by law) by sending written notice.

We shall not be prohibited from requesting a refund or retracting a payment outside the time frames set forth in this section if:

- The payment was made because of fraud or intentional misrepresentation
- You have otherwise agreed to make a refund

Follow instructions in the letter on submitting your overpayment.

You will be given 30 days to submit the refund, prior to an automatic recoupment occurring. A remittance form will be provided as well as a return envelope to submit the refund, or provider can utilize the electronic refund management tool to dispute the refund recovery. If you prefer to have an automatic retraction, no action is required.

CLAIM RECONSIDERATIONS

A claim reconsideration is a request to review or reevaluate a claim that has been finalized. The electronic claim reconsideration request option allows providers to electronically submit claim reconsiderations for situational finalized claim denials (including BlueCard out-of-area claims) using Availity Essentials Dispute Claim via the Claim Status tool. This method of inquiry submission is preferred over faxed or mailed claim disputes to us, as it allows you to upload supporting documentation and monitor the status online.

It offers the following:

- Status management
- Upload of supporting documentation with submission
- Ability to view and print confirmation and decision
- A dashboard view of claim reconsideration request activity
- Ability to view uploaded documents after attaching to the request

Refer to the instructional claim reconsideration requests user guide available on Availity.

8 PHARMACY

The following applies to members who have our Prescription Drug Rider. Depending on the member's individual contract, pharmacy services may or may not be provided through our pharmacy plan. Some plans may be carved out to other pharmacy benefit managers. The PBM name is listed on the front of the member's identification card. Prime Therapeutics is the PBM that provides drug benefits through us.

PHARMACY NETWORK

Members with a pharmacy card prescription drug benefit are normally required to use a pharmacy on the list of independently contracted participating pharmacies to maximize their benefits. This pharmacy network can include retail for up to a 30- or 90-day supply, home delivery for up to a 90-day supply or specialty pharmacy for up to a 30-day supply (except for certain U.S. Food and Drug Administration-designated dosing regimens). Some members' pharmacy benefit plans include an additionally preferred pharmacy network, which offers reduced out-of-pocket expenses to members if they use one of these pharmacies instead. Pharmacy networks and supply limits are dependent upon the member's benefit plan. Please encourage members to use one pharmacy for all their prescriptions to better monitor drug therapy and avoid potential drug-related problems.

We contract for home delivery pharmacy services to augment our retail pharmacy network. Members of our plans may receive up to a 90-day supply of maintenance medication (e.g., drugs for arthritis, depression or diabetes) through the home-delivery program. If you believe a member will continue the same drug and dose for an indefinite time, please consider writing the prescription for a 90-day supply with three refills. If the patient is starting a new medication for the first time, you should write two prescriptions, one for up to a 90-day supply with three refills and a starter supply for up to 30 days that the member can fill right away at the local retail pharmacy.

FDA-approved specialty drugs for member self-administration typically must be acquired through a specialty pharmacy provider. The member may also request these drugs be processed under their pharmacy benefit to receive maximum coverage.

PRESCRIPTION DRUG LIST EVALUATION

We use the Prime Therapeutics National Pharmacy and Therapeutics Committee for drug evaluations. The P&T committee consists of independent-practicing physicians, pharmacists and other health care professionals who are not employees or agents of Prime Therapeutics. The P&T Committee meets quarterly to review new drugs and make updates to drug information based on the currently available literature.

We remain responsible for the determination of benefit coverage and approvals for prior authorization, step therapy or dispensing limits.

PRESCRIPTION DRUG BENEFITS

Our members can have a pharmacy benefit of up to six tiers. Listed drugs on the member's drug list may be covered at generic, brand and specialty tier levels. Depending on the member's benefit plan, drug tiers may be split between preferred and nonpreferred, and members may pay a lower member share (out-of-pocket expense) for prescription drugs in the lower tiers.

For some members, the prescription drug list may only list generics and lower cost brand drugs. For other members, the prescription drug list may reference all covered prescription drugs while not listing the noncovered drugs. If the prescription drug is not covered, you may be able to submit a coverage exception request for consideration, based on the member's benefit plan. Refer to the member's certificate of coverage for more details, including benefits, limitations and exclusions.

PRESCRIPTION DRUG LIST UPDATES

The prescription drug list helps providers select cost-effective drug therapy. The drug list also describes how drugs are selected, coverage considerations and special requirements. As a reminder, drugs that have not received FDA approval are not covered under the member's pharmacy benefit for safety concerns. Please refer to the drug list when prescribing for our members.

We notifies physicians of prescription drug list additions and changes through Blue Review, the provider News and Updates page and the prescription drug list on the Pharmacy page.

Members may be notified of changes by direct mail. Members who are identified as taking medications that have been deleted from the prescription drug list are sent a letter detailing the change at least 60 days before the deletion date. Medications deleted from the prescription drug list may still be available to members at a higher copayment, or the medication may not be covered, and the member is charged for the full cost of the drug.

Prime Therapeutics and BCBSOK also provide pharmaceutical-safety notifications to dispensing providers and members regarding point-of-sale drug-drug interaction and FDA drug recalls.

Call the number on your patient's member ID card for assistance in determining the correct prescription drug list, if needed.

Note: The prescription drug list is a tool to help members maximize their benefits. The final decision about what medications should be prescribed is between the provider and the patient.

GENERIC DRUGS

The FDA has a process to assign equivalency ratings to generic drugs. An "A" rating from the FDA means that the drug manufacturer has submitted documentation demonstrating the equivalence of its generic product compared to the brand name product.

We support the FDA process for determining the equivalency and encourages its contracted providers to prescribe drugs that have generic alternatives available and not to add dispense as written to prescriptions unless medically necessary, and if clinically appropriate coverage criteria that prevent use of a generic for a particular patient has been met. Most plans require members to pay the difference between the brand-name drug and generic drug plus the prescribed drug's cost share.

If you determine the member cannot tolerate the available generic equivalent drug, some member plans may allow you to submit documentation for consideration to waive any cost share penalties that may be applied to the member otherwise. If approved, the member would only be responsible for their applicable cost share for the brand drug. Call the number on the member's member ID card for assistance in completing this process.

DRUG UTILIZATION REVIEWS

Prime Therapeutics and BCBSOK may conduct concurrent and retrospective drug utilization reviews to ensure the most appropriate and cost-effective drugs are used safely.

Concurrent DUR occurs at the point of sale (i.e., at the dispensing pharmacy). Pharmacies are electronically linked to Prime Therapeutics' claims adjudication system. This system contains various edits that check for drug interactions, overutilization (i.e., early refill attempts), safe and effective use of prescription opioids, and therapeutic duplications. The system also alerts the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist can use their professional judgment and call the prescribing provider if a potential adverse event may occur.

Safety checks on prescription opioids address permissible quantity and medication dose, as recommended by the U.S. Centers for Disease Control and Prevention and other nationally recognized guidelines. The pharmacist will receive alerts advising if authorization may be required before the full quantity of opioids as prescribed may be dispensed at the point of sale.

Retrospective DUR uses historical prescription and/or medical claims data to identify potential prescribing and dispensing issues after the prescription is filled. Examples of retrospective DUR include appropriate use of controlled substances, polypharmacy, adherence and generic utilization programs. These programs aim to promote safety, reduce overutilization and close gaps in care.

Retrospective DUR programs are developed based on widely accepted national practice guidelines. Individual letters may be mailed to you identifying potential drug therapy concerns, together with a profile listing the member's prescription medications filled during the study period, references to national practice guidelines or a survey to be completed.

CLINICAL PROGRAMS AND PRIOR AUTHORIZATION

For drugs that require a prior authorization, step therapy or quantity limits, view the pharmacy program page for detailed information, including links to forms and program criteria summaries.

Drugs with high potential for off-label use or misuse may require prior authorization. Electronic prior authorization requests may be submitted to Prime Therapeutics by using CoverMyMeds®. Other provider forms are also available.

Changes to prior authorization or step therapy requirements are published in our Blue Review and the News and Updates page. If you have additional questions, please call Prime Therapeutics at **800-289-1525**. BCBSOK allows for certain off-label uses of drugs when the off-label uses meet the requirements of our policy.

For information about prior authorization criteria, please review our medical policy.

SPECIALTY PHARMACY PROGRAM

Specialty medications are generally prescribed for people with complex or ongoing medical conditions, such as immune deficiency, multiple sclerosis and rheumatoid arthritis. Due to the unique storage and shipment requirements, some specialty medications may not be readily available at retail pharmacies. The Specialty Pharmacy Program helps deliver these medications directly to members, and sometimes you.

Specialty medication coverage is based on the member's benefit. Some members may be required to use an in-network specialty pharmacy or be subject to a split fill program for pharmacy benefits to apply.
Most specialty medications will require prior authorization. You can submit the prior authorization form electronically through CoverMyMeds. For more information about medical criteria, please refer to the medical policies.

For those medications that are approved by the FDA for self-administration, our members may be required to use their pharmacy benefit and acquire self-administered drugs (oral, topical and injectable) through the appropriate contracted pharmacy provider and not through the provider's office. Self-administered drugs must be billed under the member's pharmacy benefit for members to receive coverage. View specialty medications on the Specialty Pharmacy Program page.

When you submit a claim on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500) for a drug that is FDA-approved for self-administration and covered under the member's prescription drug benefit, we will notify you of the appropriate benefit under which you may resubmit the claim for coverage. In this situation, the following message will be returned on the electronic payment summary or provider claim summary: Self-administered drugs submitted by a medical professional provider are not within the member's medical benefits. These charges must be billed and submitted by a pharmacy provider.

If you have questions about the specialty program, a member's benefit coverage or to ensure the correct benefit is applied for medication fulfillment, please call the customer service number on the member's member identification card.

We contract with select specialty pharmacies to obtain specialty medications for physician administration to our members. The medications that you must administer to a member are typically covered under the member's medical benefit. You should only bill for the administration of the specialty medications when the specialty medication is received from these specialty pharmacies. You may not bill for the specialty medication.

The relationship between BCBSOK and the specialty pharmacies is that of independent contractors.

SPLIT FILL PROGRAM

Some members have the split fill program as part of their benefit plan. This program applies to select medications that patients are often unable to tolerate. Under this program, members who are new to therapy (or have not had claims history within the past 120 days for the drug) are provided a partial fill, or split fill for up to the first three months of therapy, giving them the opportunity to try the drug at a prorated cost. This allows the member to make sure they can tolerate the medication and any potential side effects before continuing ongoing therapy.

The split fill program applies to specific drugs known to have early discontinuation or dose modification.

Each drug is evaluated using evidence-based criteria to determine the frequency and duration of a split fill. The pharmacy program page lists all the current drugs in this program. This list of drugs is subject to change at any time.

Members may use any in-network pharmacy that can dispense the medication. Members pay an applicable prorated cost share for each fill received for the duration of the program. Once the member can tolerate the medication, the member will pay the applicable cost share amount for a full supply. All member cost share amounts are determined by the member's pharmacy benefit plan.

POINT-OF-USE CONVENIENCE KITS BILLING

Our reimbursement applies only to the drug component of a point-of-use convenience kit used in the administration of covered, injectable medications. These prepackaged kits include medication, as well as non-drug supplies, such as alcohol prep pads, cotton balls, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

We periodically check the pricing of these kits to manage costs. Often, the cost of these convenience kits is more than the cost of their components when purchased one item at a time. The non-drug supplies are considered part of the practice expense for the procedure performed, and no additional compensation is warranted. Reimbursement for these kits may be updated based on the FDA-approved drug component.

BILLING FOR UNLISTED DRUGS

Most National Drug Code numbers billed have either an assigned CPT code or an assigned HCPCS code.

CPT codes are referred to as Level I codes and are maintained by the American Medical Association. Level I codes are comprised of five characters in length (e.g., 99211, 30520). HCPCS codes are referred to as Level II codes and are maintained by CMS. Level II codes are five characters in length and are comprised of one letter and four numbers (e.g., J1950, J9217).

In most instances, NDC numbers billed are compared to a list of specific CPT or HCPCS drug codes. It is important that claims be submitted with the CPT or HCPCS code with the most specific description when billing for medications that are used during a patient's visit. We periodically check the NDC numbers and NDC units submitted with an unlisted drug code to ensure these codes are being billed correctly.

What does this mean for you?

- If a claim is submitted using an unlisted drug code (e.g., J3490) and a valid CPT or HCPCS code exists for the drug being administered, we will deny the service line and request you resubmit the claim for service using the more accurate CPT or HCPCS code.
- If a claim is submitted with an unlisted drug code (e.g., J3490) and there is not a more specific CPT or HCPCS code for the drug being administered, you will need to provide the necessary information on the claim for us to properly adjudicate the service line. Otherwise, the claim may be denied and returned with a request to resubmit the service and include the necessary information.

To avoid a claim rejection, include the following information when submitting valid, unlisted drug codes:

- NDC qualifier, N4
- NDC 11-digit billing number
- NDC product package size unit of measure (e.g., UN, ML, GR, F2)
- NDC unit to reflect the quantity of drug product billed

To submit narrative supplemental claim information, you can add:

- NDC Number
- Drug Name
- Product strength of drug administered (e.g., 25 mg/ml, 10 mg/10ml)
- Single dose vial or multidose vial
- Dosage administered (e.g., 5 mg, 10 mg, etc.)

Note: An NDC number will be reimbursed for a maximum of two years after it becomes inactive. After this time frame, the NDC number is considered obsolete.

For more information, reference the **Unlisted/Not Otherwise Classified Coding Policy** and **Wasted/Discarded Drugs and Biologics Policy** on the Reimbursement Policies page and the **NDC Billing** guidelines and the **NDC Billing Frequently Asked Questions** under claim tips. You may also contact provider customer service at **800-496-5774** and speak with a customer advocate.

FORMS

All required forms can be downloaded from the forms page under the Education and Reference page.

9 BEHAVIORAL HEALTH

We maintain a portfolio of resources that helps our members access benefits for behavioral health conditions as part of an overall care management program. The integration of behavioral health care management with medical care management allows our clinical staff to assist in the early identification of members who could benefit from co-management of behavioral health and medical conditions.

Our integrated behavioral health program supports behavioral health professionals and physicians in better assessing the needs of members using these services and engaging them at the most appropriate time and setting. Refer to the behavioral health page for more information.

BEHAVIORAL HEALTH PROGRAM COMPONENTS

The behavioral health program provides referrals to medical care management programs and wellness and prevention campaigns including:

Care/utilization management

- Inpatient management for inpatient and residential treatment center services.
- Certain outpatient services

See behavioral health prior authorization section below.

Case management programs

- Intensive case management provides intensive levels of intervention for members experiencing a high severity of symptoms.
- Condition case management for chronic behavioral health conditions such as:
    - Depression
    - Alcohol and substance use disorders
    - Anxiety and panic disorders
    - Bipolar disorders
    - Eating disorders
    - Schizophrenia and other psychotic disorders
    - Attention deficit and hyperactivity disorder

- Active specialty management program for members who do not meet the criteria for intensive or condition case management, but who have behavioral health needs and could benefit from extra support or services.

- Care Coordination Early Intervention (CCEI)® Program provides outreach to higher risk members who often have complex psychosocial needs impacting their discharge plan.

SPECIALTY PROGRAMS

Our behavioral health teams may contact providers as needed in support of members utilizing these specialty programs.

- **Eating disorder care team** is a dedicated clinical team with expertise in the treatment of eating disorders. The team includes partnerships with eating disorder experts and treatment facilities as well as internal algorithms to identify and refer members to appropriate programs.

- **Autism response team**'s focus is to provide expertise and support to families in planning the best course of autism spectrum disorder treatment for their family, including how to maximize their covered benefits.

- **Risk identification and outreach** is an industry-leading model for leveraging robust data analytics to optimize solutions for complex health care priorities. This multi-disciplinary collaboration between behavioral health, medical, pharmacy and clinical data technology groups is focused on mining, organizing and visualizing clinically actionable data for at-risk member populations and implementing clinically appropriate and effective interventions at both member and provider levels.

TELEHEALTH AND TELEMEDICINE SERVICES

Telehealth or telemedicine services give our members greater access to care. Members may be able to access their medically necessary, covered benefits through providers who deliver services through telehealth or telemedicine services, including intensive outpatient program services. Check the member's eligibility and benefits for coverage information.

HEDIS® INDICATORS

We are accountable for performance on national measures, like the Healthcare Effectiveness Data and Information Sets. Several of these specify time frames for appointments with a behavioral health professional.

- Expectation that a member attends a **follow-up appointment** for a mental health or substance use diagnosis **following a mental health or substance use inpatient admission within seven and 30 days**.

- Expectation that a member attends a **follow-up appointment** for a mental health or substance use diagnosis **following a mental health or substance use emergency department visit within seven and 30 days**.

- For children (6–12 years old) who are prescribed ADHD medication:
  - One follow-up visit, the first 30 days after medication dispensed (initiation phase).
  - At least two visits, in addition to the visit in the initiation phase with provider in the first 270 days after initiation phase ends (continuation and maintenance phase).

- For members treated with a new diagnosis of alcohol or other drug dependence:
  - Treatment initiation through an inpatient alcohol and other drugs admission, outpatient visit, intensive outpatient encounter, partial hospitalization program or telehealth or medication treatment within 14 days following the diagnosis (initiation phase).
  - At least two visits or services, in addition to the treatment initiation encounter, within 34 days of initiation visit (engagement phase).

CLINICAL SCREENING CRITERIA

Our behavioral health team utilizes nationally recognized, evidence based and/or state or federally mandated clinical review criteria for its behavioral health clinical decisions including:

- National coverage determinations
- Local and regional coverage determinations
- MCG care guidelines (mental health disorders)
- American Society of Addiction Medicine's ASAM Criteria (addiction disorders)
- BCBSOK medical policies and national clinical practice guidelines

The appropriate use of treatment guidelines requires professional medical judgement and may require adaptation to consider local practice patterns. Professional medical judgment is required in all phases of the health care delivery and management process, including consideration of the individual circumstances of any member. The guidelines are not intended as a substitute for this important professional judgement.

If a specific claim or authorization is denied and there is an appeal, we will provide the applicable criteria used to review the claim or authorization request upon request by the behavioral health professional or physician.

If a behavioral health professional or physician engages in a particular treatment modality or technique and requests the criteria that we apply in determining whether the treatment meets the medical necessity criteria set forth in the member's benefit plan, we will provide the applicable criteria used to review specific diagnosis codes and procedure codes which are appropriate for the treatment type.

BEHAVIORAL HEALTH AUTHORIZATION

Prior authorization is the process of determining medical appropriateness of the behavioral health provider's plan of treatment by us or the appropriate behavioral health vendor for approval of services. Refer to the prior authorization and postservice review lists linked on the Utilization Management page.

Prior authorization may be required for inpatient and residential treatment center admissions. Outpatient services may require prior authorization, for the following intensive outpatient behavioral health services before initiation of services for most plans:

- Applied behavior analysis
- Intensive outpatient program
- Repetitive transcranial magnetic stimulation
- Partial hospitalization program

Behavioral health authorization process

You may refer to the authorization process section of this provider manual or under the Utilization Management for the most current process to request prior authorization.

Behavioral health forms

Prior authorization for certain behavioral health outpatient services may require completion of forms located on the forms page.

Failure to prior authorize

If you do not request prior authorization when required for behavioral health treatment, it may result in the same member benefit reductions that apply to medical services. We may request clinical information from you for a clinical medical necessity review. Claims determined to be medically unnecessary will not be covered.

10 QUALITY IMPROVEMENT

The Quality Improvement Committee is responsible for the implementation and oversight of the QI Program including the review and approval of the QI plan, annual quality work plan and annual program evaluation. This committee is accountable and provides oversight for all quality improvement activities, ad hoc committees and all subcommittee activities. The QIC subcommittees include clinical services, credentialing and peer review.

QI COMMITTEES

Clinical Services Committee

This committee is responsible for the development and implementation of processes and procedures related to the measurement and evaluation of the quality of clinical care, service and identifying areas for improvement including the development of preventive health guidelines, review and approval of all clinical practice guidelines, standards of care and appropriateness of care review criteria, the review and evaluation of practitioner performance data and development of QI studies and quality improvement data collection and reporting.

Credentialing Committee

This committee is responsible for initial credentialing, recredentialing and appeals of providers and facilities, and for the annual review of credentialing and recredentialing policies and procedures, with revisions occurring as necessary. The committee has primary responsibility for developing and implementing credentialing and recredentialing policies and procedures for all network practitioners, both individual and institutional. Additionally, the committee is responsible for integrating QI, UM and member complaint or grievance data that meets minimum necessary privacy requirements and information into the recredentialing process. The committee is also responsible for making recommendations regarding corrective actions and practitioner status, based on information collected through performance monitoring and quality improvement activities.

Peer Review Committee

This committee is responsible for monitoring and evaluating quality of care and the overall performance of practitioners, formulating corrective actions for improving identified deficiencies and providing feedback to individual practitioners.

APPOINTMENT ACCESS STANDARDS

You agree to provide members access to care in compliance with the appointment access standards as described under Access to Care Standards.

DISEASE MANAGEMENT

We offer free and voluntary disease management programs designed to educate and empower members with chronic conditions. Members work with a nurse case manager and their provider to control the symptoms of their condition. The following programs are currently in place:

- Diabetes
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Hypertension

The program relies heavily on education, providing members with the tools to make healthy lifestyle choices. The types of education include:

- Digital outreach, which includes member surveys on their chronic condition.

- Digital medical education programs that use animated videos and text to explain complex health topics in a simple, easy-to-understand way for patients and their families.
- Phone support with the nurse case manager, which includes reviewing benefits or equipment to monitor these conditions.

For more information, or to enroll a member in one of the free disease management programs, contact the Oklahoma nurse case manager at **800-672-2378**.

PREVENTIVE CARE GUIDELINES

Promotion of preventive health is a major objective of our QI Program. The infant, child, adolescent, adult and preventive care guidelines have been adopted by us and are provided to Plan members. The Preventive Care Guidelines are available under clinical resources. In addition, refer to the preventive services policy on the Reimbursement Policies page.

11 PROVIDER RIGHTS AND RESPONSIBILITIES

As a provider, you have certain rights and responsibilities that may affect your practice. Some of these are noted below. We publish this information for you annually. If you're applying or reapplying to participate in our networks, you have credentialing rights to:

- Review submitted information to support your credentialing application
- Update incorrect or conflicting information
- Receive the status of your credentialing or recredentialing application upon request

Learn more about credentialing.

Case Management Programs

You can help our members maintain or improve their health by encouraging them to participate in relevant case management programs. These may include:

- Condition management programs to support members with specific conditions like asthma or diabetes
- Complex case management services for members facing multiple or complicated medical or behavioral health conditions
- Programs to help members transition home after a hospital stay or navigate the health care system
- Wellness and prevention programs for members of all ages

Members can access applicable services for complex and condition case management by:

- Calling the number on their member ID card
- Asking to enroll, or having their caregiver ask to enroll
- Referral from a PCP, practitioner, hospital or other discharge planner
- Referral through utilization management programs

To refer members to any case management programs, call the number on the member's ID card. Our clinicians will collaborate with you to provide members with available resources and additional support.

It is our policy that licensed clinical personnel make all utilization management decisions according to the benefit coverage of a member's health plan, evidence-based medical policies and medical necessity criteria. Decisions are based on appropriateness of care and service, and existence of coverage.

We prohibit decisions based on financial incentives. We do not reward practitioners or clinicians for issuing denials of coverage.

To obtain the criteria used for utilization management decisions, call the number on the member's ID card. You can also refer to our medical policies. Learn more about utilization management.

Federal Employee Program members: In addition to the details provided above, visit FEP Blue for more information about FEP members. Call **800-672-2378** for questions regarding FEP prior authorizations. For FEP expedited appeals only, the fax number is **972-766-9776**.

12 APPEALS AND GRIEVANCES

The following are guidelines for providers to submit complaints or grievances. Providers should also refer to their participating contracts.

Types of appeals

We have established appeals processes to ensure the timely and organized resolution of complaints, grievances and appeals. Complaints and grievances are oral expressions of dissatisfaction with utilization review, provider network status or quality improvement activities. When permitted by the provider's agreement, a written appeal may be filed if you can't achieve resolution of a complaint or grievance. We have different appeals processes, depending on the type of appeal and how it's generated.

- **Utilization management appeals** are related to clinical services provided to a member.
- **Credentialing committee appeals** are for decisions or actions taken by our credentialing committee that result in a change in provider network status, provider network cancellation, or the denial of an application for credentials or provider network participation.
- **Contract termination requests for reconsideration** are related to the termination of your agreement by us, which does not involve a decision or action taken by our credentialing committee. This is available to professional and ancillary providers only.
- **Contractual appeals** are disagreements relating to your agreement and all attachments and amendments, which do not fall into any of the previously stated categories. This category includes reimbursement disputes.

UTILIZATION MANAGEMENT APPEALS

Utilization management appeals are related to UM decisions for clinical services provided to members. There are two types of UM appeals available to the provider, expedited or urgent care or standard. An appeal submitted by the provider is a formal process for review or reconsideration of an adverse determination regarding a prior authorization request. Adverse determination means we determined that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied or reduced. If the issue or service has been previously reviewed by an independent review organization, we will rely on that original opinion in processing any additional appeal requests.

Refer to the Utilization Management Denials Provider Guide for more information.

- **Peer to peer**
  Prior to an appeal, the attending or ordering provider may request a peer-to-peer conversation with a BCBSOK medical director. You may call the Health Care Management Department on the member's identification card. The medical director making the adverse determination or another medical director will be available within one business day to discuss the adverse determination. If the adverse determination is upheld after the conversation, the provider has the option to proceed with an appeal.

- **Expedited appeals**
  An expedited or urgent care appeal is a request, usually by telephone or fax, for an additional review of an adverse determination. The review is conducted by a clinical peer in the same specialty who was not involved in the original adverse determination and is not the subordinate of the person making the original adverse determination. An expedited appeal applies to urgent care requests. Urgent care requests are defined as any request for medical care or treatment with respect to which the application of the time

periods for making nonurgent care decisions could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the covered person's medical condition, would subject the member to severe pain that can't be adequately managed without the care or treatment that is the subject of the request. This process does not apply to nonurgent, post-service or retrospective requests. Local specialty providers and independent review organizations are external consultants who may be utilized in the appeal process. A final determination following the expedited appeal will be made within 72 hours of receipt of the request.

- **Standard appeals**
  A standard appeal is a verbal or written request to review an adverse determination. The review is conducted by a peer reviewer in the same specialty who was not involved in the original adverse determination nor is the subordinate of the peer making the original adverse determination. A standard appeal applies to nonurgent preservice or retrospective preclaim requests. Local specialty providers and independent review organizations are review consultants who may be utilized in the appeal process. Standard appeals may be requested within 180 days from the date of notice of the original adverse determination letter.

- **To initiate an expedited or standard appeal,** you can:
  - Submit the request online using the electronic clinical claim appeal request tool
  - Call the customer service number listed on the back of the member's ID card
  - Submit in writing as instructed on the original adverse determination letter
  - Be sure to include information indicated below under **Information Needed for Appeals**

  The provider must set forth all related clinical information available for the denied services in a letter or statement indicating the issue and resolution being sought. This information must include:
  - Name of the requester
  - Phone number of the requester
  - Member name
  - Member ID number
  - Member reference number if known
  - Date of service
  - Name of the facility where health care services are being rendered, if applicable
  - Name of ordering or attending physician
  - Any new clinical or medical record information

  A final determination following the standard appeal will be made within 30 days of receipt of the request. You'll have only one standard appeal opportunity and must submit all relevant clinical information with the appeal. Re-review appeal requests will not be accepted.

- **Post claim appeals**
  A post claim appeal is a written request to review a nonapproved service or procedure that we determine does not meet the requirements for medical necessity or is experimental, investigational or unproven. The review is conducted by a peer reviewer in the same specialty who was not involved in the original adverse determination nor is the subordinate of the peer making the original adverse determination. A post claim appeal applies to a post-service adverse determination. Local specialty providers and independent review organizations are review consultants who may be utilized in the appeal process. Post claim appeals may be requested within 180 days from the date of notice of the original adverse determination letter.

  All post claim appeals must be submitted in writing using the applicable appeals form or electronic process.

You must set forth all related clinical information available for the denied services in a letter or statement indicating the issue and resolution being sought. This information must include:

- Name of the requester
- Phone number of the requester
- Member name
- Member ID number
- Reference number, if known
- Date of service
- Name of the facility where services were rendered, if applicable
- Name of ordering or attending provider
- Any new clinical medical record information

A final determination following the post claim appeal will be made within 60 days of receipt of request. You will have only one appeal opportunity and must submit all relevant clinical information with the appeal. Re-review appeal requests will not be accepted.

Information needed for appeals:
Provide all related clinical information available for the denied services in a letter or statement indicating the issue and resolution being sought. This information must include:

- Name of the requester
- Phone number of the requester
- Member name
- Member ID number
- Reference number, if known
- Date of service
- Name of the facility where services were rendered, if applicable
- Name of ordering or attending physician
- Any new clinical medical record information

CREDENTIALING COMMITTEE APPEALS

Credentialing Committee appeals are for decisions or actions taken by the Credentialing Committee that result in a change in provider network status, provider network cancellation, the denial of an application for credentials, or denial of recredentialing. The appeals process is available for all participating providers whose provider network contracts are canceled by the Credentialing Committee. Providers seeking participation under a medical group agreement, who are denied acceptance in a provider network by the Credentialing Committee, also have access to this appeals process.

If the Credentialing Committee initiates the provider network cancellation, or if the provider is denied credentials or participation in a provider network by the Credentialing Committee, you will be notified in writing.

Appeals can be made in writing and submitted to the Credentialing Committee designee at the appropriate address provided in the denial letter within 30 days of the date of the denial or cancellation notice.

The Credentialing Committee will review the appeal, all additional submitted information and credentialing file documentation pertaining to the deficiencies. You will be notified in writing of the Credentialing Committee’s final decision. No other appeal rights are available to you.

REQUESTS FOR RECONSIDERATION OF CONTRACT TERMINATION

A **professional or ancillary provider** may request reconsideration if their agreement is terminated by us if the termination does not involve a decision or action taken by our Credentialing Committee, or the termination is pursuant to immediate termination by us, or termination by either party as indicated in their agreement.

If their agreement is terminated by us other than under Immediate Termination by us or termination by either party as indicated in their agreement, submit a written request to us to reconsider its decision to terminate the professional or ancillary provider agreement. Such written request must be received by us within 30 days of the date of the letter notifying provider of the termination.

The request will be considered by one of our authorized representatives not involved in the original termination decision. A written response to the request will be sent to you for reconsideration within 60 days of receipt of the request by us. The effective date of termination will not be extended by the appeal process, provided, however, that decisions favorable to provider will be applied retroactively to the original effective date of termination. All requests for reconsideration are to be sent to:

> Vice President, Provider Network Operations
> BCBSOK
> 1400 S. Boston
> Tulsa, OK 74119

CONTRACTUAL APPEALS

These appeals are disagreements relating to the provider's agreement and all attachments and amendments. All contractual appeals must be submitted in writing by email.

Contractual Appeal Process for Pre/Post-payment DRG Reviews:
Following an adverse DRG Review determination, the hospital may submit a Level 1 written appeal. Instructions are provided in our notification to the hospital.

Level 2 Appeals (hospitals only)
For prepayment DRG reviews that result in a revision of the submitted DRG, if the hospital disagrees with a Level 1 appeal decision, it may submit in writing any additional information and an explanation of its disagreement with the Level 1 appeal decision for review. Level 2 appeals must be received by the Plan within 60 days after notification of a Level 1 decision. For the purpose of this section, notification will be deemed to have been provided as of the seventh day following the date of the letter from the Plan informing the hospital of the Level 1 decision.

Level 2 appeals will be resolved by a facility committee. The hospital may request to present via teleconference before the committee. If no virtual appearance is requested, a determination letter notifying the hospital of the decision will be sent via secure email within 60 business days after the committee meeting where the hospital's appeal is reviewed.

The hospital will be notified of a decision for Level 2 contractual appeals in a timely manner. If the appeal results in additional payment, the hospital will be notified on the detail of remittance. All other appeal responses will be sent directly to the designated hospital contact via secure email.

APPENDIX – GLOSSARY TERMS

Covered services means health care services that are specified as benefits covered under a coverage agreement and are provided or arranged for by provider to members pursuant to the terms of their agreement.

Pass-through billing occurs when the ordering provider requests and bills for a service that was performed by another provider.

Postservice review is a medical necessity review that occurs after the service is rendered and is often accompanied by a request for medical records.

Prior authorization is a required preservice utilization review to determine whether it is medically necessary according to applicable medical policies.

Under arrangements billing refers to situations where services are performed by a provider, but the services are billed under the contract of another provider, rather than under the contract of the provider that performed the services.

Checking eligibility and/or benefit information 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. If you have any questions, please call the number on the member's ID card.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the subscriber's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

BCBSOK contracts with Prime Therapeutics LLC to provide pharmacy solutions. BCBSOK, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Accredo is a specialty pharmacy that is contracted to provide services to BCBSOK members. The relationship between Accredo and BCBSOK is that of independent contractors.

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

1400 S Boston
Tulsa, OK 74119-3613

Network Services:

800-722-3730, Option 2

oknetworkmanagement@bcbsok.com

Image(s) may have been created or enhanced using artificial intelligence tools.

619741.0426