2025 Commercial/Medicare

Provider Manual

Baylor Scott & White Health Plan

PR_25PRManual-Cmrcl-MC-1224-PS

Contents

Health Plan Resources

Change Healthcare (ACH EFT Enrollment)..... 1.866.506.2830

Change Healthcare (VCC Opt-out)..... 1.855.886.3863

Health Services Division ..... 1.888.316.7947 or 1.254.298.3088

Medicare Providers..... 1.866.334.3141

Nurse Advice Line 1.877.505.7947

Pharmacy 1.800.728.7947

Email: PrescriptionServices@BSWHealth.org

Provider IVR 1.800.655.7947

Provider Service Center..... 1.800.321.7947 or 1.254.298.3064

Email: BSWHealthPlan.com/Pages/Contact.aspx

Fax: (254) 298-3044

Other Organization Phone Numbers

Superior Vision..... 1.800.507.3800 or 1.800.879.6901

EyeMed Vision (Group Plan Customer Service) – BSWHP Employee Plans only 1.844.409.3401

Online Resources at BSWHealthPlan.com

- Authorizations and Policies
- Claims
- Claims and Billing forms for Providers
- Claims Search
- Complaints and Appeals
- Eligibility and Benefits
- eviCore
- EX Code List
- Fee Lookup
- General Provider Resources
- HSD Referral Form
- Manage Provider Account
- Medical Management
- OncoHealth
- Pre-Auth Check
- Provider Manual and Training
- Quality Improvement – Policy and Procedures – Clinical Guidelines
- Redetermination

Introduction

About Us

Part of the Baylor Scott & White Health family, Baylor Scott & White Health Plan began operations in January 1982 and now covers nearly 500,000 members, with a service area covering 171 counties in North, Central and West Texas.

We work with more than 36,000 providers and 4,000+ facilities in Texas to provide a high-level continuum of care, every day.

Our Provider Relations Team is here for you, no matter where you're located. If you have questions or need support, visit the Contact Us on our website and view the Provider Relations Representative Territory map to find the right contact. You'll also find contacts and other important information in this manual, that will help you as you provide care for Baylor Scott & White Health Plan members.

Using the Provider Manual

Welcome to the Baylor Scott & White Health Plan network. This manual is designed to provide information that will be helpful to you when treating a Baylor Scott & White Health Plan member. It contains valuable information, including:

- administrative processes and procedures,
- medical management procedures and programs, and
- quality improvement programs.

New services may be added at any time.

We review this manual periodically and make changes as needed. For the most up-to-date information visit our website.

STAR (RightCare) providers: See the RightCare Provider Manual online at: https://rightcare.swhp.org/en-us/prov/provider-manual

If you have any questions or need additional information about Baylor Scott & White Health Plan, please call our Provider Service Center at 1.800.321.7947 or 254.298.3000.

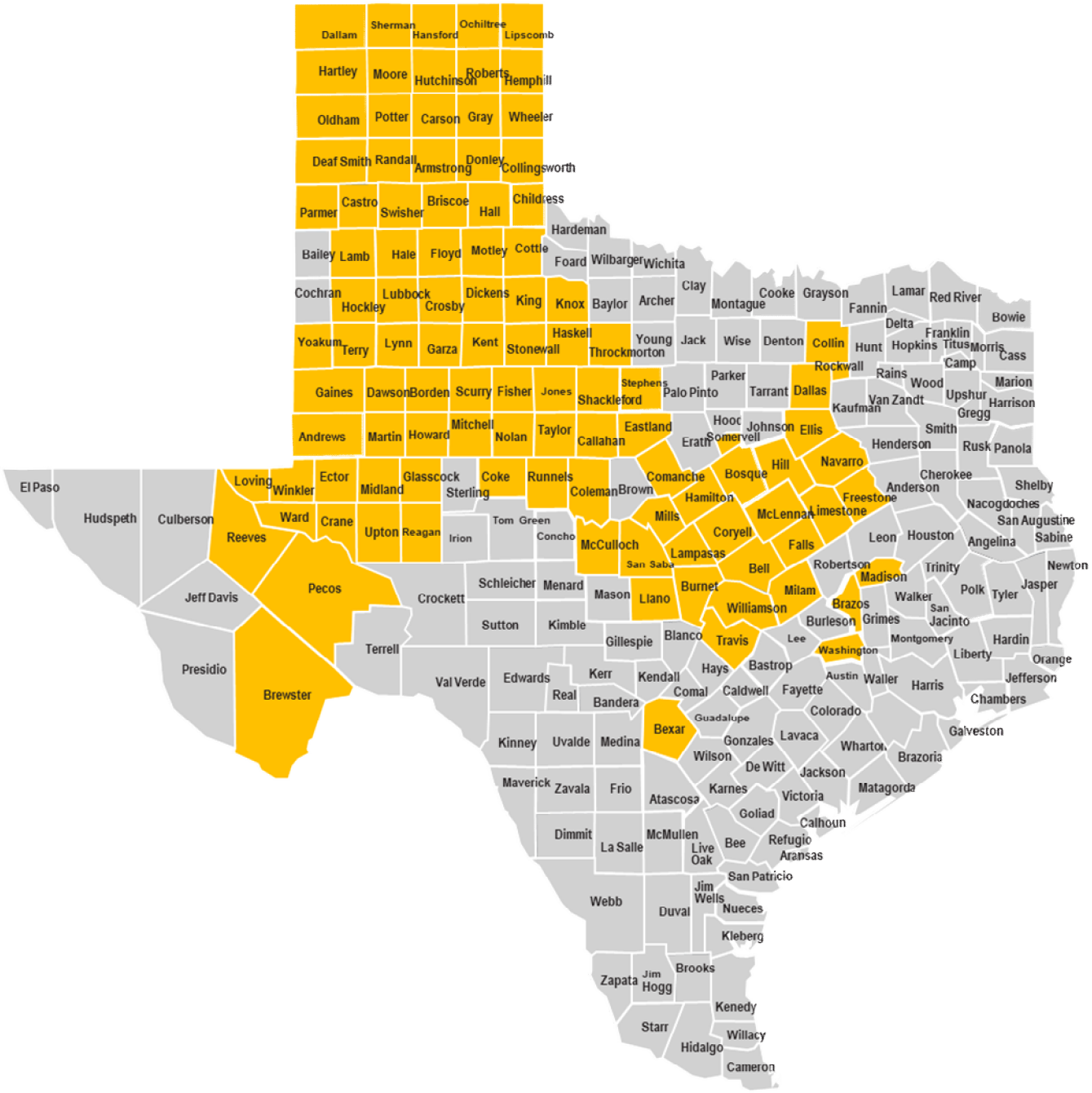
Member Confidentiality

Baylor Scott & White Health Plan follows the government regulations enacted by HIPAA that protect member confidentiality.

A HIPAA summary is available at http://www.hhs.gov/sites/default/files/privacysummary.pdf

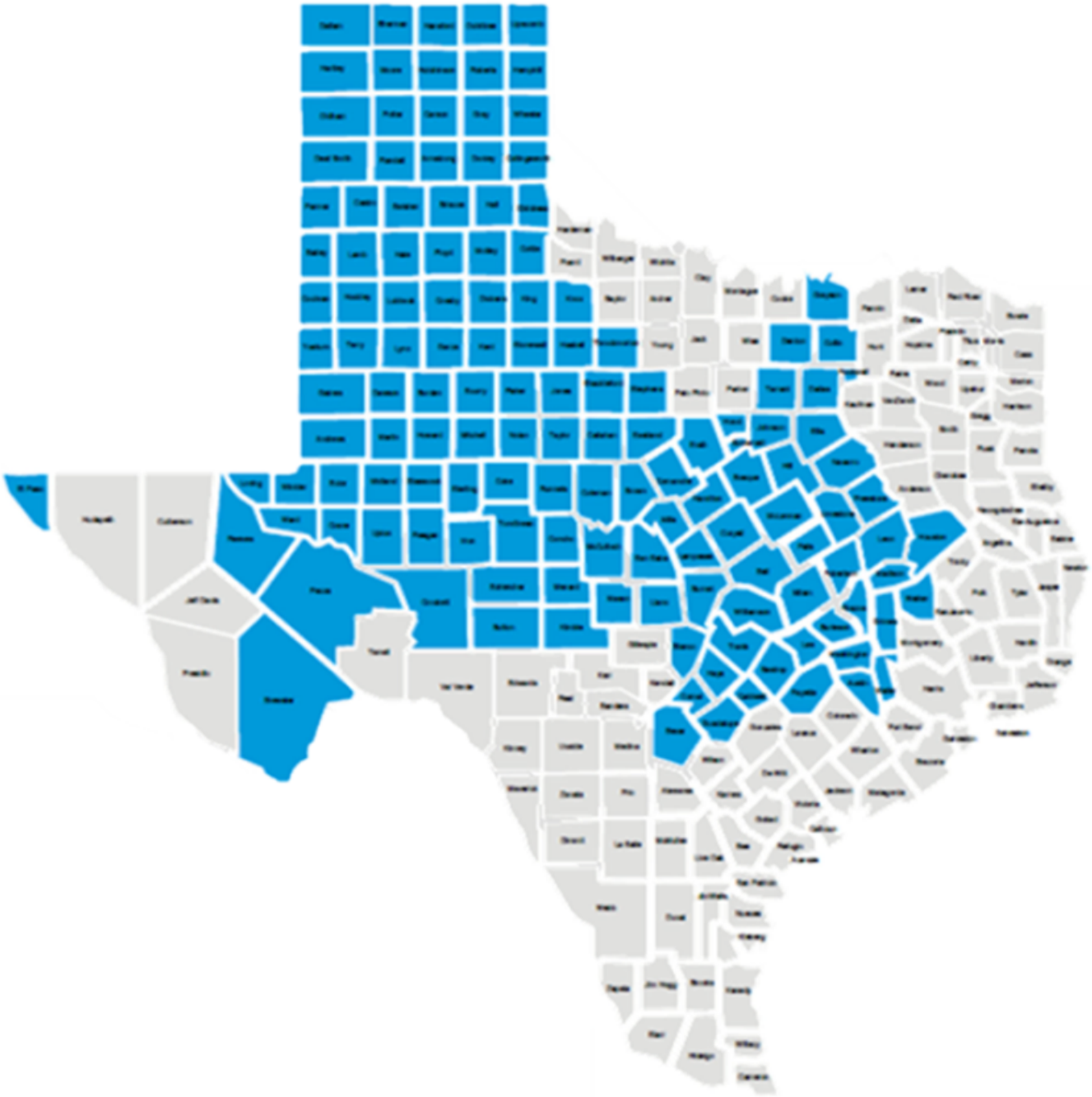
Service Area Maps – Individual & Family

Networks: BSW Premier HMO



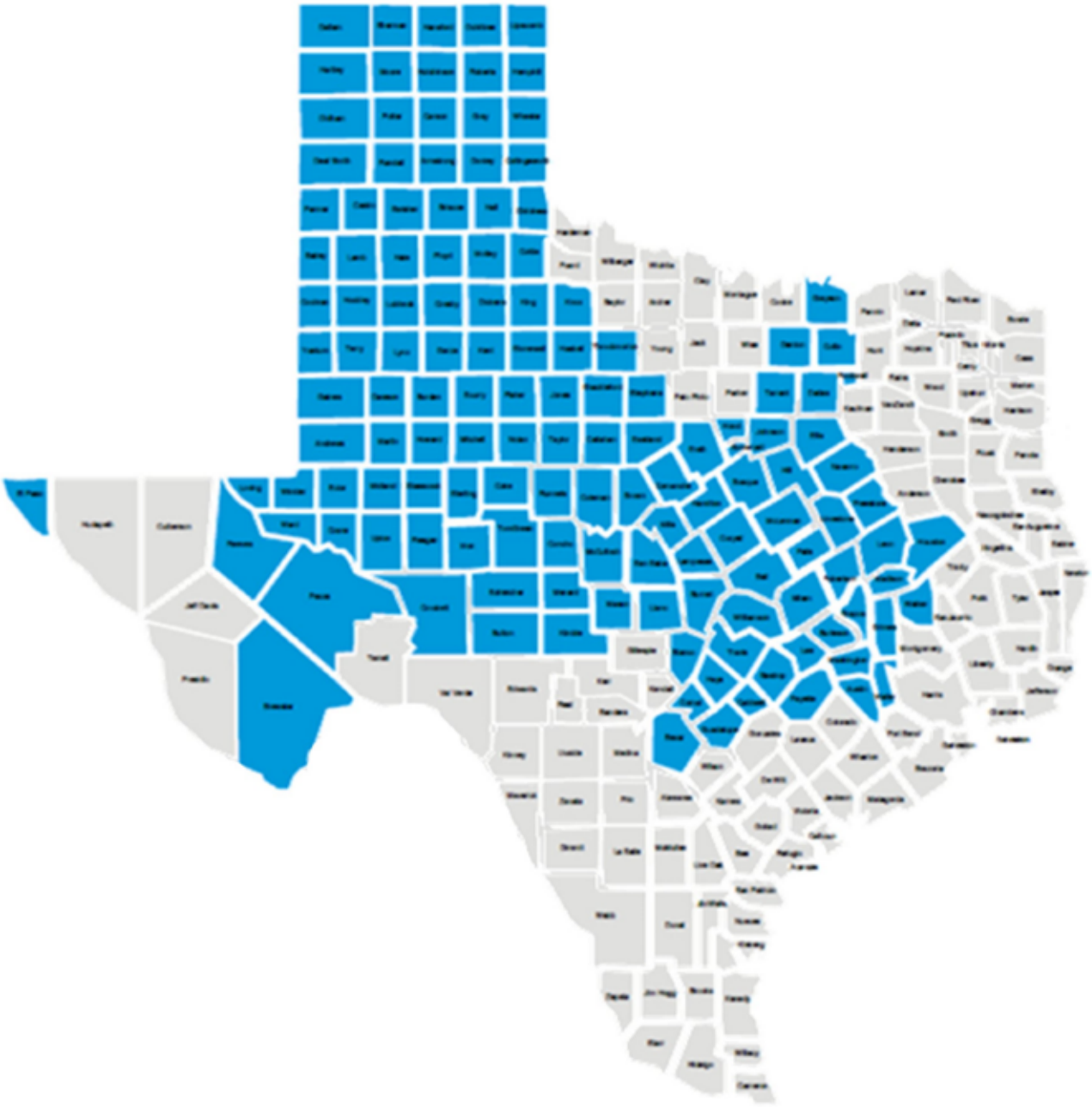
Service Area Map – Group HMO

Networks: BSW Plus HMO, BSW Premier HMO, BSWH Employees SEQA/EQA



Service Area Map – Group PPO

Networks: BSW Access PPO, BSW Plus PPO, BSW Premier PPO, BSWH Employees PPO & HSA



NOTE: BSW Access PPO members have in-network benefits within the 141-county BSW service area (blue) when visiting Baylor Scott & White Health Plan providers. Outside the BSW service area and across the country, BSW Access PPO members have in-network benefits when accessing care through the UHC Options PPO network.

Service Area Map – Medicare HMO

Network: BSW SeniorCare Advantage HMO

Service Area Map – Medicare HMO

Network: Covenant Health Advantage HMO

Service Area Map – Medicare PPO

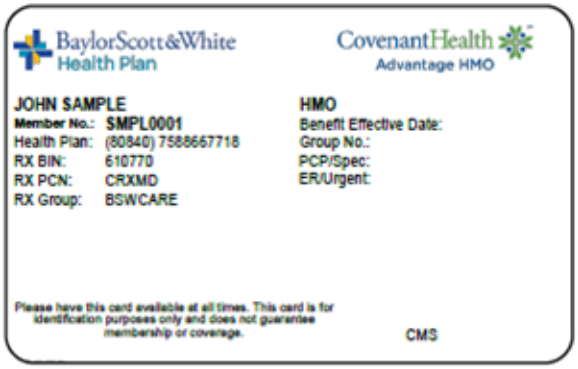
Network: BSW SeniorCare Advantage PPO

Baylor Scott & White Health Plan ID Card Samples

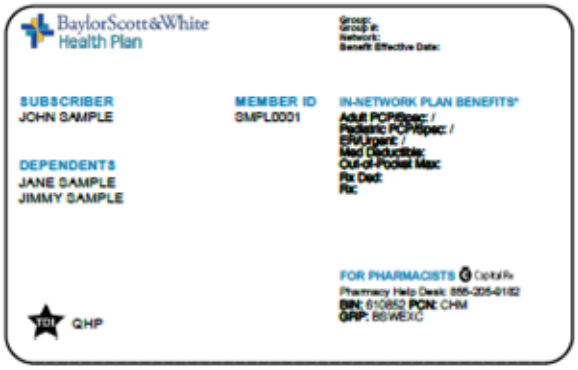
Baylor Scott & White Health Plan offers a variety of plans. We have included sample ID cards below; however, card details may vary from plan to plan.

Medicare Advantage (BSW SeniorCare Advantage)

Medicare Advantage (Covenant Health Advantage)



Marketplace ID card sample

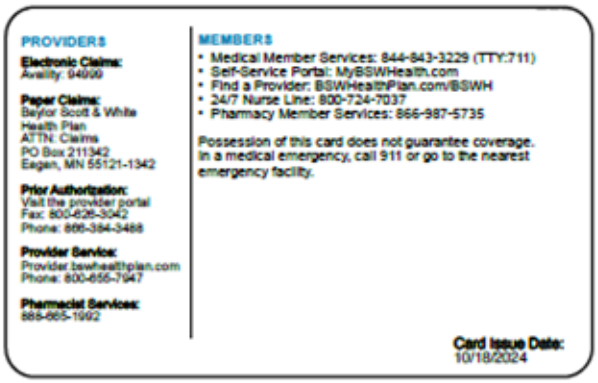


ID cards for members of group-based health plans look similar but sometimes contain unique information or logos.

BSW Access PPO

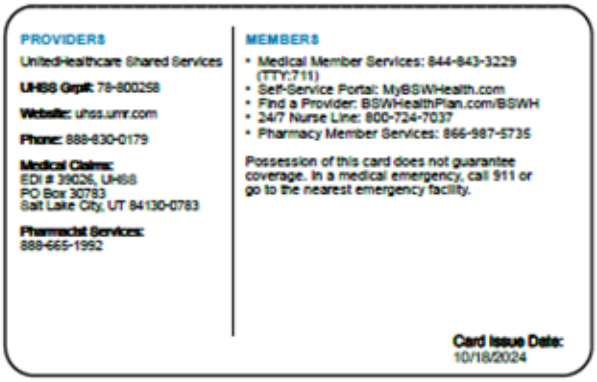
Members using our BSW Access PPO network have this card. Note the UnitedHealthcare (UHC) Options PPO Network logo in the top right corner. Members have access to the UHC network outside the BSW Health Plan service area. Filing information for UHC providers is also included on the back of the card.

BSW Employee Plan



This sample represents the BSW Employee EQA plan, as indicated by "EQA" on the front of the card. PPO, SEQA and HDHP card versions vary slightly. BSW Employee Plan ID cards do not display a medical group number, as it is not necessary to process the claim.

BSW Employee Out-of-State Plan



The BSW Employee Plan also includes Live Well plans, which are for employees living outside of Texas. Live Well Premium and Live Well HDHP plans are both based on the United Healthcare Options PPO network. The plan type is distinguished clearly above the network benefits section, as shown in the red circle above.

Provider & Member Rights and Responsibilities

Baylor Scott & White Health Plan (BSWHP) contracted providers are responsible for providing and managing healthcare services for BSWHP members until services are no longer medically necessary.

Member Rights

- You have the right to be provided with information regarding member's rights and responsibilities.
- You have the right to be provided with information about BSWHP, its services and practitioners providing member's care.
- You have the right to be treated with respect; member's provider and others caring for member will recognize his/her dignity and respect the need for privacy as much as possible.
- You have the right to participate in decision-making regarding member's healthcare.
- You have the right to have candid discussion of appropriate or medically necessary treatment options for member's conditions, regardless of cost or benefit coverage.
- You have the right to voice complaints, appeals, or grievances about the member's coverage through BSWHP or care provided by BSWHP providers in accordance with member's Health Care Agreement.
- You have the right to make recommendations regarding Baylor Scott & White Health Plan's members' rights and responsibilities policies.
- You have the right to have an advance directive Such as Living Will or Durable Power of Attorney for Health Care Directive, which expresses member's choice about future care of names someone to decide if member cannot speak for himself/herself.
- You have the right to expect that medical information is kept confidential in accordance with member's Health Care Agreement.
- You have the right to select a Primary Care Physician (PCP) to coordinate your healthcare. It is not a requirement to select a PCP.

Member Responsibilities

- It is your responsibility to notify BSWHP regarding any out-of-plan care.
- It is your responsibility to follow BSWHP instructions and rules and abide by the terms of your healthcare agreement.
- It is your responsibility to provide information (to the extent possible) to the organization and its practitioners and providers need in order to provide care.
- It is your responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

- It is your responsibility to follow plans and instructions, to the best of your ability, for care you have agreed on with your practitioner(s) and provider(s).
- It is your responsibility to give BSWHP providers a copy of an advance directive, if one exists.
- It is your responsibility to advise BSWHP or BSWHP providers of any dissatisfaction you have regarding your care while a patient, and to allow the opportunity for intervention to alter the outcome whenever possible.

Providers have the right to:

- Be treated courteously and respectfully by BSWHP staff at all times.
- Request information about BSWHP's utilization management, case management, and disease guidance programs, services, and staff qualifications and contractual relationships.
- Upon request, be provided with copies of evidence-based clinical practice guidelines and clinical decision support tools used by BSWHP.
- Be supported by BSWHP to make decisions interactively with members regarding their healthcare.
- Consult with BSWHP Medical Directors at any point in a member's participation in utilization management, case management, or disease guidance programs.
- Provide input into the development of BSWHP's Case Management and Disease Guidance Programs.
- File a complaint on own behalf of a BSWHP member, without fear of retaliation, and to have those complaints resolved.
- Receive a written decision regarding an application to participate with BSWHP within 90 days of providing the complete application.
- Communicate openly with patients about all diagnostic testing and treatment options.
- The right to appeal claims payment issues.
- The right to 90 days prior written notice of termination of the contract.
- The right to request a written reason for the termination, if one is not provided with the notice of termination.

Provider Responsibilities

Primary Care Physicians (PCPs):

- Provide primary health care services not requiring specialized care. (i.e., routine preventive health screening and physical examinations, routine immunizations, routine office visits for illnesses or injuries, and medical management of chronic conditions not requiring a specialist)
- Obtain all required pre-authorizations as outlined in the Provider Manual.

- Refer BSWHP members to BSWHP contracted (in-network) specialists, facilities, and ancillary providers when necessary.
- Assure BSWHP members understand the scope of specialty and/or ancillary services that have been authorized and how or where the member should access the care.
- Communicate a BSWHP member's medical condition, treatment plans, and approved authorizations for services to appropriate specialists and other providers.
- Keep panel open to BSWHP members until it contains at least 100 BSWHP members on average per individual PCP.
- Will give BSWHP at least 7 days advance written notice of intent to close panel and must not close panel to BSWHP unless closing panel to all payors.

Specialists:

- Deliver all authorized medical health care services related to the BSWHP member's medical condition as it pertains to specialty.
- Deliver all medical health care services available to BSWHP members though self-referral benefits.
- Determine when the BSWHP member requires services of other specialists or ancillary providers for further diagnosis or specialized treatment, as well as, if the member requires admission to a hospital, rehabilitation facility, skilled nursing facility, or etc.
- Provide verbal or written consult reports to the BSWHP member's PCP for review and inclusion in the member's primary care medical record.

All Providers:

- Follow BSWHP's administrative policies and procedures and clinical guidelines when providing or managing healthcare services within the scope of a BSWHP member's benefit plan.
- Uphold all applicable responsibilities outlined in the BSWHP Member Rights & Responsibilities Statement.
- Maintain open communications with BSWHP members to discuss treatment needs and recommended alternatives, regardless of benefit limitations or BSWHP administrative policies and procedures.
- Provide timely transfer of BSWHP member medical records if a member selects a new primary care practitioner, or if the practitioner's participation with BSWHP terminates.
- Participate in BSWHP Quality Improvement Programs, which are designed to identify opportunities for improving healthcare provided to BSWHP members and the related outcomes.
- Comply with all utilization management decisions rendered by BSWHP.
- Respond to BSWHP Provider Satisfaction Surveys.

- Provide BSWHP with any BSWHP member's written complaints or grievances against provider or practice immediately (within 24 hours). The process for resolving complaints should be posted in the provider's office or facility and should include the Texas Department of Insurance's toll-free number. **Consumer Help Line** at 1.800.252.3439 between 8 a.m. and 5 p.m., Central time, Monday-Friday.
- Must verify eligibility and obtain prior authorization before initiating certain procedures, admissions, or specialty services, which will be available on the provider portal.

Maintenance of Provider Information

Changes in Address or Practice Status

Providers are required to notify Baylor Scott & White Health Plan of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is NOT an acceptable form of notification. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement.

Please submit the following changes within 10 calendar days of occurrence via the BSWHP website:

- **Changes in address** (physical location or accounting),
- **Telephone number or fax number** must be updated online; providers will also update address information using the Provider Information Change Form. A W9 is required if the provider is changing the mailing address.
- **Changes in name, federal tax ID,** and any other information that pertains to the **structure of the provider's organization** (for example, performing providers).
- Change of ownership and tax identification number (TIN).
- **Adverse actions** impacting practitioner's ability to provide services.
- **Termination from or opt out** of participation in Medicare or Medicaid.

All changes reported should include an effective date.

Credentialing

Physician/Physician Group

Baylor Scott & White Health Plan (BSWHP) implements a rigorous credentialing and re-credentialing process to evaluate and select the practitioners who assume responsibility for managing the healthcare of its members, consistent with state and federal requirements and guidelines specified by the National Committee for Quality Assurance (NCQA).

Each practitioner is credentialed separately. As required by the Texas Department of Insurance (TDI), BSWHP uses the Texas Standardized Credentialing Application for credentialing and re-credentialing of all practitioners. Re-credentialing is required at least every three years.

Professional Practitioners

The scope of Providers to be credentialed and re-credentialed includes, but is not limited to, licensed physicians, podiatrists, psychiatrists, psychologists, mental health professionals, optometrists, master social workers, audiologists and professional counselors (licensed professional counselors, licensed clinical social workers, licensed chemical dependency counselors, licensed marriage and family therapists). Medicaid physician assistants and nurse practitioners who will be practicing as Primary Care Providers will be credentialed. Practitioners and providers that are not required to be credentialed or re-credentialed include:

- Healthcare professionals who are permitted to provide services only under the direct supervision of another practitioner
- Hospital-based healthcare professionals who provide services to members only incidental to hospital services, unless those healthcare professionals are separately identified in Provider directories available to members
- Students, Residents, and Fellows

Verisys

Verisys, LLC is BSWHP's Credentialing Verification Organization (CVO). Verisys will perform primary source verification functions on behalf of BSWHP through the Texas Association of Health Plans, and the joint standard credentialing initiative with HHSC for credentialing and re-credentialing. After contracting is initiated, BSWHP will notify Verisys to begin the credentialing process with the practitioner or institutional Provider. Verisys will then contact the Provider for a completed application with current attestations and will perform primary source verifications. BSWHP utilizes the CAQH web-based solution to capture provider data. Verisys will then pull the information from CAQH to perform primary source verifications.

Once verifications have been completed, the Providers' completed application packet and primary source verification documentation are released back to BSWHP to complete the credentialing process.

BSWHP will incorporate the information into our systems and submit it to the Credentialing Committee for final consideration and approval before acceptance into the network. Providers that do not meet the minimum acceptable standards are denied participation in our Network. If we decline to include individual or groups of providers in our Network, we inform the affected providers by written notice.

Hospital Privileges

Providers must have hospital privileges at a BSWHP-contracted facility. If the provider does not have privileges, a letter must be signed by the practitioner stating that he/she will send BSWHP members to a contracted facility and is aware this will mean transferring the care to another provider who is contracted with BSWHP. If the provider is a specialist, a letter of agreement must be provided from the physician/group who will admit the member to a BSWHP facility when needed.

Full Residency Requirement

Physicians who graduated from medical school after 1970 must have completed a full internship and residency. The internship and residency must be a minimum of 3 years and can be a combination of internship and residency. An exception would be DO physicians who graduated from medical school prior to 1985. They must have completed a one-year internship and be board certified by the American Osteopathic Association (AOA). DO physicians who graduated from medical school after 1985 must have completed a full internship and residency.

Board Certification

Baylor Scott & White Health Plan (BSWHP) requires physicians to have current American Board of Medical Specialties (ABMS) board certification or American Osteopathic Association (AOA) certification (or be in the active process of obtaining such) in the specialty physicians are currently practicing.

If a physician is NOT board certified, or let their certification lapse, and do not fall within the grace period allowed per the ABMS, a CME agreement is required. BSWHP requires that, each year, the physician obtain at least 50 AMA Physician Recognition Award (PRA) or equivalent CME credits, of which 25 are Category I. Twenty-five of those 50 credits (either Category I, II or combination) must be in the field in which the physician is practicing medicine. Failure to complete the 50 CME credits per year will result in failure to be an eligible practitioner within BSWHP's network.

Medicaid Providers

To be reimbursed for services rendered to Medicaid managed care members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with Medicaid for BSWHP until they have enrolled in Texas Medicaid and have provided BSWHP with their TPI number.

Institutional Providers

BSWHP confirms before contracting, and every three years thereafter, that the institutional providers meet NCQA, TDI, CMS, HHSC and BSWHP standards. Institutional providers credentialed by BSWHP include, but are not limited to hospitals, skilled nursing facilities, home health agencies, rehabilitation facilities, dialysis centers, free-standing surgical centers, diagnostic imaging centers, cancer centers, inpatient behavioral health facilities, residential behavioral health facilities, ambulatory behavioral health facilities, rural health clinics, and federally qualified health centers.

Prior to contracting with an institutional provider, BSWHP requires the following:

- A copy of state licensure, if one is required by the State of Texas
- Documentation of an appropriate Medicare certification as required by state or federal regulations. A copy of the Medicare certificate or provision of the Medicare number will be acceptable proof of participation certification. New facilities awaiting a Medicare number can be considered for participation if they have received accreditation.
- A current copy of the provider's malpractice liability coverage face sheet showing expiration and coverage amounts.
- Evidence of applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, Texas Mental Health and Mental Retardation certification for community mental health centers and CLIA (Clinical Laboratory Improvement Amendments of 1998) certification for laboratories.
- The most recent accreditation certificate, if applicable to the institution. BSWHP accepts certifications from recognized accrediting bodies that assure an independent measure of the quality of services.
- If the institution is not accredited, BSWHP requests a copy of the most recent state or Medicare site survey results. If a national accrediting body does not accredit the institution and if the institution has not had a recent State or Medicare site visit within the past 3 years, BSWHP will delay credentialing of the institution pending a Medicare site visit or BSWHP will conduct an on-site evaluation. BSWHP reviews state or Medicare site surveys for the deficiencies found by the accrediting body or Medicare.

BSWHP utilizes the CAQH web-based solutions to collect the credentialing application developed in conjunction with the Texas Association of Health Plans. Verisys then pulls the information from CAQH and verifies the information prior to sending to BSWHP for Credentialing Committee approval/denial.

BSWHP re-credentials institutional providers at least once every three (3) years utilizing the same process as initial credentialing.

Expedited Credentialing

If a provider qualifies for expedited credentialing under Texas Insurance Code 1452, Subchapters C, D and E (regarding providers joining established medical groups or professional practices already contracted with us), our claims system will be able to process claims from the provider as if the provider was fully contracted, no later than 30 days after receipt of a clean and complete application, even if BSWHP has not yet completed the full credentialing process.

BSWHP will provide expedited credentialing for certain provider types and allow services to members on a provisional basis as required by Texas Government Code §533.0064 and our state contract with HHSC. Provider types included are physicians, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists and psychologists. The provider must meet the following criteria:

- Be a member of a provider group already contracted with BSWHP
- If Medicaid, have a TPI#
- Agree to comply with the terms of the existing provider group contract
- Submit all documentation and other information required by us to begin the credentialing process

Mid-level Providers

Mid-level providers must have a supervising physician in a similar specialty who is a participating provider in the BSWHP network.

Credentialing Decisions

All credentialing decisions are made by the Credentialing Committee and all proceedings are confidential and privileged. Information obtained, or documentation created by BSWHP credentialing staff for credentialing and re-credentialing, is treated in a confidential manner. Providers or groups are not denied participation with BSWHP, or have any such contract terminated, based on sex, race, creed, color, national origin, age, or disability. The selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions.

Providers are notified within 60 calendar days of their status in the network according to the determination made by the committee. If initial provider participation is denied, the provider is notified in writing. If an existing providers participation is altered based on quality of care or service, the provider is notified in writing of the reason for the denial and is given an opportunity to appeal the decision of the Credentialing Committee through a review panel.

Rights of Applicants to the Baylor Scott & White Health Plan

Right to Inquire About Credentialing Status

- Each applicant to the Baylor Scott & White Health Plan retains the right to inquire at any time about their credentialing status. The practitioner may contact the Provider Relations Department at any time to obtain the current status.
- **Right to Review**

  Practitioners will have the right to review the information submitted in support of their credentialing applications. However, BSWHP respects the right of the Peer Review aspects that are integral in the credentialing process. Therefore, practitioners will not be allowed to review references or recommendations or any other information that is peer review protected. If, through the review process, a practitioner discovers an error in the credentialing file, the practitioner does have the right to request a correction of the information in question.
- **Right to Notification**

  Practitioners will be notified of any information obtained during the credentialing process that varies substantially from the information provided by the practitioner.
- **Right to Correct Erroneous Information**

  Practitioners will have the right to correct erroneous information. The practitioner will be afforded fifteen (15) working days to provide corrected information in a written format to the QI Coordinator and/or Credentialing Delegate.

A provider has the right to inquire about the status of an application by the following methods:

- Phone: 254.298.3064
- Email: hpcredentialinggroup@bswhealth.org

Ongoing Monitoring

BSWHP monitors network providers between provider credentialing cycles to encourage the provision of safe, quality care to BSWHP members. BSWHP reviews the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), the Office of Personnel Management (OPM), SAM, the state licensing board of each provider, as well as member and provider complaints and adverse events, on a monthly basis.

Advance Directives

Baylor Scott & White Health Plan Policy on Advance Directives and Acceptance or Refusal of Treatment

It is the policy of Baylor Scott & White Health Plan to comply with the applicable state and federal law regarding advance directives and medical powers of attorney. It is also the policy of the Health plan to require its providers to comply with Texas law regarding informed consent and the patient's right to accept or refuse medical or surgical treatment. Because of these requirements and in order to honor the wishes of the member or member's legal representative regarding treatment and the withdrawal of withholding of life-sustaining procedures, it is the policy of the Health Plan to provide written information to all adult members, regarding: (1) their right to accept or refuse treatment; (2) their right to formulate advance directives; and (3) the written policies of the Health Plan respecting the implementation of such rights.

It is the policy of the Health Plan to require appropriate contracted providers to document in each adult member's medical records whether the member has executed an advance directive. It is the policy of the Health Plan to require appropriate contracted providers to treat all members equally in the provision of care without regard as to whether the member has executed an advance directive. It is the policy of the Health Plan to provide educational opportunities to its staff and the community on issues concerning advance directives. It is the policy of the Health Plan to require appropriate contracted providers to comply with the Patient Self Determination Act, Omnibus Budget Reconciliation Act of 1990, P.L. 101508, sec. 4206 and 4751, 104 stat. 1388, 1388-115, and 1388.204 (classified respectively at 42 U.S.C. 1395cc(f) and 1396(a) (1994)) and the Advance Directives Act, Texas Health and Safety Code §§ 166.01 et seq. The above policy statements shall not be interpreted to supersede or obviate the provisions contained in the members' evidence of coverage, including the Schedule of Benefits.

Advertising

Contracted Practitioner and Contracted Organizational Provider Advertising or Promotion

I. A contracted practitioner or contracted organizational provider will not use the name of Scott and White and/or Baylor Scott & White Health Plan (BSWHP) in advertising or promotion without prior approval. In accordance with rules and regulations governing health maintenance organizations, a practitioner or organizational provider must not solicit membership or services from potential BSWHP members. Practitioners and organizational providers are informed of policy and procedure through individual contracts, provider manuals, and provider newsletters.
II. The purpose is to ensure that dissemination of information is reasonable, accurate and consistent.

III. Advertising or promotion using variations of Scott and White's and/or Baylor Scott & White Health Plan's name, logo, or information by any type of provider will be considered on an individual basis and must obtain prior approval by Provider Relations Division. Proposed advertising or promotion will be considered from those practitioners or organizational providers who formally contract with Scott and White Clinic or Baylor Scott & White Health Plan.

Submission from a practitioner or organizational provider who is affiliated through a letter of agreement or verbal agreement will not be considered. A written copy or facsimile of the proposed advertising or promotion must be submitted to Provider Relations Office. Information submitted will be reviewed for accuracy, consistency of information, and type size.

In general, acceptable wording includes: "Approved Provider for Baylor Scott & White Health Plan." In general, acceptable size is 0.125 inches in height, 2.0 inches in length. Variances from the generally acceptable wording and size are reviewed with the BSWHP Medical Director, President, and/or Executive Director, as appropriate, to determine how the information fits with overall organizational needs. Written confirmation of acceptance, rejection, or recommendations for change is sent to the practitioner or organizational provider by the Provider Relations Division.

Complaints and Appeals Policies

BSWHP recognizes that a member, physician, provider, or other person designated to act on behalf of a member may encounter an event in which performance does not meet expectations. It is important that such an event be brought to the attention of BSWHP. BSWHP is dedicated to addressing problems quickly, managing the delivery of health care services effectively, and preventing future complaints or appeals. The Medical Director has overall responsibility for the coordination of the complaint and appeal procedure. If needed, individuals should contact BSWHP for assistance with this procedure. While complaints, grievances and appeals are governed by different regulatory requirements, as a rule, the below is applied.

Complaints (Commercial Member Rights)

BSWHP will send an acknowledgment letter of the receipt of oral or written complaints from complainants no later than five (5) business days after the date of the receipt of the complaint. The acknowledgment letter will include a description of BSWHP's complaint procedures and time frames. If the complaint is received orally, BSWHP will also enclose a one-page complaint form, which should be returned for prompt resolution of the complaint.

BSWHP will acknowledge, investigate, and resolve all complaints within thirty (30) calendar days from the date of the complaint. However, investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the immediacy of the case and will not exceed 72 hours or three business days from receipt of the complaint.

BSWHP will investigate the complaint and issue a response letter to the Complainant within thirty (30) days from receipt of the complaint explaining the specific contractual reasons for the resolution. The response letter will contain a full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.

Complaints (Provider Rights)

BSWHP requires receipt of a written complaint from a provider within 60 days of the specific event on which the complaint is based. Complaint is defined as a grievance that you communicate to your health insurer or plan. BSWHP will investigate and resolve all complaints within 30 calendar days of the date of the written complaint. The response letter will contain the outcome of the investigation

Appeals (Commercial Member Rights)

If the Complainant is not satisfied with BSWHP's resolution of the complaint, the Complainant will be given the opportunity to appear before an appeal panel or address a written Appeal to an appeal panel. BSWHP will send an acknowledgment letter of the receipt of oral or written appeal from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of BSWHP's Appeal procedures and time frames. If the Appeal is received orally, BSWHP will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

BSWHP will appoint members to the complaint appeal panel, which shall advise BSWHP on the resolution of the complaint. The complaint appeal panel shall be composed of equal numbers of BSWHP staff, Participating Providers,

and members. No member of the complaint appeal panel may have been previously involved in the disputed decision.

The Participating Providers must have experience in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination.

If specialty care is in dispute, the appeal panel must include a person who is a specialist in the field of care to which the appeal relates. The members may not be employees of the Health Plan. No later than five (5) business days before the scheduled meeting of the panel, unless the Complainant agrees otherwise, BSWHP will provide to the Complainant or the Complainant's designated representative: any documentation to be presented to the panel by Health Plan staff; the specialization of any physicians or providers consulted during the investigation; and the name and affiliation of each BSWHP representative on the panel.

The Complainant, or designated representative if the enrollee is a minor or disabled, is entitled to: appear before the complaint appeal panel in person or by other appropriate means; present alternative expert testimony; and request the presence of and question any person responsible for making the prior determination that resulted in the Appeal.

Notice of the final decision on the Appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and the address of the Texas Department of Insurance. BSWHP will complete the Appeals Process no later than the thirty (30) calendar days after the date of the receipt of the written request for Appeal or one-page appeal form from the Complainant.

Appeal of Adverse Determinations (Commercial Member Rights)

A member, a person acting on behalf of the member, or the member's physician or healthcare provider must appeal an Adverse Determination orally or in writing to a Member Relations Coordinator. An appeal is defined as a formal request for the Plan to reconsider an adverse (denial) organization determination or coverage determination on service/drug requested or received. BSWHP will send an acknowledgment letter of the receipt of oral or written Appeal of Adverse Determination from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of the BSWHP's Appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the Complainant for the Appeal.

BSWHP will issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or healthcare provider, explaining the resolution of the appeal; and provide written notification to the appealing party of the determination of the Appeal, as soon as practical, but in no case later than thirty (30) calendar days after the date the Health Plan receives the Appeal from the Appellant. If the Appeal is denied, the written notification shall include a clear and concise statement of: the specific clinical basis for the Appeal denial; the specialty of the physician or other healthcare provider making the denial; and notice of the appealing party's right to seek review of the denial by an Independent Review Organization as provided in this Evidence of Coverage. If the "Appeal of Adverse

Determinations" is denied and within ten (10) business days the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the Appeal denial shall be reviewed by a Participating Provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review in the Adverse Determination, and such specialty review will be completed within fifteen (15) business days of receipt of the request from the provider.

BSWHP will provide an expedited Appeal procedure for emergency care denials, denials of care for Life-Threatening Conditions and denials of continued stays for hospitalized patients. The procedure will include a review by a Participating Provider who has not previously reviewed the case and who is of the same or a similar specialty who typically treats the medical
condition, performs the procedure, or provides the treatment under discussion for review. The time in which such expedited Appeal will be completed will be based on the medical immediacy of the condition, procedure or treatment, but in no event exceed 72 hours.

Notwithstanding any provisions to the contrary, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate Appeal to an Independent Review Organization and is not required to comply with procedures for an "Appeal of Adverse Determination" described in this Evidence of Coverage. BSWHP reserves the right to refer any "Appeal of Adverse Determinations" directly to an Independent Review Organization prior to any determination being made through the internal review process described in this Evidence of Coverage.

Independent Review of Adverse Determinations (Commercial Member Rights)

BSWHP will permit any party whose Appeal of an Adverse Determination is denied, to seek a review of that determination by an Independent Review Organization assigned to the appeal. BSWHP will provide to the Independent Review Organization no later than the three (3) business days after the date of request by the Party a copy of: any medical records of the enrollee that are relevant to the review; any documents used by the plan in making the determination; the written notification described in Section 5.2 of this document; any documentation and written information submitted to the Health Plan in support of the Appeal; and a list of each physician or healthcare provider who has provided care to the enrollee and who has medical records relevant to the Appeal.

BSWHP will comply with the Independent Review Organization's determination with respect to the medical necessity or appropriateness of healthcare items and services for an enrollee.

Billing and Claims

How to Submit Claims

Whether you're filing electronic or paper claims, you'll need to:

- Meet filing deadlines and
- Submit clean claims

to avoid having claims delayed, denied, or sent back to you for corrections.

Filing Deadline

All claims must be received in our office within 95 days of the date of service for Commercial, and 365 days for Medicare, or they will be denied. Coordination of Benefit (COB) claims must be submitted within 95 days of the primary payer's Explanation of Benefits (EOB) date for Commercial or 365 days from the primary payer's Explanation of Payment for Medicare.

Paper Claims

These will take longer to process than electronic claims. You're expected to follow Texas Department of Insurance (TDI) requirements, as well as the Health Plan's requirements, for filing claims.

For paper claims, the claims receipt date is when your claim reaches our mailroom. Claims received after 2 p.m. will be considered received the next business day. Please note that members cannot be billed for claims denied by BSWHP for missing the filing deadline.

Paper Claims Address:
Baylor Scott & White Health Plan
ATTN: Claims
P.O. BOX 211342
Eagan, MN 55121-1342

Claim Refund Address:
Baylor Scott & White Health Plan
ATTN: Claim Refunds
PO Box 840523
Dallas, TX 75284-0523

Electronic Claims

Faster responses mean everything in the healthcare industry, so let's reduce the time it takes to process your claims. By filing electronic claims, you can expect:

- Timelier payments
- Faster claim status responses
- Lower overhead costs
- More control over claim data accuracy
-

About Availity

Availity offers a secure web portal that is simple to use, integrating with software systems found in most physician's offices and hospitals around Texas. Availity also delivers information beyond what is available in standard HIPAA transactions.

- Medical software vendors may charge a fee for installation and maintenance of system enhancements that support claims transmissions. Check with Availity for information on any fees.
- You must use your National Provider identifier (NPI) number when submitting claims through Availity so proper provider identification can be made
- When submitting claims, use the Baylor Scott & White Health Plan Payer ID Number: 94999
- Both UB-04 and CMS 1500 claim forms are accepted electronically
- You are strongly advised by your clearinghouse to review your accepted/rejected reports from Availity daily to determine if any claims were rejected by BSWHP
- Patients' Member Identification Numbers must be complete (and include the two- digit suffix) for a claim to be accepted electronically

Providers who wish to utilize a clearinghouse other than Availity must inform the clearinghouse that BSWHP's payer ID (94999) is being used, and ensure the clearinghouse has the ability to submit claims to Availity.

Clean Claims

Baylor Scott & White Health Plan follows TDI clean claim requirements. Any claims not deemed to be a clean claim will be rejected. These are claims that we will accept without having to investigate or send back for more information:

Electronic Claims

Clean electronic and paper claims should have:

- Patient's full name
- Patient's date of birth
- Valid BSWHP member identification number (11-digit number)
- Complete service level information
    - Date of Service
    - Industry-standard diagnosis codes
    - CMS-defined industry-standard place of service codes
    - Industry-standard procedure codes (e.g., CPT, HCPCs)
    - Charge information and units
- Service provider's name, address, and National Provider Identification (NPI) Provider's federal tax identification number (TIN)
- Only one servicing provider per claim
- All claim forms must be typed; no handwritten information or corrections
- All required fields completed
-

Paper Claims

For paper claims, we use an imaging system for claims entry. Follow these guidelines to ensure your claim is processed accurately, and without delay or rejection.

DO NOT SEND:

- A fax or a copy of a filled-out form
- A claim that's been torn, taped, or crumpled
- A claim that's been stamped or handwritten on DO NOT USE:
- Correction fluid or tape
- Ink that is fading, and/or a color other than black
- Staples
- Highlighters

Claims that are rejected for any of the reasons listed above will be returned to you with a letter explaining the reason for the rejection. These non-clean claims are considered never received and must be corrected and resubmitted within the BSWHP claims filing deadline for reconsideration. We reimburse medically necessary surgical services and other procedures. For more information, see procedure-specific payment policies.

Corrected Claims

BSWHP has a process for submission of corrected claims:
If the original claim was denied for incorrect information, providers can submit a corrected claim. Claims submitted are considered NEW claims if they are not marked as a corrected claim. These claims are subject to new claims initial filing deadlines, which are 95 days from date of service for Commercial and 365 days for Medicare. If a provider submits a claim intended to be a corrected claim, and does not note it as such, the claim will be denied as a duplicate. A corrected claim is a replacement claim of a previously submitted claim that needs a change or correction to charges, clinical or procedural codes, dates of service, member information, etc. It is not an inquiry or redetermination.

A corrected claim must be submitted within 90 days from the date of determination on the initially filed clean claim for Commercial or 365 days from the date of determination on the initially filed clean claim for Medicare.
Corrected claim notation:

- 1500 - Box 19= CORRECTED CLAIM
- UB04 – Bill Type = xxx

Fill out and submit the claim form with the correct information. Mail your corrected claim form to:

Baylor Scott & White Health Plan
Attn: Claims Department
P.O. Box 211342
Eagan, MN 55121-1342

How to File a Redetermination

For contracted providers, if your claim was denied and you do not agree with the outcome, you must file a redetermination. A redetermination is a formal request submitted by the provider requesting for BSWHP to review a claim providing supporting documentation. A redetermination can be considered for the following reasons:

- Filing limits
- Claim check or code editing
- Contracted rate or payment policy
- Coordination of Benefits (COB)
- Data entry error
- Overpayment or underpayment

To file a redetermination, you must complete and submit a Provider Claim Redetermination Request Form to include the elements below:

- BSW Claim Number
- Member Name
- Member Insurance ID
- Member DOB
- Provider Name
- Provider TIN
- Provider NPI

- Provider Address
- Provide relevant documentation
- Submit the redetermination within 90 days from the payment by BSWHP

If there are multiple claims in question, provide an Excel spreadsheet that contains the additional information. Attach the spreadsheet to a copy of the request form. Mail your redetermination or request for adjustment to:

Baylor Scott & White Health Plan
ATTN: Claims Review Dept.
P.O. Box 211342
Eagan, MN 55121-1342

The provider redetermination time limit for receipt of redetermination request is calculated from the date of original denial or Explanation of Payment (EOP). Requests received after this period will be rejected. The Provider Claim Redetermination Request Form is processed within 30 days of receipt. A redetermination must be submitted to initiate a claim review for an original claim determination.

Hold Harmless

Provider agrees that in no event, including, but not limited to, non-payment by BSWHP or BSWHP's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any other recourse against any Covered Persons or persons acting on their behalf other than BSWHP for Covered Services provided under this Agreement. This provision shall not prohibit collection of Copayments or supplemental charges on BSWHP's behalf made in accordance with the terms of the applicable Plan. Provider further agrees that the terms of this Section shall: (1) survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Covered Persons; and (2) supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and Covered Persons or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this Section shall be effective on a date no earlier than fifteen (15) days after the Texas Commissioner of Insurance has received written notice of such proposed change. Provider shall cooperate with BSWHP to ensure that any payments received from Covered Persons by Provider in violation of this provision are reimbursed to the Covered Person. Repeated violation of this provision will result in the termination of this Agreement.

Code Editing Software (Claim Check)

In order to keep pace with ever-changing medical technology and coding complexities, Baylor Scott & White Heath Plan utilizes (Cotiviti) Claim Check, a code editing software program designed to evaluate billing and coding accuracy on submitted claims.

Claim Check uses clinically valid edits for automated claims-coding verification and to ensure that BSWHP is processing claims in compliance with general industry standards. The following list represents an example of the different edits and their definitions.

Rebundling edits

Unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists which more accurately describes the complete service performed by the provider. Procedure codes are re-bundled as a single procedure code and paid the correct reimbursement for that one code.

- **Mutually exclusive auditing**

  Identifies two or more procedures that are usually not performed during the same patient encounter on the same date of service and therefore not allowable for separate reimbursement.
- **Incidental procedure auditing**
  Identifies procedures that are performed at the same time as a more complex primary procedure and not allowable for separate reimbursement.
- **Medical Visits auditing**
  Adheres to the "Surgical Package Concept" and does not allow separate reporting of E&M services when a substantial diagnostic or therapeutic procedure is performed. CPT guidelines for E&M services support this medical visit auditing.
- **Pre-Operative and Post-Operative edits**
  Identifies E&M services that are reported with surgical procedures during the associated pre/post operative periods. The pre and post operative periods are designated in CMS's National Physician Fee Schedule. Claim check denies medical visits related to the procedure, within the timeframe, as an unbundled component of the total surgical package.
  - Minor Surgical procedures have a 0-day preoperative, and 0 or 10 day(s) postoperative, timeframe.
  - Major Surgical procedures have a 1-day preoperative, and 90 day(s) postoperative, timeframe.
- **Age/Sex conflicts**
  Identifies a discrepancy between the billed procedure codes that are inconsistent with the patient's age or gender.

- **Assistant surgeon edits**
  Determines if an assistant surgeon is clinically necessary for the billed procedure.
- **Cosmetic surgery edits**
  Identifies procedures that BSWHP considers to be cosmetic and suspends the claim for Medical review.
- **Duplicate edits**
  There are six duplicate categories:
  - Category I: Bilateral procedure can only be performed once on a single date of service
  - Category II: Unilateral/Bilateral procedure can be performed only once on a single date of service
  - Category III: Unilateral or Single procedure with a procedure whose description specifies bilateral with performance of the same procedure, the unilateral can only be performed once on a single date of service.
  - Category IV: Procedures allowed specified number of times per date of service, per lifetime or per site specific modifier
  - Category V: Procedures billed more than once on a single date of service and not addressed by Categories I, IV or VI are flagged for further review
  - Category VI: Procedures bypassed from Duplicate editing and may be performed an indefinite number of times on a single date of service.
- **New visit frequency edits**
  This edit prevents the inappropriate reporting of a new patient E&M service and is based on following CPT guideline:
  A new patient is one who has not received any professional services from the physician or another physician of the same specialty that belongs to the same group practice, within the past three years
- **Intensity of service edits**
  Reviews edits that identifies when the intensity of the E&M code submitted is higher than expected based on the accompanying diagnosis. The claim review replaces the submitted code with the most intensive code expected for the diagnosis.
- **Diagnosis to procedure edits**
  This edit encompasses all billed professional claims and occurs when the procedure billed is unexpected based on the diagnosis billed.
  Example: claim billed with diagnosis code of 424.0 (Mitral Valve Disorders) and procedure code 43500 (gastrotomy; with exploration or foreign body removal). This procedure would be identified as unexpected for the diagnosis and would deny.
- **Correct Coding Initiative (CCI)**
  The purpose of the CCI edits is to prevent improper payment when

incorrect code combinations are reported. CMS developed the edit tool for coding policies based on coding conventions defined in the AMA's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

- **Outpatient Code Editing (OCE)**
  These are targeted edits that help manage outpatient facility claims. OCE, a subset of the CCI, applies to outpatient facility and ambulatory surgical center (ASC) edits.
- **Multiple Component Billing (MCB)**
  Example 73550 x-ray exam of thigh. Global code billed by Provider A. Same date of service: 73550-26 professional component billed by Provider B. MCB edit will deny.
  NOTE: Depending on our settings for this edit, either the current or the history code would be denied. The claim processed first will get paid and the second will be recommended for denial. Duplicate Component Billing (DCB) Example 73550 x-ray exam of thigh. Global code billed by Provider A. Same date of service: 73550-26 professional component billed by Provider B.
  NOTE: Depending on our settings for this edit, either the current or the history code would be denied. The claim processed first will get paid and the second will be recommended for denial.
  All Claim Check edits are reflected in the Explanation Code on the appropriate service line of the Explanation of Payment (EOP) issued to the provider. Providers who disagree with an edit, must send a corrected claim with the appropriate modifier or request a review of the claim. A request for review/appeal will need appropriate documentation along with medical records which should be sent to the BSWHP claims department. The Medical Directors will review the documentation for appropriateness and send back a response to the provider with the determination.

Emergency Admissions and Direct Admissions

It is the responsibility of the admitting physician to contact BSWHP's Health Services Department within 24 hours or the next business day of any emergency or direct admission. **Failure of the physician to contact BSWHP will result in denial of payment or delay of payment for services rendered by the admitting physician and/or other providers involved in the case. Physicians and hospitals will not bill the members for services denied as a result of failure to contact BSWHP following an emergency or direct admission**.

Inpatient Admission and Length of Stay Authorization

BSWHP uses InterQual evidence-based criteria, as well as internal guidelines, peer literature review, or direct physician supervision for review of clinical information in determining if inpatient level of care will be authorized. At the time initial clinical and discharge plans are received and reviewed for level of care medical necessity, BSWHP will assign an expected length of stay. Additional days may be authorized based on clinical information supplied by the physician.

Please note that many denials during the prior authorization process are a result of incomplete, absent or inadequate medical information. BSWHP requires participating providers to provide specific and accurate clinical information to process a request for authorization properly. It is essential that the physician or physician's representative submitting the request have the information available at the time of prior authorization to avoid possible delay and/or denial of authorization request.

Concurrent Review of Inpatient Admissions

BSWHP will monitor the course of inpatient care services received by a member. The Utilization Management (UM) Nurse may conduct any of the following:

- Review of member's chart;
- Communicate with the member/guardian/parent;
- Discuss the case with the hospital UM staff;
- Speak directly to the admitting physician regarding the progress of the case;
- Identify discharge or alternative care needs; and
- Assist the facility, physician, and/or member with post-facility care arrangements, coverage information, benefit information, etc.

If, during the review, the UM Nurse determines, based on established guidelines, that the available documentation indicates the member can be transitioned to a lower level of care, the attending physician or the facility will be contacted to discuss the justification of any continued services and possible alternatives. The UM Nurse, in collaboration with the BSWHP Medical

Director, may reduce the authorized level of services and notify the attending Physician of same, and suggest appropriate alternatives to current services.

If the attending physician disagrees with BSWHP's determination regarding denial of continued services, he or she must request a further review by the BSWHP Medical Director. (Refer to: COMPLAINT AND MEDICAL APPEAL PROCEDURES section, "Appeals to Adverse Determinations").

Requesting Extensions to the Authorized Length of Stay

If, during hospitalization or other services, the attending physician believes the approval for reimbursement of hospitalization or other services should be extended beyond what has been authorized, he or she should submit a clinical update to the Health Services Department to request an extension of the length of stay or other services. Failure to obtain authorization for additional days of inpatient stay or other services will result in denial of payment for services.

The request for extension will be evaluated based on the clinical information provided. If the extension is denied by the Medical Director, the attending physician must pursue the next level of the appeals process (Refer to: COMPLAINT AND MEDICAL APPEAL PROCEDURES section, "Appeals to Adverse Determinations").

Availability of Criteria

Providers are notified that clinical criteria are available upon request. They are provided to all providers within 10 days of request. A copy of the most recent version of the requested clinical criteria will be faxed, emailed or mailed to the provider based upon their request. The clinical criteria are also available in the letter provided to both the Member and Provider.

Pharmacist Fraud, Waste & Abuse Training

All members of the pharmacy staff must complete the Fraud, Waste & Abuse Training. Training is available online. Only one FWA Training Attestation Form is required per pharmacy; it should be completed by the Head Pharmacist or Store Manager.

Provider Fraud, Waste & Abuse Training

Provider training is available online. If you have already completed your training requirements through another mechanism, complete and submit the FWA Training Attestation Form.

If you have any questions or need assistance with this process, please contact Compliance at HPCOMPLIANCE@BSWHealth.org or Customer Advocacy at 1.800.321.7947.

Reporting

Because healthcare fraud costs millions of dollars annually, Baylor Scott & White Health Plan proactively seeks opportunities to minimize fraudulent activity through education, timely identification of issues and ongoing monitoring efforts.

As part of an ongoing effort to improve the delivery and affordability of healthcare to our customers, Baylor Scott & White Health Plan conducts periodic analyses of all levels of Current Procedural Terminology (CPT), ICD-10 and HCPCS, codes billed by our providers. The analysis allows BSWHP to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. BSWHP will review your coding and may review medical records of providers who continue to show significant variance from their peers.

BSWHP strives to ensure compliance and enhance the quality of claims data, a benefit to both BSWHP's medical management efforts and our provider community. As a result, you will be contacted by BSWHP to provide medical records to conduct reviews to substantiate coding and billing.

To report waste, abuse or fraud, choose one of the following:

- Call the BSWHP Compliance HelpLine at 1.866.245.0815
- Direct reports to the health plan:
  Baylor Scott & White Health Plan
  Attn: Compliance Department
  1206 West Campus Drive
  Temple Texas 76502

- Texas Department of Insurance at 1.800.252.3439. You can download the Fraud Reporting Form located on the TDI website
    - Email to: FraudReport@tdi.texas.gov
    - Fax to 512.490.1001
    - Mail to:

      MC109-3A
      Fraud Unit
      Texas Department of Insurance
      PO Box 149336
      Austin, TX 78714-9336

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

Website and Online Portal

Managing Your Provider Account:

At Baylor Scott & White Health Plan, it is critical for us to provide accurate information to our members, participating providers and government agencies we work with. Anytime you have Demographic Changes or Contract Changes, we request that you notify us as soon as you have that information. Demographic changes or any other **requested changes will not be processed immediately** and usually require a minimum of thirty (30) days to go into effect.

We require you to request all changes via our website. Scroll down to the section titled **Account Management.** You can request changes listed below:

- **Address Changes or other Demographic Changes** including adding or terming locations
- **Add a New Provider to your existing Agreement**

  To add a new provider, use the link above. It is recommended that you check your Contract Agreement to verify that the provider's services are part of the Agreement. For example, if an Orthopedic office wants to add PT providers, verify that PT services are included in your agreement. If those services are not listed, you will be required to modify the Agreement to add those services and complete the form under Modify Your Existing Contract.
- **Term a Provider from your existing Agreement**
- **Modify Your Existing Contract**

  This includes requesting new services/billing codes be added to your existing Agreement, as well as other contractual changes, such as a Tax ID Change, add a product to your existing Agreement or Legal Name Change.
- **Update Medicaid/Medicare Number(s)**
- **Update Provider Name**

  This form is for updating Provider names only. In some cases, if the contract name is in the providers name, a modification will be required to be updated. This form is not for contract or Tax ID updates.

Baylor Scott & White Health Plan Policies

Policy Categories

Baylor Scott & White Health Plan (BSWHP) utilizes InterQual evidence-based criteria and internal medical policies for review and decision-making regarding hospitalization and treatment requests. Medical Policies can be found at BSWHealthPlan.com

Payment of Premiums for Individual Plans

Premiums for individual plans are personal expenses to be paid for directly by individual and family plan subscribers. In compliance with federal guidance, BSWHP will accept third-party payment for premium from the following entities:

- The Ryan White HIV/AIDS Program under title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations, or urban Indian organizations; and
- State and federal Government programs.

Except as provided above, third-party entities shall not pay BSWHP directly for any or all of a member's premium.

Referrals to Out-of-Network Providers

Referrals to out-of-network providers for medically necessary and covered health services will require prior authorization by BSWHP. Referrals should be submitted to BSWHP before services are rendered to allow BSWHP to determine medical necessity.

To Initiate an Out-of-Network Referral

- **Fax:** Download and complete the Prior Authorization form and cover sheet available at BSWHealthPlan.com Then fax form and all supporting clinical documentation to 800.626.3042
- **Online:** Log into the secure Provider Portal at BSWHealthPlan.com to complete and submit the Prior Authorization form
- **After-hours emergencies or weekend/holiday admissions:** Call the Health Services Department within 24 hours of admission at 888.316.7947.

Approval Requirements

Referrals to out-of-network providers are pre-authorized and covered by BSWHP when one or more of the following conditions are present:

- Life-threatening conditions exists and appropriate or timely;
- Access to an in-network facility or service is not reasonably practical or possible;
- Covered transplant is required and approved;
- Medically necessary, covered medical service is not available through an in-network Provider;
- Service or care is available in-network, but not accessible; and/or
- Service is available in-network, but there is a continuity of care concern for a new member (e.g. any high-risk pregnancy in the second trimester, a pregnancy in the third trimester or any other situation which, in the judgment of the Medical Director warrants an out-of-network authorization to complete a particularly complex episode of care).

Failure to obtain prior authorization for out-of-network referrals will result in denial of payment for services rendered. The provider is not not bill the member for services so denied.

Out-of-Network Services

BSWHP has developed contractual arrangements with a number of specialists, hospitals and centers of excellence throughout the State of Texas. Before recommending a specific specialist or facility to a member for care, the referring physician should consult with BSWHP Customer Service Department about providers available through the BSWHP network. To find

in-network physicians and providers, please visit the BSWHP 'Find a Provider' online search located at: BSWHealthPlan.com.

For coordination of care for members on an HMO plan, the referring physician should discuss with the out-of-network provider any lab or radiology studies expected to be performed prior to the member's visit and have those services performed by an in-network provider or facility before the visit to the out-of-network provider. Lab, X-ray and/or ancillary services performed by, or ordered by, an out-of-network provider not specifically authorized by BSWHP in advance will not be covered.

Note: PPO plans allow members to obtain services without having to use providers within the plans network. PCPs are not required to coordinate care and specialist care can be received without a referral. To find physicians and providers that participate in our PPO network please visit the BSWHP 'Find a Provider' online search located at: BSWHealthPlan.com.

When a covered transplant is required, members must have that procedure performed through a BSWHP-contracted transplant facility. Consult with the BSWHP Health Services Department on available centers and the process of evaluation necessary to make a valid referral for transplants.

Extending a Referral

There may be occasions when a treatment by a specialist or other provider may need to be extended beyond the initial referral. Extension requires prior authorization. Any follow-up care to the out-of-network provider must also be pre-authorized by BSWHP prior to care being rendered. Follow-up care is not included in the initial out-of-network prior authorization.

Transition of Care/Continuity of Care

There are situations that arise when BSWHP may need to approve services out of network. BSWHP may need to provide authorization for continuity in the care of a Member whose health condition has been treated by a specialty care Provider or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted. In these cases, BSWHP may provide authorization to a non-contracted Provider to provide the medically necessary services until the transition to a network Provider can be completed. For questions about Transition of Care/Continuity of care, please call Customer Services at 800.321.7947 or visit BSWHealthPlan.com.

Prior Authorization Program & Requirements (Medical Benefit)

Services Requiring Prior Authorization

BSWHP defines "prior authorization" as having received BSWHP's approval for a service to be delivered based on evaluation of medical necessity prior to the time the service is rendered.

Prior Authorization Requirements

We require that certain medical services, care, or treatments be pre-authorized before we pay for all related Covered Health Services. Prior authorization means that we review and confirm that proposed services, care or treatments are Medically Necessary. Providers are responsible to receive approval for any proposed services before rendering services. If you fail to get proper Prior Authorization, care or treatment will not be covered or will incur payment penalties. Please verify the service codes submitted in the prior authorization request align with the information you intend to use when filing claims.

BSWHP Health Services Department (HSD) does not accept retroactive authorization requests. If a service requires prior authorization and the authorization is not obtained prior to the service being rendered the claim for the service will be denied.

Baylor Scott & White Health Plan (BSWHP) will conduct an enhanced review to ensure appropriate guidelines are met. When service codes submitted do not align with the documentation provided, an approved authorization, or do not meet the criteria for the billed codes services will be denied. For example, if authorization is obtained for service code J9259, but service code J9264 is submitted on the claim and the authorization has not been updated to reflect J9259, the claim will be denied.

It is imperative to correct the discrepancy by contacting BSWHP HSD at 888.316.7947 prior to any claims submission. By proactively addressing any inconsistencies in the coding information, it will prevent unnecessary claim denials.

To view the list of services requiring prior authorization, please visit our website, access the provider portal, or contact Customer Services at 800.321.7947.

How to Obtain a Prior Authorization

Prior authorization requests for services and drugs obtained under the medical benefit (i.e., drug will be billed on a medical claim by a provider) are processed by BSWHP Health Services. Prior authorization requests must be submitted to Health Services via:

- **Fax:** Download and complete the Prior Authorization form and cover sheet available at BSWHealthPlan.com. Then fax form and all supporting clinical documentation to 800.626.3042
- **Online:** Log into the secure Provider Portal at BSWHealthPlan.com to complete and submit the Prior Authorization form
- **After-hours emergencies or weekend/holiday admissions:** Call the Health Services Department within 24 hours of admission at 888.316.7947.

BSWHP Health Services does not process prior authorization requests for drugs obtained under the pharmacy benefit (i.e., prescription drug benefit). The submission process and forms described above apply only to requests for medical

benefit coverage of services and drugs. For information regarding the prior authorization submission process for drugs obtained under the pharmacy benefit, visit BSWHealthPlan.com/Providers, and click on the "Pharmacy" tab.

Information Required for Authorization

- Member's name, date of birth, member ID number;
- Ordering provider's name, Group and Individual NPI and TIN;
- Servicing Provider's name, Group and Individual NPI and TIN;
- Expected date of service (if date changes, please notify BSWHP);
- Diagnosis (ICD-10);
- Procedure (CPT/HCPCS) code number;

Clinical information for determining coverage will include but is not limited to:

- Office and hospital records
- A history of the presenting problem
- Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other practitioners
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services
- Information regarding the local delivery system
- Patient characteristics and information
- Information from family members
- Expected length of stay;
- Anticipated discharge needs;
- Treatment plan; and
- Other information.

Admitting Physician Responsibilities

It is the admitting physician's responsibility to obtain authorization for services specified in this section and to provide the clinical and member information necessary to process authorization requests. Although any physician participating in an admission, either directly or through consultation, must supply prior authorization information, responsibility for this authorization falls to the admitting physician. Failure to obtain prior authorization for the specified services will result in denial of payment for services rendered. In such cases, providers will not bill members for denied services.

Routine, Urgent, and Emergent Care Services

Routine Care Services

Those covered health services a physician commonly performs within the scope of the physician's practice or license are considered routine care. Routine care services are to be performed in the same manner, in accordance with the same standards, and within the same time availability as offered by other physicians to private pay members. Services must be provided in compliance with generally accepted medical and behavioral health standards for the community in which services are rendered. Routine Care is to be scheduled within two (2) weeks of the member's request.

Urgent Care Services

Those medical conditions which are not an emergency but are severe or painful enough to cause a prudent layperson, possessing average knowledge of medicine and health, to believe that the condition requires medical treatment or evaluation within 24 hours to prevent serious deterioration of the member's condition or health is considered Urgent Care. Urgent Care is to be scheduled within 24 hours of request.

Emergency Care Services

Health Care provided in a hospital emergency facility or trauma center for evaluating and stabilizing the onset of a severe medical condition that could reasonably be expected to cause permanent and significant physical harm, or loss of life or limb, is considered Emergency Care.

BSWHP uses the following set of criteria to determine when a member has an emergency condition: a medical condition of recent or sudden onset and severity that would lead a prudent layperson possessing an average knowledge of medicine, to believe the condition, sickness, or injury was of such a nature that failure to obtain immediate medical attention could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily function;
- In the case of a pregnant woman, serious jeopardy to the health of the fetus;
- Serious dysfunction of any bodily organ or part; and/or
- Serious disfigurement.

BSWHP members should contact their Primary Care Provider (PCP) regarding a need for emergency care before receiving the care whenever possible and/or practical. The PCP shall determine the emergent nature of the situation and use professional discretion in directing the member to the most appropriate location to receive the service (i.e., the office, urgent care center, minor emergency room, or hospital ER or trauma center). When the PCP directs the

member to the nearest emergency facility, the PCP should notify BSWHP of the referral for the emergency care. Notification of emergency services should be made to the BSWHP Health Services Department within 24 hours or next business day of the member being directed to seek emergency care.

Should it not be reasonable to contact the PCP before obtaining emergency attention due to the serious nature of the illness or injury, BSWHP should be notified by the member or the PCP within 24 hours, or as soon as possible and/or practical following the treatment. Notification must be made by the PCP or their designee (e.g., emergency room staff, hospital admitting department, physician office personnel, member's family, or the member). Failure of the PCP to notify BSWHP of a member being directed to the hospital for emergency services will result in no authorization for services and will result in the member's medical services being denied or payment being significantly delayed.

BSWHP will cover the professional, facility and ancillary services that are medically necessary to perform the medical screening examination and stabilization of a member with an emergency condition. Emergency services claims will be processed according to BSWHP's standard claims adjudication process in accordance with state and federal regulations.

Any need for post-emergency stabilization, including admission to inpatient or observation status, must be authorized within the appropriate timeframe by the BSWHP Health Services Department.

Outpatient follow-up care resulting from an emergency facility visit or facility stay must be rendered by an in-network provider.

Ambulance Services

Medically necessary ambulance services do not require authorization when used for emergency transportation to the nearest hospital emergency room or trauma center. All non-emergent ambulance transfers require prior authorization.

To avoid denial in payment, prior authorization should be obtained before the transport occurs for ambulance transports between facilities.

*NOTE – All ambulance services should be billed according to the BSWHP contract.

Administrative Denials and Adverse Determinations

Administrative Denials

An “administrative denial” is a denial of requested services based on non-medical issues such as: non-covered services and benefit limits. Administrative denials are issued by the Health Services Department.

BSWHP will notify the member or a person acting on behalf of the member and requesting provider of an administrative denial made during the course of utilization review.

The notification of an administrative denial will include:

- Principal reason for the administrative denial;
- Description or the source of any screening criteria that were utilized as guidelines in making the administrative denial; and
- Description of the procedure for the complaint process, including notification of:
  - The member’s right to file a complaint related to a technical denial; and
  - The member’s right to contact the Texas Department of Insurance (TDI), including TDI’s toll-free telephone number and address.

Adverse Determinations – Denials Based on Lack of Medical Necessity

Anytime BSWHP is questioning the medical necessity or appropriateness of healthcare services, the healthcare provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the member and the clinical basis for the BSWHP Medical Director’s decision with a physician or dentist prior to the issuance of the adverse determination.

With the issuance of an adverse determination, the requesting/ordering provider will be given the opportunity to request a peer-to-peer review with a BSWHP Medical Director. The UM Nurse informs the requesting/ordering provider how to contact a BSWHP Medical Director or other appropriate reviewer to discuss a denial.

When the UM Nurse notifies the physician or office staff by telephone, the information communicated must include:

- The name of the contact and the practitioner/facility,
- The time and date of the denial notification, and
- Notification of the physician reviewer availability (normal business hours of 8:00 AM – 5:00 PM, Monday through Friday, for non-urgent peer-to-peer communication and 24/7 availability for urgent and post stabilization reconsiderations).

BSWHP will notify the member, or a person acting on behalf of the member, and the member’s provider of record of an adverse determination made during utilization review.

The notification of an adverse determination will include:

- Principal reason(s) for the adverse determination;
- Clinical basis for the adverse determination;
- Description or the source of the screening criteria that were utilized as guidelines in making the determination; and
- Description of the procedure for the appeal process, including:
- Notification to the member of the member's right to appeal, including provisions for filing an expedited (72 hour) appeal; (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you).
- Notification to the member of the procedures for appealing BSWHP will provide notification of the adverse determination:
  - Within one (1) working day by telephone or electronic transmission to the provider of record in the case of a patient who is hospitalized at the time of the adverse determination, along with a letter notifying the member advising of the right to appeal;
  - Within three (3) working days in writing to the provider of record and the member if the member is not hospitalized at the time of the adverse determination;
  - Within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member, but in no case to exceed one (1) hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such circumstances, notification shall be provided to the treating physician or healthcare provider.

The processes described above apply to requests for medical benefit coverage of services and drugs.

For information regarding prior authorization process for drugs obtained under the pharmacy benefit, visit BSWHealthPlan.com.

Medical Management Overview

The philosophy and goals of Baylor Scott & White Health Plan are to ensure that its members receive personalized, high-quality, cost-effective, comprehensive medical care within the specifications of the Member's covered benefits and in accordance with federal and state requirements. This healthcare should be consistently delivered by providers within the established Baylor Scott and White Health Hospital and Clinic system and/or through approved BSWHP-contracted providers.

The goals and objectives are designed, implemented and maintained by the BSWHP/BSWIC Health Services Division (HSD) to continually assess and improve the quality of care available to Members. The Health Services department includes:

- Board Certified Medical Directors
- Registered Nurses
- Licensed Vocational Nurses
- Case Managers
- Social Workers
- Care Navigators
- Intake Support Staff

Functions handled by HSD include:

- Prospective, concurrent and retrospective review of services proposed or rendered
- Coordination of care between levels of care
- Case Management/Complex Case Management
- Disease Management
- Wellness

Utilization Management Program

The goals and objectives of the UM Program are balanced to advance the management of medical services and are designed to support the delivery of services in a timely, appropriate and cost-efficient manner for BSWCP/BSWHP/BSWIC membership. BSWCP/BSWHP/BSWIC provides enrollees with a comprehensive healthcare delivery system within the specifications of the Member's covered benefits in accordance with federal and state requirements. The goals and objectives of the UM Program are designed, implemented and maintained by the BSWCP/BSWHP/BSWIC Health Services Department (HSD) to continually assess and improve the quality of care available to members and include:

- Use of standardized regulatory, nationally recognized and internally based criteria for decision-making.
- Coordination of care between levels of care.

- Identification and appropriate referral of potential quality/safety issues.
- Use of a service network of credentialed providers.
- Referral facilitation of case management (CM) for members with complex healthcare needs.
- Referral facilitation of disease management (DM) for members with chronic disease.
- Facilitation of access to appropriate medical and community resources.
  Prospective, concurrent, and retrospective review of services proposed or rendered to members.
- Use of data and information to identify areas of focus for management activities based on population and sub-population characteristics, provider behavior, benchmarks, and identified needs.
- Production of reports that analyze the utilization of resources and identify trends.
- Design of mechanisms to prevent or improve areas of over or under utilization.
- Audit of processes and decisions.
- Use of policies to interpret benefits and assess new technology.

Case Management Program

BSWHP provides a broad array of local Case Management services to support participating providers in managing complex medical cases. In addition, the Case Management program is designed to focus on providing the highest quality of care by assisting in coordinating the multiple resources needed for specific medical conditions. By using BSWHP's Case Management program, hospitals and physician/Providers can alleviate some of the burden of caring for complex cases. Participation is voluntary and there is no cost to our members.

Providers can take advantage of BSWHP's Case Management for cases such as:

- Catastrophic illness (all ages)
- Accidents (all ages; i.e., MVAs, burns)
- High risk pregnancy
- Premature infants
- Stroke, disability, and rehabilitation cases
- Organ transplants
- Transition of Care
- Care Coordination

To initiate BSWHP's Case Management program, please contact the Case Management department by calling 1.855.395.9652 or completing the Case Management referral form online at BSWHealthPlan.com

Disease Management Program

Disease management is a system of coordinated healthcare interventions and communications for populations with identified conditions in which member self-care efforts are significant. BSWHP focuses on managing disease conditions common to the population and demographics.

Conditions currently being managed include the following:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)

Behavioral Health Services

For members in need of behavioral health services, our conditional guidance program identifies and addresses psychosocial issues. As they demonstrate a readiness to change, we guide members to take the necessary steps to achieve goals and improve health. To refer a member to our Behavioral Health Case Management, please contact the department by calling for Medicare Advantage BSW SeniorCare Advantage Plans 866.334.3141 or Individual & Family (including employer-sponsored plans) 844.633.5325 or completing the Case Management Form and/or email the Behavioral Health at HPBHCaseManagement@BSWHealth.org. BSWHP defines "behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

Covered Services

For all covered behavioral health services, please refer to the member's benefit plan and/or call BSWHP's Customer Service department. BSWHP provides utilization management for all levels of care including inpatient hospital services in freestanding psychiatric facilities for children and adults.

Behavioral Health Scope of Services*:* BSWHP will coordinate the behavioral health services, which include, but are not limited to, the services listed in the Covered Services section. These services include acute, diversionary and outpatient services. BSWHP will work with other participating behavioral healthcare practitioners, primary care providers, medical/surgical specialists, organizational providers, and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health. These programs may include:

- Educational programs to promote prevention of substance use
- Parenting skills training
- Developmental screening for children
- ADHD screening
- Postpartum depression screening
- Depression screening in adults

Primary Care Providers

- May treat mental health and/or substance use disorders within the scope of their practice and bill using the appropriate ICD diagnosis code(s);
- Inform members how and where to obtain behavioral health services: and
- Understand that members may self-refer to any behavioral healthcare provider without a referral from the member's primary care provider.

BH Coordination of Care

Behavioral health service providers are expected to communicate at least quarterly— and more frequently, if necessary—regarding the care provided to each member with other behavioral health service providers and PCPs. Behavioral health service providers are required to refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment.

Copies of prior authorization/referral forms and other relevant communication between providers should be maintained in both providers' files for the member. Coordination of care is vital to ensuring members receive appropriate and timely care. Compliance with this coordination is reviewed closely during site visits for credentialing and re-credentialing, as well as during quality improvement and utilization management reviews.

Coordination between Physical and Behavioral Health

BSWHP is committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated, and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation or developmental disabilities.

BSWHP will designate a Case Manager to facilitate coordination of care and case management efforts.

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below, based on NCQA standards. All documentation must be clear and legible. Further, the treatment record should contain clear documentation using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications:

Member Identification Information. The treatment record contains the following member information

- Member name and health plan identification # on each page
- Member's address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

Informed Member Consent for Treatment. The treatment record contains signed consents for the following:

- Implementation of the proposed treatment plan
- Any prescribed medications
- Consent forms related to interagency communications
- For adolescents, ages 12-17, the treatment record contains consent to discuss substance use disorder issues with their parents.
- Signed document indicating review of member's rights and responsibilities

Medication Information. Treatment records contain medication logs clearly documenting the following:

- All medications prescribed

- Dosage of each medication
- Dates of initial prescriptions
- Information regarding allergies and adverse reactions are clearly noted
- Lack of known allergies and sensitivities to substances are clearly noted

Medical and Psychiatric History. Treatment record contains the member's medical and psychiatric history including:

- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous interventions
- Sources of clinical information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports

Substance Use Information. Documentation for any member 12 years and older of past and present use of the following:

- Cigarettes
- Alcohol, and illicit, prescribed and over-the-counter drugs

Adolescent Depression Information. Documentation any member age 13-18 years was screened for depression

- If yes, was a suicide assessment conducted?
- Was the family involved with treatment?

ADHD Information. Documentation members aged 6-12 years were assessed for ADHD

- Was family involved with treatment?
- Is there evidence of the member receiving psychopharmacological treatment?

Diagnostic Information.

Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures

- All relevant medical conditions are clearly documented, and updated as appropriate
- Member's presenting problems and the psychological and social conditions that affect his/her medical and psychiatric status

A complete mental status evaluation is included in the treatment record, which documents the member's:

- Affect
- Speech
- Mood
- Thought control, including memory
- Judgment

- Insight
- Attention/concentration
- Impulse control
- Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation and/or other relevant assessment information
- Diagnoses updated at least on a quarterly basis

Treatment Planning

The treatment record contains clear documentation of the following:

- Initial and updated treatment plans consistent with the member's diagnosis, goals, and progress
- Objective and measurable goals with clearly defined timeframes for achieving goals or resolving the identified problems
- Treatment interventions used and their consistency with stated treatment goals and objectives
- Member, family, and/or guardian's involvement in treatment planning, treatment plan meetings, and discharge planning
- Copy of Outpatient Review Form(s) submitted, if applicable

Treatment Documentation:

The treatment record contains clear documentation using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications and the following:

- Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives
- Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidally suicidality, or the inability to function on a day-to-day basis
- Referrals and/or member participation in preventive and self-help services (e.g., stress management)
- Relapse prevention (Alcoholics Anonymous, etc.) is included in the treatment record
- Member's response to medications and somatic therapies

Coordination and Continuity of Care

The treatment record contains clear documentation of the following:

- Documentation of communication and coordination among behavioral health providers, primary care physicians, ancillary providers, and healthcare facilities
- Dates of follow-up appointments, discharge plans and referrals to new providers

Additional Information for Outpatient Treatment Records

These elements are required for the outpatient medical record:

- Telephone intake/request for treatment

- Face-sheet
- Termination and/or transfer summary, if applicable
- The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information:
  - Clinician's Name
  - Professional Degree
  - Licensure
  - NPI
  - Clinician signatures with dates

Additional Information for Inpatient and Diversionary Levels of Care

These elements are required for inpatient medical records:

- Admission history and physical condition
- Admission evaluations
- Medication records
- Consultations
- Laboratory and X-ray reports
- Discharge summary and Discharge Review Form

Information for Children and Adolescents

A complete developmental history must include the following information:

- Physical, including immunizations
- Psychological
- Social
- Intellectual
- Academic
- Prenatal and perinatal events are noted

Utilization Management Reporting Requirements

BSWHP conducts focus studies to look at the quality of care. Examples of focus studies are diabetes care and treatment, and asthma care and treatment.

Utilization Management reports reviewed at the Provider Advisory Subcommittee and the QI Committee. Utilization reports include:

- Review of admissions and admission/1,000 Members (Medical and Behavioral Health)
- Review of bed days and bed days/1,000 Members (Medical and Behavioral Health)
- Average length of stay for inpatient admissions (Medical and Behavioral Health)
- ER utilization and health services utilization/1,000 Members
- Denials and appeals
- Other reports as needed to evaluate utilization of services by Membership

Procedures for follow-up on missed appointments

Providers must document attempts to conduct follow-up calls within 24 hours to all members who have missed appointments.

Member discharge from inpatient psychiatric facilities need to have follow-up within 7 days from the date of discharge.

BSWHP requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The follow-up/outpatient treatment must occur within seven days from the date of discharge. BSWHP providers will follow up with members and attempt to reschedule missed appointments.

Accessible Intervention and Treatment

BSWHP promotes early intervention and health screening for identification of behavioral health problems and member education. Providers are expected to screen, evaluate, and treat and/or refer (as medically appropriate) any behavioral health problem. Providers who need to refer members for further behavioral healthcare should contact BSWHP Health Services Department.

Member Access to Behavioral Health Services

Routine, Urgent, and Emergency Services

- **Routine Care:** Healthcare for covered preventive and medically necessary healthcare services that are non-emergent or non-urgent
- **Urgent Behavioral Health Situation:** A behavioral health condition that requires attention and assessment within 24 hours but that does not place the member in immediate danger to himself or others and the member is able to cooperate with treatment
- **Emergency Services:** Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition, including post-stabilization care services.

Accessibility Standards

Appointment Standards and After-Hours Accessibility

Providers must offer the following service appointment availability:

General Appointment Standards:

- Routine/Non-Urgent Services within 14 calendar days, sooner if required
- Emergency Services Immediately, 24 hours per day, 7 days per week

Aftercare Appointment Standards:

- Inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member's discharge.

Type of Appointment/Service Appointment must be offered:

- Non-24 hour diversionary within 2 calendar days
- Psychopharmacology services/ Medication Management within 14 calendar days
- All other outpatient services within 10 business days
- Crisis Intervention Services must be available 24 hours per day, 7 days per week
- Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours.
- After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician agency-affiliated staff, crisis team, or hospital emergency room

- Outpatient providers should have services available Monday through Friday, from 8 a.m. to 5 p.m., CST, at a minimum, evening and/or weekend hours should also be available at least 2 days per week.
- Interpreter Services under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

*NOTE – Providers are required to meet these standards, and to notify BSWHP if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day, informing the member and provider the waiting time access standard was not met.

Emergency Transportation

Emergency transportation by ambulance is reimbursable with limitation to basic life support (BLS) ambulance services provided to the member in two situations:

- Emergency
- Non-emergency for the severely disabled

Emergency transportation does not require authorization. Ambulance transports are covered for emergent transports and for transport from facility to facility. BSWHP staff will assist providers and members as needed to ensure appropriate transportation is available. Claims for ambulance transports should be submitted to the plan. BSWHP staff will assist providers and members as needed to ensure appropriate transportation is available.

Wellness Programs

Baylor Scott & White Health Plan's wellness program, BSW BeWell™, offers a variety of programming designed to meet the wellness needs of our population. Through a comprehensive suite of effective resources and tools, BSW BeWell provides a tailored experience built on the demands of our members. As we strive to continuously provide the right care in the right place at the right time, it is our mission to promote a healthy lifestyle and empower our members to become active participants in their healthcare team.

Wellness Assessment

BSWHP provides members with access to a National Committee on Quality Assurance (NCQA) certified online Personal Wellness Assessment as the initial step for identifying the needs of each member. Immediately upon completion, members are provided a summary of their responses and any identified potential risks in their personal health assessment. The personal health assessment also provides a plan of action on how members can utilize the online lifestyle management programs. Online lifestyle management programs are designed by healthcare professionals and are aimed at providing members with educational resources showing how and why to make healthier choices and personalized lifestyle changes.

Online Lifestyle Management Programs

BSWHP BeWell offers a variety of online lifestyle management programs to assist members with healthy choices.

BSW BeWell™ Coaching

The BSW BeWell™ Coaching program offers a meaningful, one-on-one experience tailored to fit members' needs and help them to achieve their personal best. As the member works with an accountability partner, they will build confidence, feel empowered and improve the overall quality of everyday life.

Each member is assigned a coach to guide them through the 16-week, curriculum-based program of their choice. Meetings are virtual. The program includes:

- One-on-one Coaching
- Accountability
- Helpful Resources
- Educational Videos

Current topics include nutrition management, stress management and tobacco cessation. BSW BeWell™ Coaching is offered to commercial group members at no additional cost.

The BSW Be Well™ with Diabetes program provides support for members to help improve their health, better manage their diabetes, and save them money. Members can enroll in this incentive-based wellness program by meeting American Diabetes Association (ADA) Standard of Care and attending 8 virtual visits with a health coach through the BSW Be Well™ Coaching program.

Members who apply and meet program requirements receive:

- $0 copays for diabetic medications and supplies annually
- a glucometer and glucose tracking app at no cost
- BSW Be Well™ Coaching visits

Additionally, a clinical pharmacist who is a Certified Diabetes Care and Education Specialist performs a medication review for every member of the program and is available to meet virtually with each member in addition to their coach.

The program is available for members of a large employer group, or their dependent, and are at least 18 years old with Type 2 diabetes.

Daily Habits

Daily Habits, available through WebMD, offers a personalized set of activities based on an individual's health information and personal interests, making it simple to stay engaged, make progress and accomplish well-being goals.

Instead of requiring individuals to complete a specific form of exercise (such as running, for example), Daily Habits asks if they completed cardio and strength training exercise in a manner that is appropriate for their interests and skill level. To achieve their goal, individuals have the freedom to choose from a variety of activities and complete them in a way that suits their lifestyle. This open-ended, holistic approach to behavior change involves self-directed planning, action-based education and targeted user feedback.

Topics include exercise, balanced diet, stress management, weight loss, tobacco, sleep and more.

Pharmacy Benefit Information

BSWHP Pharmacy Services

To access information regarding BSWHP Pharmacy benefit, visit BSWHealthPlan.com/Providers and click on the "Pharmacy" tab.

Pharmacy search and directories

With our online search tool you can help your patients find a convenient, in-network pharmacy. Medicare pharmacy directories are also available.

Prescription drug formularies

BSWHP formularies list drugs covered under the pharmacy benefit. The formularies also include coverage restrictions such as step therapy, prior authorization, or quantity limits. Formularies can differ based upon plan type, so refer to the formulary applicable to the member's plan.

Upcoming Prescription Drug List Changes

Monthly BSWHP Commercial formulary updates from the BSWHP P&T Committee are posted on this page.

Request an Addition to the BSWHP Commercial Drug List

Request a drug be considered for formulary addition to the BSWHP Commercial formularies by completing the Formulary Addition Request Form.

Pharmacy Benefit Drug — Prior Authorization & Exception Requests

Find detail regarding the prior authorization and exception request process for medications obtained through the pharmacy benefit.

Overview of Quality Improvement (QI) Program

Introduction

Baylor Scott & White Quality Improvement program is a comprehensive system designed to assess and continually improve the processes and outcomes of care and services provided to members and providers. The program identifies opportunities for improvement, develops interventions and measures to improve processes of care and services, evaluates results of interventions, and identifies additional opportunities to improve care and services for internal and external customers, (i.e., members, providers, practitioners, regional partners). The scope of this program is broad and includes the monitoring of administrative processes, quality of care, quality of service, and utilization of services for corporate and regional operations.

All contracted providers are required to cooperate with the Utilization Management and Quality Improvement programs. This includes providing clinical data related to prior authorization requirements, cooperation with focused study data collection and medical record review requests, re-credentialing requirements, cooperation with complaint resolution, and verification required by federal and state regulations. The organization may use performance data in conducting quality improvement activities.

A covered entity must maintain reasonable and appropriate administrative, technical and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use of disclosure. For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or passcode, and limiting access to keys or passcodes.

Scope and Purpose

The scope of quality improvement activities includes quality improvement-related regulatory compliance and performance on measures of member wellbeing, care quality and member experience. Monitoring measures and activities allows identification of areas of risk and opportunities for improvement so that corrective action and performance improvement can be initiated in a timely manner. Areas within the program scope include:

- Network Adequacy
- Coordination with Behavioral Healthcare
- Clinical Practice Guidelines
- Complaints and Appeals
- Delegation Oversight

- Credentialing
- Pharmacy Services
- Performance Improvement Projects (PIPs)
- Chronic Care Improvement Program (CCIP)
- CAHPS and QHP Enrollee Satisfaction Survey Data Collection and Reporting
- Potential Quality of Care Concerns/Issues
- Availability and Accessibility of Care
- Claims Payment Processes
- Care Management and Disease Management
- Customer Service
- HEDIS® Data Collection and Reporting
- Provider Satisfaction Survey Reporting
- Provider and Member Involvement and Education
- SNP Model of Care

QI Program Goals and Objectives

1. Establish QI as an entity-wide function by enlisting participation, input, and investment by providers, members and stakeholders throughout the entity to accomplish QI initiatives.
2. Promote patient safety through identifying and responding to high-risk patient safety areas such as potential quality of care issues, sentinel events, potentially preventable admissions and readmissions, and adverse pharmaceutical utilization patterns.
3. Promote member wellness preventive care and population health.
4. Promote high-quality, effective and comprehensive healthcare of chronic conditions.
5. Align activities to comply with federal and state guidelines as well as NCQA accreditation standards.

National Committee for Quality Assurance (NCQA) Accreditation

NCQA Accreditation is a comprehensive evaluation of health plans' clinical measures and consumer experience measures. Standards are developed with the help of health plans, providers, insurance customers, unions, regulatory agencies and consumer groups. NCQA's Health Plan Accreditation is considered the industry's gold standard. NCQA Accreditation measures five areas of performance: Staying Healthy, Getting Better, Living with Illness, Access and Service, and Qualified Providers. To see how BSWHP Providers measured up, click below:

http://www.ncqa.org/report-cards/health-plans

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a registered trademark of NCQA. BSWHP uses HEDIS to measure clinical quality performance and evaluate areas of care: preventive services, treatment of acute illness, management of chronic illnesses, and patient experience with services provided (as measured through the CAHPS, a standardized survey used by all plans).

Clinical Practice Guidelines

The Quality Improvement Sub-Committee (QIS) adopts clinical practice guidelines every two years. These guidelines are generally obtained from professional organizations with expertise in the area but may be developed internally by designated board-certified specialists. The practice guidelines assist providers in standardizing evidence-based care in areas related to preventative screening/care, care of chronic medical conditions, behavioral health and medication management.

The clinical practice guidelines are continually updated throughout the year and providers can access the most recent guidelines at BSWHealthPlan.com.

Providers will also contact their Provider Relations Representative to obtain a copy of the practice guidelines.

The current approved clinical practice guidelines are provided below. QI encourages providers to review these guidelines and associated recommendations.

- Attention-Deficit/Hyperactivity Disorder (ADHD) Guideline
- Depression Screening and Follow-Up Guideline
- Asthma Guideline
- COPD Assessment Management and Use of Spirometry Guideline
- Hypertension Management Guidelines

Keeping Pace with Innovation

Every year brings new findings and research breakthroughs. Our Technology Assessment Committee (TAC) reviews new, replacement, and currently non-covered medical and behavioral procedures, devices, tests, and treatments for consideration of coverage. We evaluate all on the basis of efficacy, safety, and cost-effectiveness. New pharmaceuticals and biologicals are reviewed by our Pharmacy and Therapeutics Committee (PTC).

Coverage determinations apply to all BSWHP facilities and providers. New advancements not approved by the TAC and PTC are considered to be experimental and investigational, and not covered benefits. Download our Technology Assessment Program guide.

Technology Assessment Program Forms

- BSWHP Systems Providers Technical Assessment Form
- BSWHP Systems Providers Technical Assessment Form (Excel version)

Appointment Availability Requirements

To ensure members receive care in a timely manner, Primary Care Providers (PCPs), specialty care providers , and behavioral health providers must maintain the following appointment availability standards.

Appointment Availability Standards

Level of Service/Appointment Type	Standard
Newborn	
Newborn Care (less than six months of age)	14 calendar days
Primary	
Urgent Primary Care	24 Hours
Routine Primary Care	Commercial and Medicaid:14 business days Medicare: 30 calendar days
Specialty	
Urgent Specialty Care	24 Hours
Routine Specialty Care	Commercial and Medicaid: 21 business days Medicare: 30 calendar days
OB/GYN	
High-Risk Prenatal Care New Member of 3rd Trimester Care	5 calendar days or immediately if an emergency exists
Routine Prenatal Care	14 calendar days
Preventive Care	
Preventive Care Child (6 months of age through 20 years of age)	60 calendar days
Preventive Care Adult (21 years of age and older)	Commercial and Medicaid: 90 calendar days Medicare: 30 days
Behavioral Health	
Care for a Non-Life-Threatening Emergency	Within 6 Hours or Directs Member to the ED or Behavioral Health Crisis Unit
Urgent Behavioral Health Care	24 hours
Initial Behavioral Health Care	Within 10 business days
Routine Follow-up Behavioral Health Care	14 calendar days

Baylor Scott & White Health Plan

Update your clinic contact information at:
BSWHealthPlan.com/Provider

If you have questions, contact your Provider Relations representative.

After-hours Accessibility Requirements for Practitioners

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for member contact after normal business hours.

ACCEPTABLE

Phone answered by an answering service	The person who answers the phone can contact the PCP, and all calls must be returned within 30 minutes. *Note: An answering machine recording that directs members to leave a message, even if it is indicated that the call will be returned, would not be an appropriate example of an answering service.*
Phone answered by a recording	Recording directs member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the call at the second number (e.g., the recording directs the member to dial 123-456-7890 to reach the PCP after-hours).
Phone transferred to another location (e.g. nearest emergency room, after-hours answering service)	The person answering the call must be able to contact the PCP to return the call within 30 minutes.
After-hours message available in English and Spanish	To accommodate non-English speaking members, after-hours messaging must be provided in both English and Spanish or provide options such as 1 for English and 2 for Spanish.

NOT ACCEPTABLE

Answering only during office hours	Examples: Calls not picked up by an answering machine recording that directs the member in reaching the PCP, calls not answered by or transferred to an after-hours answering service, calls not transferred to another location.
Recording telling member to leave a message	The answering machine recording should not direct the member to leave a message even if it is indicated that the call will be returned. However, the recording can direct the member to call another number to reach their PCP. Someone must be available to answer the phone at the second number.
Other unacceptable practices	○ Recording directing the member to go to the emergency room for needed services. ○ Returning after-hours calls outside of a 30-minute time frame. ○ Failing to provide after-hours messaging in both English and Spanish

*Standards for after-hours accessibility may be applicable to PCPs in the following areas: General Practice; Family Practice; Internal Medicine; Pediatrics. APRNs & PAs (where the APRN or PA is working under the supervision of a physician specializing in one of the above areas who also qualifies as a PCP).

*Standards are applicable to Commercial/Exchange, Medicaid & Medicare.

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Glossary/Definition of Terms

“Affiliate” means, as to any Person, any other Person controlling, controlled by or under common control with such Person. For the purposes of this definition, “controlling,” “controlled” and “control” means the possession, directly or indirectly, of the power to direct the management and policies of a Person, whether through the ownership of voting securities, member control, board control, by Contract or otherwise.

"Agreement" means a contract, along with all amendments, attachments, addenda, and exhibits attached hereto.

“Appeal” means a formal request for the Plan to reconsider an adverse (denial) organization determination or coverage determination on service/drug requested or received.

“Authorization” means a decision by your health insurer or plan that a health-care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested is medically necessary. This decision or approval is also known as prior authorization, prior approval, or pre-certification.

"Benefit Determination" means a statement from BSWHP or a Payor that a proposed medical care or health care service is a Covered Service under the Covered Person’s benefit plan. A Benefit Determination is not a Statutory Verification.

"Clean Claim" means, with regard to:

A. A non-electronic claim, a claim that is submitted on a current CMS claim form and accurately contains all the following information: patient name; patient’s date of birth; Covered Person’s identification number; Provider’s name, address and tax identification number; date(s) and place of service or purchase; diagnosis narrative and ICD-10 code; procedure narrative and CPT-4 code that is also not rejected by standard coding edits, which includes any appropriate modifiers; services and supplies provided; Provider’s National Identification Number; Provider’s charges.

B. An electronic claim, a claim that complies with applicable federal laws (e.g., Health Insurance Portability and Accountability Act) applicable to electronic claims, subject to applicable implementation guides, companion guides, and trading partner agreements.

"Claims Payment Period" means 45 days from receipt of a Clean Claim for non-electronic claims, and 30 days from receipt of a Clean Claim for electronic claims.

“Complaint” means any written expression of dissatisfaction with any aspect of the Health Plan's operation, including, but not limited to, dissatisfaction with:

- Plan administration;
- Procedures related to review or appeal of an adverse determination;
- The denial, reduction or termination of a service for reasons not related to medical necessity;
- The way a service is provided; or
- Disenrollment decisions expressed by a Complainant. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information. The term does not include dissatisfaction or disagreement with an adverse determination

“Confirmation of Eligibility" means a statement from BSWHP or a Payor in response to an inquiry from Provider that a patient is shown to be currently eligible for benefits under a benefit plan. A Confirmation of Eligibility is not a Statutory Verification. Any services provided based on a Confirmation of Eligibility is subject to regulatory required grace periods, and any payments for such services are subject to recoupment if the Covered Member is later to be determined to have been ineligible for benefits under the plan.

"Copayment" means that portion, if any, of the cost of the Covered Services that a Covered Person is obligated to pay under a particular benefit plan, including any deductible or coinsurance.

"Covered Person" means a person who is eligible to receive Covered Services under a benefit plan included in this agreement.

"Covered Services" means Medically Necessary health care services and supplies that are available to Covered Persons pursuant to a benefit plan included in this agreement, except Excluded Services.

"Declination" means BSWHP's or a Payor's response to a request for Statutory Verification in which a Statutory Verification is not issued. A Declination is not a determination that a Clean Claim resulting from the proposed service will not ultimately be paid.

"Eligibility Statement" means a statement from BSWHP in response to a request for an Eligibility Statement from Provider as to a patient's identification and eligibility, benefits and Copayment requirements under a Health Plan. An

Eligibility Statement is not a Statutory Verification.

"Emergency" means a medical condition of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate medical care could result in (1) serious impairment to bodily functions, (2) serious dysfunction of any body organ or body part, (3) placing a Covered Person's health in serious jeopardy, (4) serious disfigurement, (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus, or (6) an Emergency Behavioral Health Condition. Accordingly, "Emergency Care" or "Emergency Services" means the healthcare services provided in a hospital emergency facility or comparable facility to evaluate and stabilize the Emergency.

"Emergency Behavioral Health Condition" means any condition, without regard to the nature or cause of the condition, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person’s condition requires immediate intervention and/or medical attention without which an individual would present an immediate danger to himself/herself or others or which renders the individual incapable of controlling, knowing or understanding the consequences of his/her actions.

"Excluded Services" means health care services and supplies which are determined to not be Medically Necessary, which otherwise are not Covered Services under the applicable Plan, or are health care services and supplies specifically excluded under the applicable Plan.

“Facility-based Physician” means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist: (A) to whom the facility has granted clinical privileges; and (B) who provides services to patients of the facility under those clinical privileges.

"Group" means a professional association, nonprofit corporation, professional limited liability company, individual practice association, accountable care organizations, or other public or private entity, that is qualified to provide or arrange for the provision of professional health care services and/or medical products to Covered Persons.

"Health Plan" or "Plan" means a contract with, or evidence of coverage issued by, BSWHP or a Payor to a federal or State instrumentality, employer, group, or individual under which payment for health care services is provided, or an agreement or contract issued to an employer or group on a self-funded basis that is administered by BSWHP.

"Medically Necessary" means those health care services, which in the opinion of Covered Person's healthcare provider, whose opinions are subject to the review, approval or disapproval, and other applicable actions of a BSWHP medical director or the Quality Assurance Committee in their appointed duties, are:

(1) essential to preserve the health of Covered Person; and

(2) consistent with the symptoms or diagnosis and Treatment of the Covered Person's condition, disease, ailment or injury; and

(3) appropriate with regard to standards of good medical practice within the surrounding community; and

(4) not solely for the convenience of the Covered Person, Covered Person's physician, hospital, or other health care provider; and

(5) the most appropriate supply or level of service which can be safely provided to the Covered Person

"Participating Facility" or "Facility" means a hospital or other health care facility who or which (1) has entered into a written agreement to provide Covered Services to Covered Persons, (2) is duly licensed under applicable State law, and (3) is currently credentialed and designated by BSWHP or its designee as a Participating Provider.

"Participating Provider" means an individual physician, provider or other professional, who or which (1) has entered into a written agreement to provide Covered Services to Covered Persons, (2) is duly licensed under applicable State law, and (3) is currently credentialed and designated by BSWHP or its designee as a Participating Provider

"Payor" includes BSWHP, any BSWHP wholly owned subsidiaries, the federal government, or the State of Texas, that provides, administers, funds, insures, or is responsible for paying Participating Providers or BSWHP for Covered Services rendered to Covered Persons under a benefit plan included in this Agreement.

“Person” means any natural person and any corporation, partnership, limited liability company, other legal entity or Governmental Authority.

"Policies" mean the policies and procedures of BSWHP as set forth in its Provider Manual, as it may be amended from time to time, which are incorporated as though fully set forth herein. To the extent that a term in the Provider Manual conflicts with a term in this Agreement, this Agreement shall control. You can view the Medical Policies at the following link: Medical Resources for Providers | Baylor Scott & White Health Plan

"Primary Care Physician" or "PCP" means a Participating Provider who holds an unrestricted license to practice medicine (allopathic or osteopathic) in the State of Texas, and who is responsible for coordinating and managing the delivery of

Covered Services to Covered Persons who have selected or been assigned to such physician.

"Prior Authorization" means the approval by BSWHP or other permitted person or entity, prior to admitting a Covered Person to a hospital, or prior to providing certain other Covered Services to a Covered Person, which approval may be required pursuant to BSWHP's Utilization Management Program. A Prior Authorization is not a Statutory Verification.

"Quality Assurance Program" means the functions including, but not limited to, credentialing and certification of providers, review and audit of medical and other records, outcome rate reviews, peer review, and provider appeals and grievance procedures performed or required by BSWHP, a Payor, or any other permitted person or entity, to review the quality of Covered Services rendered to Covered Persons.

“Quality Improvement Program” means BSWHP’s program to implement corrective actions based on the assessment of results aimed at addressing identified deficiencies and improving outcomes.

“Redetermination” means a formal request submitted by the provider requesting for BSWHP to review a claim providing supporting documentation.

"Referral" means, when required under a Health Plan, the written approval from the Covered Person's Primary Care Physician (usually for a specified number of visits, treatments, or period of time) for a Covered Person to receive Covered Services from a physician (usually a Specialist) or other health care professional, organization, or facility.

"Specialist" means a physician or dentist who (1) is a Participating Provider; (2) holds an unrestricted license to practice allopathic or osteopathic medicine, or dentistry, in the State of Texas; (3) is engaged in a specialty medical practice; (4) accepts referrals from Primary Care Physicians for the purpose of providing Covered Services to Covered Persons within that specialty; and (5) is not a specialty care physician who meets the criteria of a "Primary Care Physician" as defined above.

"Statutory Verification" means BSWHP’s guarantee of payment pursuant to the Texas Insurance Code that provides that proposed medical care or health care services will be paid for if such service is rendered within 30 days to the Covered Person for whom the services are proposed and the Provider’s request is in compliance with Texas Department of Insurance Requirements. Statutory Verification is only available for Plans regulated by the Texas Department of Insurance. Statutory Verification is not available for Medicare replacement plans or ERISA self-insured plans. See also [Claims and Billing | Baylor Scott & White Health Plan]

"Urgent Care" means services provided for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties other than those of sudden onset and persistent severity. An individual patient's urgent condition may be determined to be emergent upon evaluation by a Participating Provider.

"Utilization Management Program" means those functions, including, but not limited to, Prior Authorization, Referral, and prospective, concurrent, and retrospective review, performed or required by BSWHP, a Payor, or any other delegated person or entity, for the purpose of reviewing and determining whether medical services or supplies which have been or will be provided to Covered Persons are covered under a Health Plan and are Medically Necessary.