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MANAGEMENT
Practice Management, Medical Billing & Consulting
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Excellus BC-BS-Federal Requirements Effective January 1, 2022

September 17, 2021

The mandate applies to Commercial, Essential Plan and Federal Employee Program lines of business.

Provider Directories

⇒ Excellus BCBS must maintain a provider directory available to members and other consumers online that lists in-network providers and facilities along with standard provider information, including the name address, specialty, phone number and digital contact information for the provider or facility.

⇒ All providers and facilities must confirm their directory information at least every 90 days. Under the regulation, providers and facilities who do not meet this requirement will be removed from the directory.

⇒ If a member provides documentation that they received incorrect information about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount. The cost of the visit will apply toward any applicable deductible or out of pocket maximum the member may have.

⇒ The Excellus website and each Explanation of Benefits (EOB) will contain a disclosure of the balance billing prohibitions required by law and information on state and federal contacts if the member believes there has been a violation

Advance EOB (AEOB)

⇒ Excellus BCBS must provide an AEOB for scheduled services in advance to give patients transparency into which providers are expected to provide treatment, their network status, a good faith cost estimate, member cost-sharing and progress toward meeting any applicable deductible or out-of-pocket maximum. The AEOB will also share whether a service requires medical management by the health plan and share disclaimers about the cost estimates.

⇒ When a provider notifies Excellus BCBS of the scheduled service, the AEOB will be triggered and sent to the member.

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Patient Protections through Transparency

⇒ Providers and facilities must verify, three days in advance of service, and not later than one day after scheduling of service, their patient's health insurance coverage.

⇒ Providers and facilities must provide a good faith estimate to the payer (if the patient is enrolled in a plan or insurance coverage and intends to use such coverage) or patient.