New to Blue Advantage

For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly.

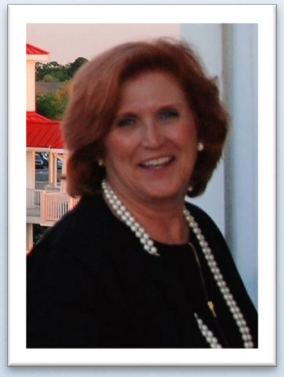
- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform only.

How to submit questions:

- Open the Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

August 2022

New to Blue Advantage



Presented by: Anna Granen
provider.relations@bcbsla.com

Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO). Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

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Our Mission

To improve the health and lives of Louisianians.

Our Core Strategies

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

To serve Louisianians as the statewide leader in offering access to affordable health care by improving quality, value and customer experience.

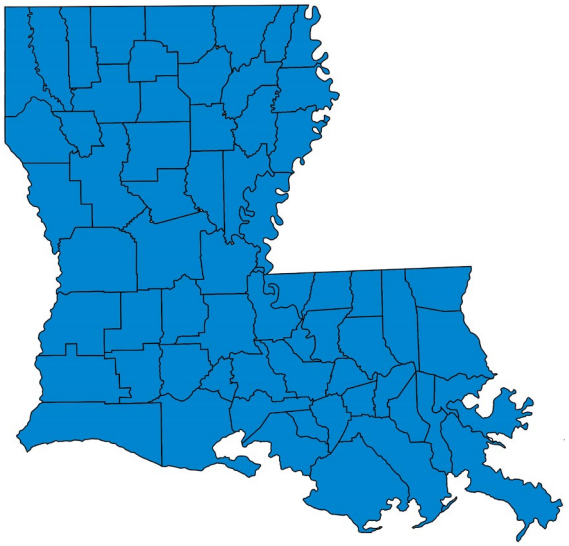
Welcome to the Blue Advantage Network!

- Thank you for participating in our Blue Advantage (HMO) and Blue Advantage (PPO) provider networks.
- As a participating provider, you play an important role in the delivery of health care services to Blue Advantage plan members.
- You have our commitment to work collaboratively with you to provider members access to excellent care and coverage.

Welcome to the Blue Advantage Network

Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

Blue Advantage is our Medicare Advantage product currently available to Medicare-eligible persons statewide.



Who are we?

- Blue Advantage provides HMO and PPO networks to our Blue Advantage members.

- Partners with Blue Cross and Blue Shield of Louisiana to provide Customer Service, Utilization Management, Claims expertise & Quality improvement support to our Blue Advantage HMO and PPO members.

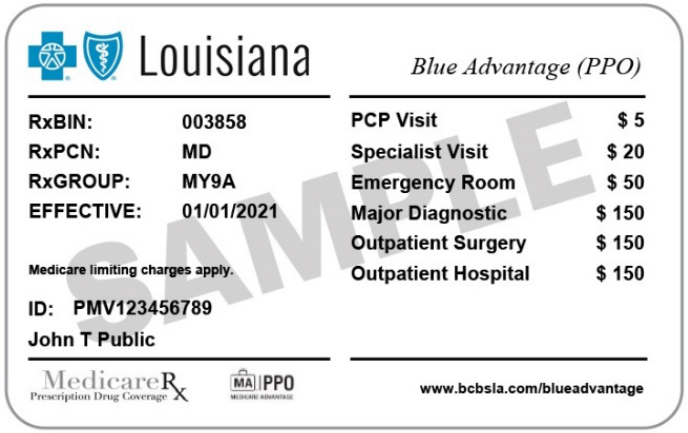
- Offers support for Population Health visits as well as additional quality programs such as the Blue Advantage Coupon program and HEDIS/Star ratings improvement for Blue Advantage members.

Member ID Cards

Blue Advantage provides each member with an ID card containing the following:

- Name of the covered member
- Copayment or coinsurance responsibilities
- Important phone numbers

The member ID card is used for all types of coverage such as Medicare Part A, Part B and Part D (pharmacy).



PMV prefix

MDV prefix

Blue Advantage Customer Service

For inquiries that cannot be addressed through the Blue Advantage Provider Portal, providers may contact customer service at:

1-866-508-7145

Customer Services prompts have been updated, please listen carefully to the new options when calling in. Blue Advantage Customer Services is available from 8 a.m. to 8 p.m., seven days a week from October – March and 8 a.m. to 8 p.m., Monday – Friday from April – September.

1-877-528-5820

customerservice@blueadvantage.bcbsla.com

Blue Cross and Blue Shield of Louisiana/HMO
Louisiana, Inc.
130 DeSiard St, Ste 322
Monroe, LA 71201

Providers may also contact customer service on the patient's behalf and request a representative call the member to assist with their questions.

Primary Care Roles

Role of Primary Care Provider (PCP)

The PCP should be involved in the overall care of the member.

- Oversee, coordinate, discuss and direct the member's care with the member's care team, specialists and hospital staff.
- Develop and grow the provider-member relationship while being proactive and cost effective.
- Responsible for coordinating members' medically necessary services.

- When a member changes PCPs, upon request, the prior PCP has 10 business days of request to submit records to new PCP.

Blue Advantage does not require a referral from the PCP for the member to obtain services from a specialist or another primary care provider.

Appointment Scheduling & Waiting Time Guidelines for PCPs

Blue Advantage network PCPs should make their best effort to adhere to the following standards for appointment scheduling and waiting time.

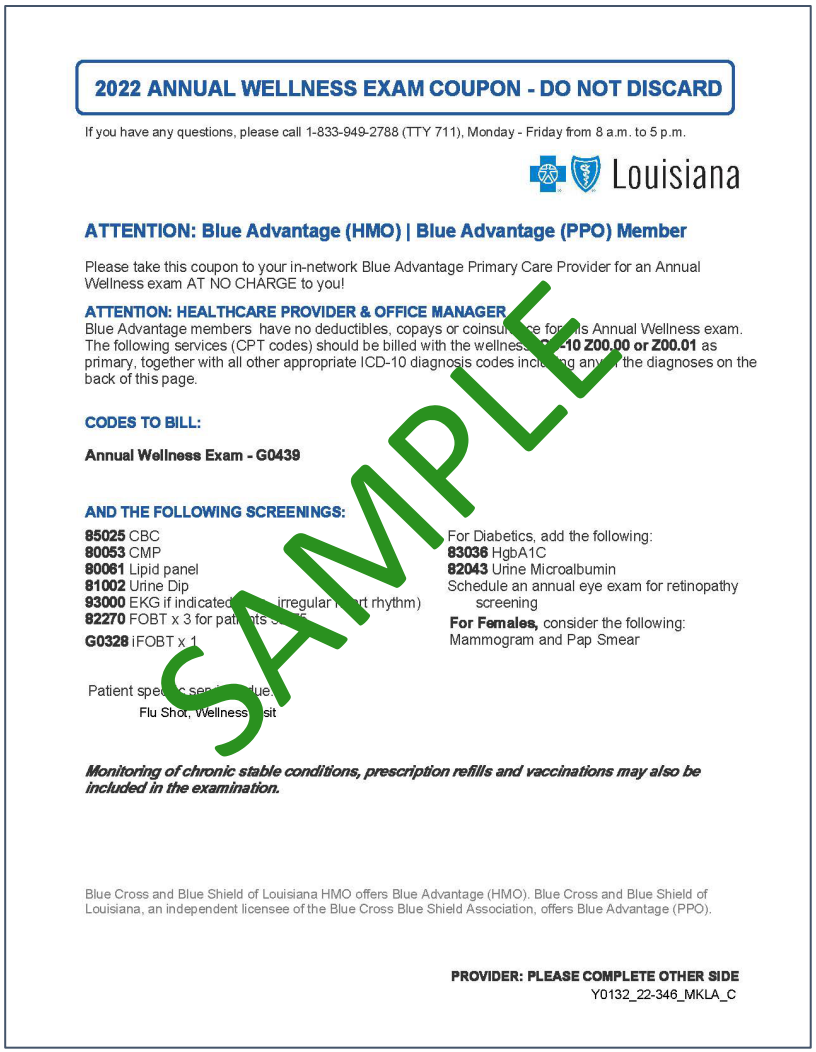
PCP-New Patient	Within 30 days of the patient's effective date on the PCP's panel – to be initiated by the PCP's office.
Routine Care without symptoms	Within 30 days.
Non-routine Care with symptoms	Within five business days or one week.
Urgent Care	Within 24 hours.
Emergency	Must be available immediately 24 hours per day, seven days per week via direct access or coverage arrangements.
OB/GYN	First and second trimester within one week. Third trimester within three days. OB emergency care must be available 24 hours per day, seven days per week.
Phone calls into the provider office from the member	Same day; no later than next business day.

Blue Advantage Annual Wellness Coupon Program

- Blue Advantage members will receive a paper coupon in the mail as part of our Annual Wellness Coupon Program.
- The coupons are for the patient's annual wellness exam, which should be provided by a primary care provider.

- The current coupon program is limited to only Blue Advantage members.

Annual Wellness Coupon



2022 ANNUAL WELLNESS EXAM COUPON - DO NOT DISCARD

If you have any questions, please call 1-833-949-2788 (TTY 711), Monday - Friday from 8 a.m. to 5 p.m.

Louisiana

ATTENTION: Blue Advantage (HMO) | Blue Advantage (PPO) Member

Please take this coupon to your in-network Blue Advantage Primary Care Provider for an Annual Wellness exam AT NO CHARGE to you!

ATTENTION: HEALTHCARE PROVIDER & OFFICE MANAGER
Blue Advantage members have no deductibles, copays or coinsu[illegible]ce for this Annual Wellness exam. The following services (CPT codes) should be billed with the wellness [illegible]-10 **Z00.00 or Z00.01** as primary, together with all other appropriate ICD-10 diagnosis codes incl[illegible]ng any of the diagnoses on the back of this page.

CODES TO BILL:

Annual Wellness Exam - G0439

AND THE FOLLOWING SCREENINGS:

85025 CBC
80053 CMP
80061 Lipid panel
81002 Urine Dip
93000 EKG if indicated [illegible] irregular [illegible]rt rhythm)
82270 FOBT x 3 for pati[illegible]
G0328 iFOBT x 1

For Diabetics, add the following:
83036 HgbA1C
82043 Urine Microalbumin
Schedule an annual eye exam for retinopathy screening

For Females, consider the following:
Mammogram and Pap Smear

Patient spec[illegible]c ser[illegible]due
Flu Shot, Wellness [illegible]sit

Monitoring of chronic stable conditions, prescription refills and vaccinations may also be included in the examination.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO).

PROVIDER: PLEASE COMPLETE OTHER SIDE
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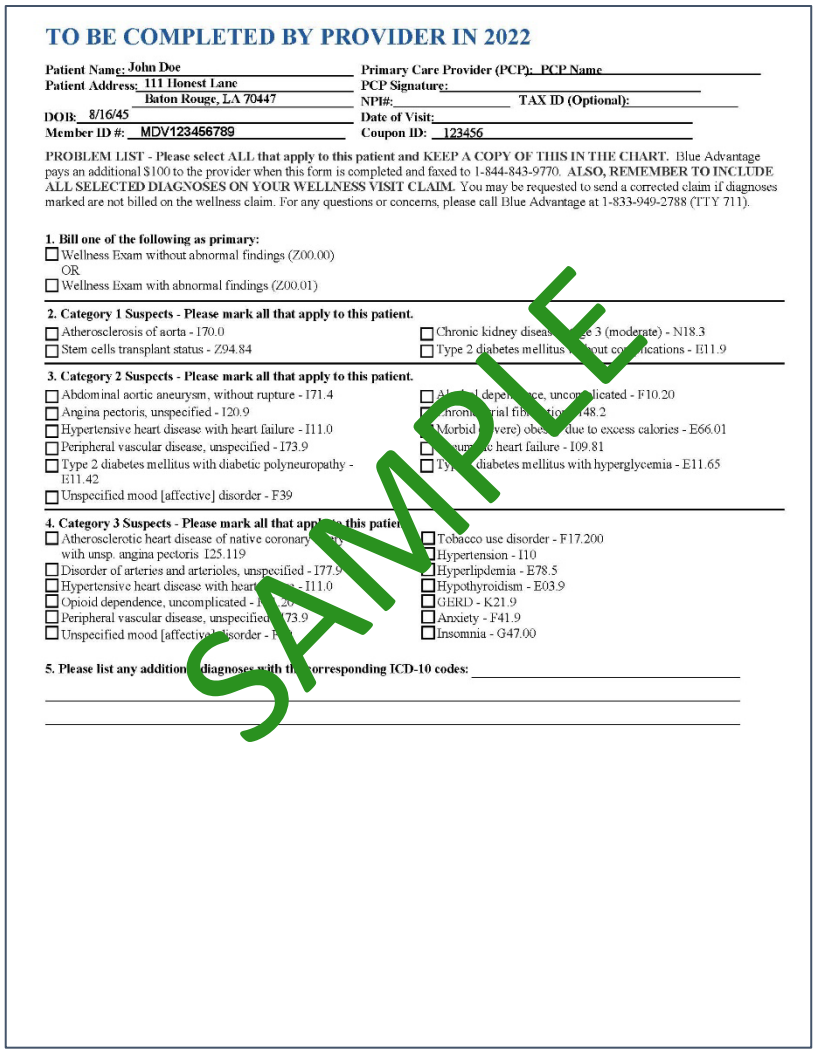
SAMPLE



TO BE COMPLETED BY PROVIDER IN 2022

Patient Name: John Doe
Patient Address: 111 Honest Lane
Baton Rouge, LA 70447
DOB: 8/16/45
Member ID #: MDV123456789

Primary Care Provider (PCP): PCP Name
PCP Signature:
NPI#: **TAX ID (Optional):**
Date of Visit:
Coupon ID: 123456

PROBLEM LIST - Please select ALL that apply to this patient and KEEP A COPY OF THIS IN THE CHART. Blue Advantage pays an additional $100 to the provider when this form is completed and faxed to 1-844-843-9770. **ALSO, REMEMBER TO INCLUDE ALL SELECTED DIAGNOSES ON YOUR WELLNESS VISIT CLAIM.** You may be requested to send a corrected claim if diagnoses marked are not billed on the wellness claim. For any questions or concerns, please call Blue Advantage at 1-833-949-2788 (TTY 711).

1. Bill one of the following as primary:
☐ Wellness Exam without abnormal findings (Z00.00)
OR
☐ Wellness Exam with abnormal findings (Z00.01)

2. Category 1 Suspects - Please mark all that apply to this patient.
☐ Atherosclerosis of aorta - I70.0
☐ Stem cells transplant status - Z94.84
☐ Chronic kidney disea[illegible]e 3 (moderate) - N18.3
☐ Type 2 diabetes mellitus [illegible]out co[illegible]ications - E11.9

3. Category 2 Suspects - Please mark all that apply to this patient.
☐ Abdominal aortic aneurysm, without rupture - I71.4
☐ Angina pectoris, unspecified - I20.9
☐ Hypertensive heart disease with heart failure - I11.0
☐ Peripheral vascular disease, unspecified - I73.9
☐ Type 2 diabetes mellitus with diabetic polyneuropathy - E11.42
☐ Unspecified mood [affective] disorder - F39
☐ [illegible] depen[illegible]ce, uncomplicated - F10.20
☐ Chroni[illegible]rial fib[illegible]tio[illegible]48.2
☐ Morbid [illegible]vere) obes[illegible]due to excess calories - E66.01
☐ [illegible]ic heart failure - I09.81
☐ Ty[illegible] diabetes mellitus with hyperglycemia - E11.65

4. Category 3 Suspects - Please mark all that appl[illegible] this patie[illegible]
☐ Atherosclerotic heart disease of native coronary [illegible]
with unsp. angina pectoris I25.119
☐ Disorder of arteries and arterioles, unspecified - I77.9
☐ Hypertensive heart disease with heart[illegible] - I11.0
☐ Opioid dependence, uncomplicated - [illegible]20
☐ Peripheral vascular disease, unspecified[illegible]73.9
☐ Unspecified mood [affective] disorder - [illegible]
☐ Tobacco use disorder - F17.200
☐ Hypertension - I10
☐ Hyperlipidemia - E78.5
☐ Hypothyroidism - E03.9
☐ GERD - K21.9
☐ Anxiety - F41.9
☐ Insomnia - G47.00

5. Please list any addition[illegible]diagnoses with th[illegible]orresponding ICD-10 codes: _____

SAMPLE

What Should Providers do When They Receive the Coupon?

- Review and complete the back of the coupon at the visit, marking appropriate diagnoses and adding notes as applicable. As with a standard claim, the diagnoses and clinical values should also be documented on the claim and in the provider's medical record.
- To attest to the accuracy of the notes and diagnoses, add the provider's NPI, date of visit and provider's signature, then fax the completed coupon to **1-844-843-9770.**

Providers will be compensated $100 per coupon for the additional administrative work associated with documentation and billing.

Providers may be asked to submit a corrected claim if diagnoses marked on the coupon are not billed on the claim.

Importance of Annual Wellness Visits

- Provides the ability to effectively assess your patients' chronic conditions, as well as close care and coding gaps for Blue Advantage patients.
- Covered at 100%, **once every 12 months**, for Blue Advantage patients.

Quality

- Assess and capture outstanding Star Rating Care Gaps for value-based contract performance and better patient outcomes.

Risk Adjustment

- Greater appointment time allotment for comprehensive assessment and care planning for chronic conditions.

Coding for Annual Wellness Visits

G0438: Initial Annual Wellness Visit (AWV)

G0439: Subsequent AWV

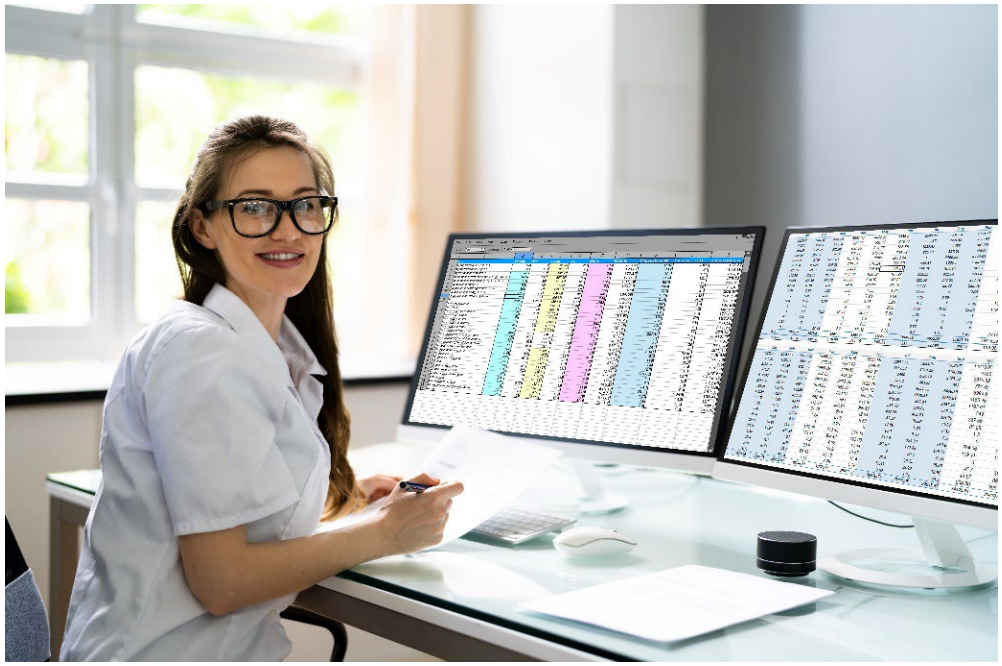
ICD-10: Z00.00 or Z00.01 medical examination with or without abnormal findings

The Annual Wellness Examination costs nothing for the patient.

Coding

Importance of Complete and Accurate Clinical Documentation and ICD-10 Coding

- Physicians that treat sicker populations have higher average cost and utilization per patient. Risk-adjusted reporting can accurately reflect these sicker patients.
- The Centers for Medicare and Medicaid Services (CMS) sets Risk Scores for a calendar year based on diagnoses from the previous calendar year.
- All existing diagnoses must be submitted every calendar year for risk scores to be accurate.
- Member attribution is done by wellness exams.



Complete and Accurate Clinical Documentation and ICD-10 Coding

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.
- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., leg amputation and/or transplant status must be reported each year).
- Include condition specificity where required to explain severity of illness, stage or progression (e.g., staging of chronic kidney disease).
- Treatment and reason for level of care needs to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented.

Authorizations

Authorizations

Hospital Admissions:

- Providers can report inpatient admissions to the Medical Management team by:
  - Phone: 1-866-508-7145

    Phones are forwarded to a secure voicemail system during non-business hours.
  - Fax: 1-877-528-5818 *(available 24 hours a day)*
- Confirmed by Blue Advantage Medical Management staff with a reference number *(a reference number does not guarantee payment)*.

Services requiring authorization are listed in the *Provider Quick Reference Guide* that is available on the Blue Advantage Resources page and the Provider Portal.

Authorizations

Inpatient Admission:
Plan requires notification within one business day of inpatient (IP) admission.

Observation:
Plan requires notification within one business day of observation (OBS) admission.

Notification is required within one business day of **discharge**.

Once the member is discharged, the visit and discharge summary must be faxed to Blue Advantage Medical Management.

The plan reviews and makes determinations for IP/OBS, SNFs, Acute Rehabs, LTACs, HHCs, LOSs, LOCs and discharge planning.

Medical Necessity Criteria:
- InterQual (IQ)
- Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD)

Prior Authorizations

Standard

- Determination and member notification provided within 14 days of receipt (not emergent/urgent care).
- Favorable – member and provider notified verbally or in writing within 14 days of request.
- Partially Favorable or Denied – member and provider notified verbally or in writing within 14 days of receipt.
- Integrated Denial Notice (IDN) mailed to member within three days of oral communication.

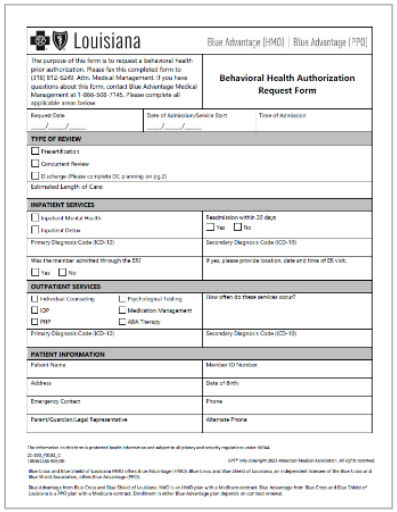
Expedited

- Determination and member notification provided within 72 hours of receipt (emergent/urgent care).
- Favorable – member and provider notified verbally or in writing within 72 hours of request.
- Partially Favorable or Denied – member and provider notified verbally or in writing within 72 hours of receipt.
- Integrated Denial Notice (IDN) mailed to member within three days of oral communication.

*Contracted providers can submit an appeal **only** when it involves a pre-service request.*
Member sent written Notice of Right to an Expedited Appeal.

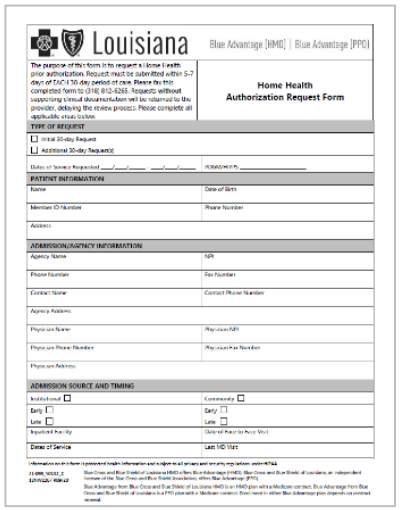
Prior Authorizations

Providers may submit prior authorization requests by using one of the following authorization forms:


Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

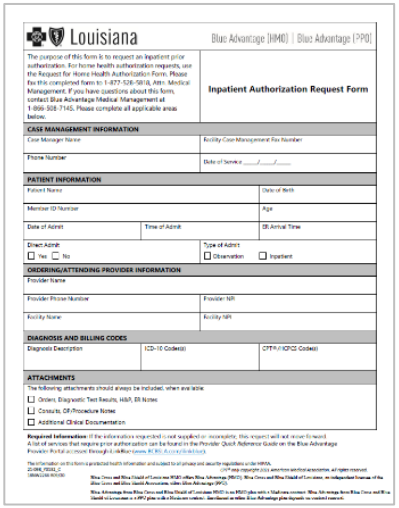
Behavioral Health Authorization Request Form

Behavioral Health Authorization Request Form


Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

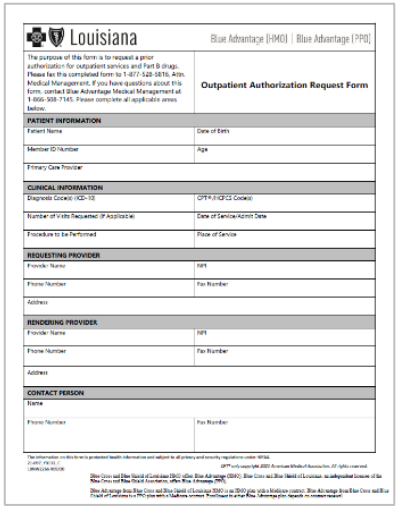
Home Health Authorization Request Form

Home Health Authorization Request Form


Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

Inpatient Authorization Request Form

Inpatient Authorization Request Form


Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

Outpatient Authorization Request Form

Outpatient Authorization Request Form

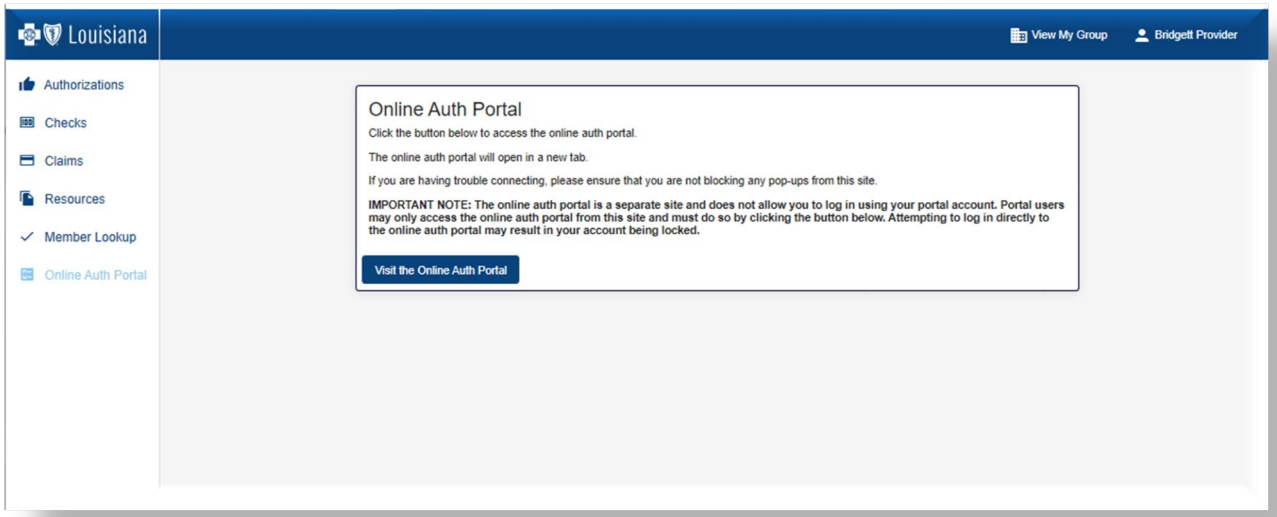
Download authorization forms by going to **www.bcbsla.com/providers**, then clicking on Blue Advantage under the "Other Sites" section. Click "Resources" then "Forms."

The 2022 *Provider Quick Reference Guide* includes the list of services requiring prior authorization. It is available on the Blue Advantage Resources page, **www.bcbsla.com/providers**, then click "Go to BA Resources" at the bottom of the page.

Prior Authorizations

Providers can use the "Online Auth Portal" to request a prior authorization for the following services:

- OPMD – a procedure performed in the office setting
- OPFAC – a procedure performed in an outpatient facility setting
- ASU – a procedure performed in an ambulatory surgical setting
- POC – authorization for post op care for surgeries with 90-day global periods
- BH – outpatient behavioral health services



Pharmacy

Part B vs Part D Overview

B

Part B Covered Drugs

- Mostly drugs received as part of a physician's service or at an outpatient hospital/infusion center.
- Members have a 20% Part B coinsurance.
- This amount applies to the **Max Out-Of-Pocket (MOOP)**.

D

Part D Covered Drugs

- Most prescription drugs filled at a retail pharmacy or by mail.
- Member cost share depends on the drug's assigned tier.
- This amount applies to the **True Out-Of-Pocket (TrOOP)**.

B/D

Part B or Part D Covered Drugs

- Coverage depends on what the drug treats or where/how it is given.
- Drugs that qualify for coverage under Part B, cannot be covered under Part D.
- Drugs eligible for coverage under Part B or D may require a prior authorization to determine, which benefit is appropriate.

Overview of Drug Coverage Rules

B

Some drugs are covered under Part B at a pharmacy under specific circumstances.

- Drugs that require a medical device to administer (e.g., albuterol from a nebulizer).
- Select oral chemotherapy drugs (generally those with an IV formulation).
- Immunosuppressive drugs following a Medicare-covered transplant.
- Select vaccines such as influenza or pneumococcal.
- Blood clotting factors.

D

Part D

- Oral chemotherapy drugs without an IV formulation.
- All other vaccines.

Part D Exclusions

- Drugs used for cosmetic purposes, weight loss or weight gain (covered when used for AIDS wasting and cachexia due to a chronic disease).
- Drugs for symptomatic relief of cough and colds.
- Nonprescription/OTC drugs.
- Drugs when used for sexual dysfunction or to promote fertility.

The Basics: Your Outpatient Drug Coverage

Part D drugs

- Prescription drugs filled at a retail pharmacy or by mail.
- Vaccines not covered under Part B.

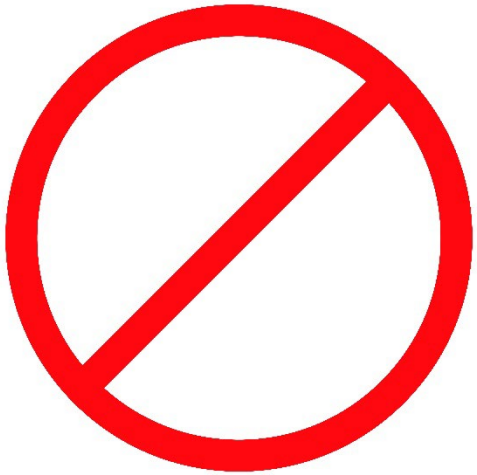
This amount applies to the **True Out-Of-Pocket (TrOOP)**.

Part B drugs

- Drugs received at a doctor's office or outpatient hospital setting (infusion center).
- Vaccines such as COVID-19, influenza, pneumonia, hepatitis B (with certain risk factors).
- Immunosuppressive drugs following a Medicare-covered transplant.
- Drugs taken at home for certain conditions such as kidney disease, blood clotting disorders.
- Drugs that require a medical device or pump to administer. (ex. albuterol from a nebulizer)

Members have a 20% Part B coinsurance.
This amount applies to the **Max Out-Of-Pocket (MOOP)**.

The Basics: Your Outpatient Drug Coverage



What we do <u>not</u> cover:

- Drugs used for weight loss or weight gain (some exceptions)
- Drugs used for cosmetic purposes
- Nonprescription/over-the-counter drugs
- Drugs to treat sexual dysfunction
- Drugs for symptomatic relief of cough and colds
- Vitamins and supplements

Part D Exclusions: Examples

Vitamins and supplements

- Vitamin D supplements (alone and combination)
- Vitamin B and Cyanocobalamin supplements (oral and injection)
- Calcium citrate/calcium carbonate (alone and combination)
- Magnesium oxide/Mag oxide/Magnesium citrate
- Ferrous sulfate/Ferrous fumarate
- Folic acid

Drugs for symptomatic relief of cough and colds

- Tessalon Perles®
- Cough syrups (ex. codeine/promethazine/guaifenesin)

Nonprescription/OTC drugs

- Acetaminophen
- Gas-X® (simethicone)

Drugs used for weight loss or weight gain (some exceptions)

- Adipex-P® (phentermine)
- Megace® (megestrol)

Drugs used for cosmetic purposes, hair growth, hair removal

- Retin-A® (tretinoin)
- Vaniqa®

Drugs to treat sexual dysfunction

- Levitra®
- Viagra®
- Addyi®

Benefits of Home Medication Delivery

No-cost Shipping

- Standard shipping right to the member's door at no extra cost.

Refill Reminders

- Refill reminders make it less likely to miss a dose.

Avoid Interactions

- Safety reviews to find possible interactions with other drugs.

Pharmacists Available

- Access to a pharmacist 24/7 from the privacy of member's home.

Medication Adherence

Maintenance medications are written for a 90-day supply to help ensure that patients continue to take as directed. Express Scripts Pharmacy® also has autofill options to help avoid forgetting refills.

Express Scripts Mail-order Pharmacy

Two Steps to set up home delivery:

1) **Prescribe a 90-day supply**
   - Prescription can be sent electronically from the EMR or called in to Express Scripts Pharmacy. Autofill options for refills are also available for select prescriptions.
2) **Member can contact Express Scripts directly to have prescription transferred.**

Starting home delivery is easy:

Call: 1-800-841-3351 Monday through Friday, 9 a.m. to 7 p.m. Eastern Time (except office holidays)
TTY users: **1-800-716-3231**

Go Online: express-scripts.com/get90
Express Scripts ePrescribing NCPDP ID: 2623735
NPI: 1558443911
Email: eprescribingsupport@express-scripts.com

TO BE SAFE:

- New prescriptions and refills should allow 14 days for processing and shipping.
- When first switching from retail to mail-order, we recommend members have a 30-day supply of medication on hand to allow processing time.

Diabetic Testing Supplies

How members may get a FREE meters and stripes:

- **Go to a Blue Advantage network pharmacy**
  - Members can take their prescription for a covered meter to a Blue Advantage network pharmacy.
  - All the covered meters are available through network pharmacies.

Freestyle and OneTouch Traditional Blood Glucose Meters are preferred. Members can find specific product information online at **www.bcbsla.com/blueadvantage**.

Claims and Billing

Billing Requirements

Providers should bill according to Medicare guidelines.
CMS guidelines are followed for all claims, both electronic and paper:

- Faxed claims are not accepted.

Timely Filing

- Participating providers have **12 months from the date of service** to file an initial claim.
- Participating providers have **12 months from the date the claim was processed** (remit date) to resubmit or correct the claim.

Refer to **www.cms.hhs.gov** for specific details.

Telehealth New Place of Service Code 10

- Effective for dates of services January 1, 2022, there is a new place of service 10 code established for telehealth provided in a home setting.
- With this new place of service code, Blue Cross is updating the telehealth billing guidelines for direct to consumer (DTC) telehealth services.
- We define DTC telehealth as telehealth services delivered directly between the provider and patient in their home environment (e.g., residence, workplace, personal space, etc.).
- To ensure the appropriate benefits and reimbursement apply, do not bill place of service 02 to Blue Cross for telehealth services. Blue Cross does not consider place of service 02 valid for claims submission and claims billed with place of service 02 may reject.
- Providers should continue to use the appropriate telehealth modifiers to identify telehealth claims and continue to follow additional guidelines.

For more information about our telemedicine requirements, billing and coding guidelines, see Section 5.37 Telehealth/telemedicine our *Professional Provider Office Manual* at **www.bcbsla.com/providers** >Resources >Manuals.

Reimbursement for COVID-19 Treatments

CMS will reimburse for COVID-19 vaccines and monoclonal antibody treatment claims with 2020 and 2021 dates of service. For dates of service on or after January 1, 2022, the obligation to pay these claims is the responsibility of Blue Advantage.

Providers should **not** submit claims with 2022 dates of service to Original Medicare. Submit claims for dates of service on and after January 1, 2022, to Blue Advantage. Use the product-specific coding provided by CMS and American Medical Association.

For questions on this update, please contact Blue Advantage at 1-866-508-7145.

For current and future billing guidelines related to COVID-19, providers should access the COVID-19 section for the Blue Advantage Resources page (**www.bcbsla.com/providers**, click on "Go to BA Resources" at the bottom of the page).

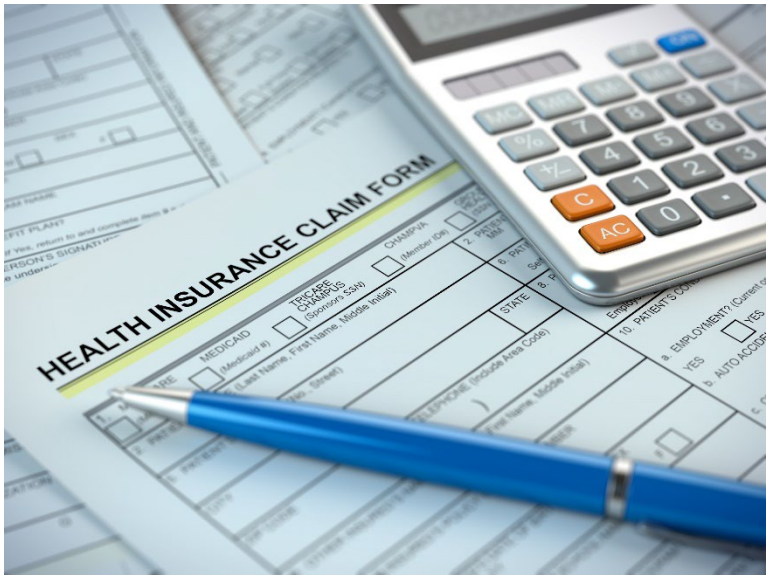
ABNs Not Used for Blue Advantage

CMS does not allow use of Advanced Beneficiary Notices (ABNs) for MA plans.

To hold members financially liable for non-covered services not clearly excluded in the member's Evidence of Coverage (EOC), contracted providers must do the following:

- If contracted provider knows or has reason to know that a service may not be covered, request a prior authorization from Blue Advantage.
- If the coverage request is denied, an Integrated Denial Notice (IDN) will be issued to the member and requesting provider.
- If the member desires to receive the denied services **after** the IDN has been issued, the provider may collect from the member for the specific services outlined in the IDN after services are rendered.

Claims Submission



Providers submitting directly to Change Healthcare must make the system changes necessary to send their Blue Advantage claims with the Payer ID **72107**.

Providers who do not send directly to Change Healthcare, please notify your clearinghouse of the new Payer ID **72107** for Blue Advantage claims.

Mail all paper claims to:

Blue Cross and Blue Shield of LA/HMO Louisiana, Inc.
130 DeSiard St, Ste 322
Monroe, LA 71201

Resolving Claims Issues

Contact Blue Advantage Customer Service at **1-866-508-7145**

- Request a review for correct processing.
- Be specific and detailed.
- Allow 10-15 working days for first request.
- Check the Blue Advantage Provider Portal for a claims resolution.
- Request a second review for correct processing.
- Allow 10-15 working days for second request.

When to Contact Provider Relations for Claims Help

If unresolved after second request, you may email an overview of the issue along with documentation of your two requests to Provider Relations.

provider.relations@bcbsla.com

It is required to document the customer service representative's name for each call.

Provider Pay Disputes

When a participating provider disagrees with the amount that has been paid on a claim or line item:

- Disputes over the payment amount must be filed within the timeframe specified in your contract, which is based on the date the claim was processed.
- The dispute notice should be submitted in writing and include the basis for the dispute and documents supporting your position.
- Regardless of the existence or outcome of the dispute, participating providers are not allowed to seek additional compensation from members other than copayments, coinsurance and payment for non-covered services.

Once a decision has been made:

- Blue Advantage will communicate the decision in writing if it is determined the correct amount was previously paid.
- If payment is corrected, it will appear on a remittance advice to the requesting provider.
- If you still disagree with Blue Advantage's decision, you have opportunities for additional levels of administrative review. Please follow the instructions in your contract.

Provider Pay Dispute Address:

Blue Cross and Blue Shield of LA/HMO Louisiana, Inc.
Provider Disputes
130 DeSiard St, Ste 322
Monroe, LA 71201

Corrected Claims

EDI/1500/Professional claims can be submitted electronically as "Corrected Claims"

- Loop 2300 ~ CLM05-03 must contain a "7," REF01 must contain an "F8" and REF02 must contain the original reference claim number.
- Indicate a reason for the correction in the note field.

1500 paper claim forms can be submitted as "corrected claims"

- The paper 1500 claim submitted must indicate a frequency of 7 in Block 22 (Resubmission Code Box) and the original reference claim number in Block 22 (Original Ref. No. Box).

The claim form should reflect a clear indication as to what has been changed. All previous line items must be submitted on the corrected claim.

EDI/UB-04/Facility corrected claims can be submitted electronically as "Corrected Claims"

- The type of bill must indicate a frequency of 7.
- "F8" must indicate in Loop 2300 REF01.
- REF02 must contain the original reference claim number.
- Indicate a reason for the correction in the note field.

UB-04 corrected claims can also be submitted on paper as "corrected claims"

- The paper UB-04 corrected claim submitted must indicate a frequency of 7 in Block 4.
- The original reference claim number in Block 64.
- Reason for the correction in Block 80.

The corrected claim will be denied as a duplicate if the original claim number is not included.

Member Appeals

When a member disagrees with a denial of services, an appeal:

1. Must be filed within **60 days** from the date of the organizational determination (e.g., EOB or provider remit is issued, whichever is applicable).

2. Must be submitted in writing and **does not apply to participating providers unless it involves a pre-service request**.

3. Claim appeals can be filed by either a member or a non-contracted provider.

4. Pre-service appeals can be filed by both participating and non-participating providers, the member or the member's authorized representative, and can be submitted in writing or requested by calling Blue Advantage Customer Service at 1-866-504-7145.

Other Services

Other Services

- **United Concordia**

  administers routine dental services

  phone: 1-866-445-5825

- **Express Scripts**

  administers pharmacy benefit management

  phone: 1-800-935-6103/TTY:711

See the "Plan Information Contact List" section of the *Blue Advantage Provider Administrative Manual* for more information about these services.

Outpatient Lab Tests

Blue Advantage network providers can:

- Perform lab work in the office if they are Clinical Laboratory Improvement Amendments (CLIA) certified.
- Draw specimens and send to one of our participating lab facilities identified in our Provider/Pharmacy Directory.

Blue Advantage Preferred Labs:

- Clinical Pathology Laboratories (CPL)

  www.cpllabs.com

- Laboratory Corporation of America (LabCorp)

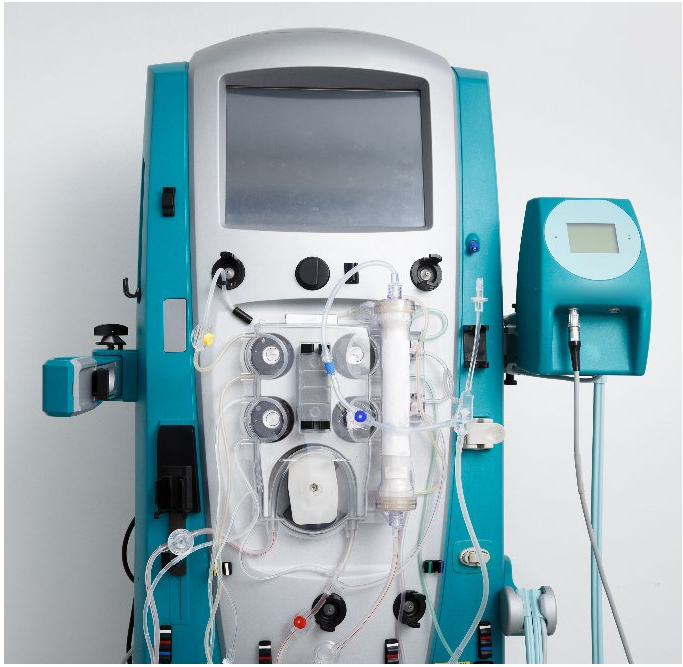
  www.labcorp.com

- Quest Diagnostics

  www.questdiagnostics.com

Dialysis Patients

- Dialysis providers initiating hemodialysis for ESRD patients must enter the CMS-2728 form into the CMS system, CROWNWeb.
- Once entered into the system, the provider must print the form, sign it, then have the member sign and mail it to the Social Security Administration office.



The CROWNWeb is located at **www.projectcrownweb.org**.

Refractions

- Refractions are not covered unless performed by a Blue Advantage Davis Vision provider.
- As a CMS requirement, contracted providers are not permitted to render non-covered services and hold the member responsible.
- For network vision providers, please search the Davis Vision website at **www.davisvision.com** or call 1-800-773-2847.

Blue Cross to Process EFT and ERA for Blue Advantage Claims

- On October 31, 2022, Blue Advantage is transitioning its electronic funds transfer (EFT) and electronic remittance advice (ERA) 835 business from RedCard to Blue Cross and Blue Shield of Louisiana.
- All payments made after October 31 will be made through Blue Cross.
- Blue Advantage providers should continue to use the Blue Advantage Provider Portal for claims research and payment information.

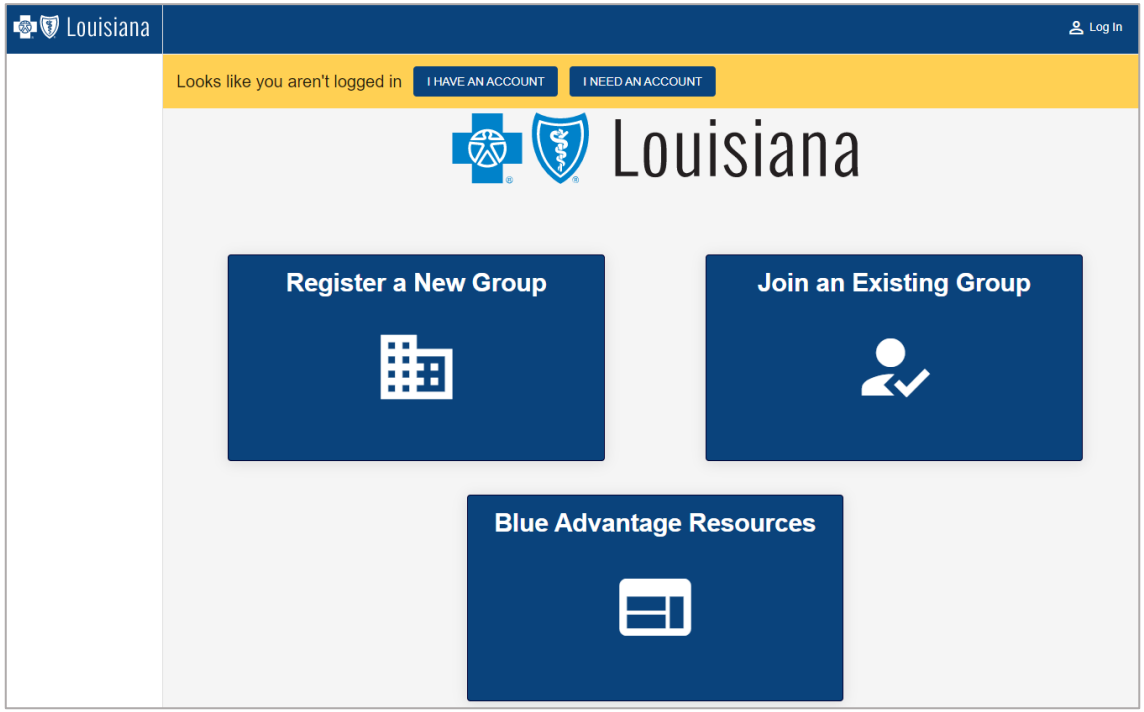
Below are details on how this transition could affect you. It is important that if you are not currently enrolled to receive Blue Cross EFT and ERA, that you do so before October 31 to ensure continued receipt of these electronic services.

	Already Enrolled with Blue Cross	Has Never Enrolled with Blue Cross
EFT	No additional EFT registration is required. You will continue to use the same trading partners you have in place for submitting your Blue Advantage claims. You will file your Blue Advantage claims the same as you do today and instead receive direct payment from Blue Cross.	To receive electronic payments for your Blue Advantage claims, you MUST enroll for EFT with Blue Cross. The Blue Cross EFT Enrollment Form is available in DocuSign® format at www.bcbsla.com/providers >Electronic Services >Electronic Funds >Quick Links.
ERA	Because you are enrolled to receive 835 ERA transactions from Blue Cross for your non-Blue Advantage claims, no action is required. Once we transition, you will receive your Blue Advantage ERAs from Blue Cross instead of RedCard.	You must register with Blue Cross to receive your ERAs for your Blue Advantage claims. To enroll, complete the ERA Enrollment Form. It is available at www.bcbsla.com/providers >Electronic Services >Clearinghouse Services >Quick Links.

Online Resources

Blue Advantage Provider Portal

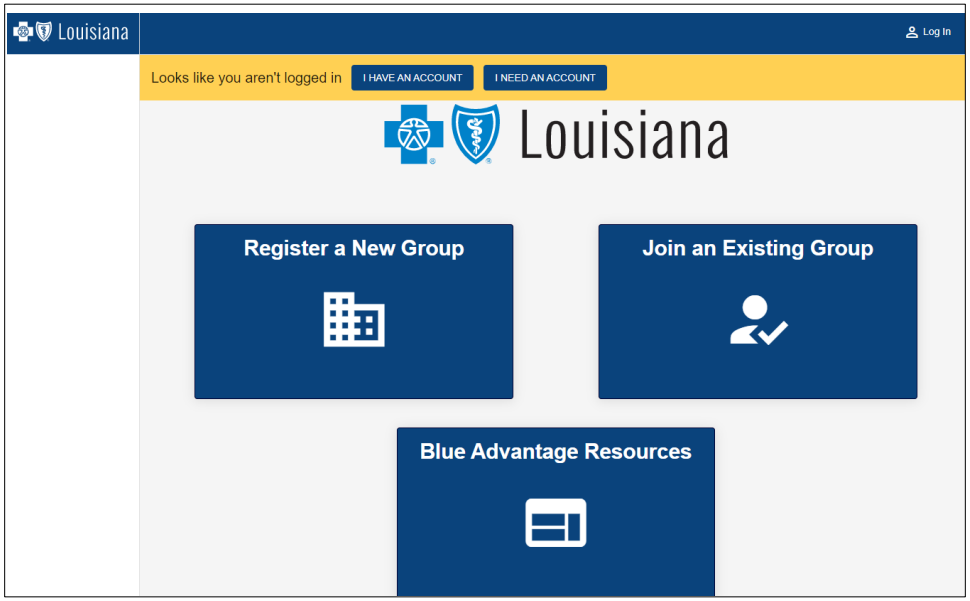
- Claims Inquiry
- Member Eligibility
- Provider Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more



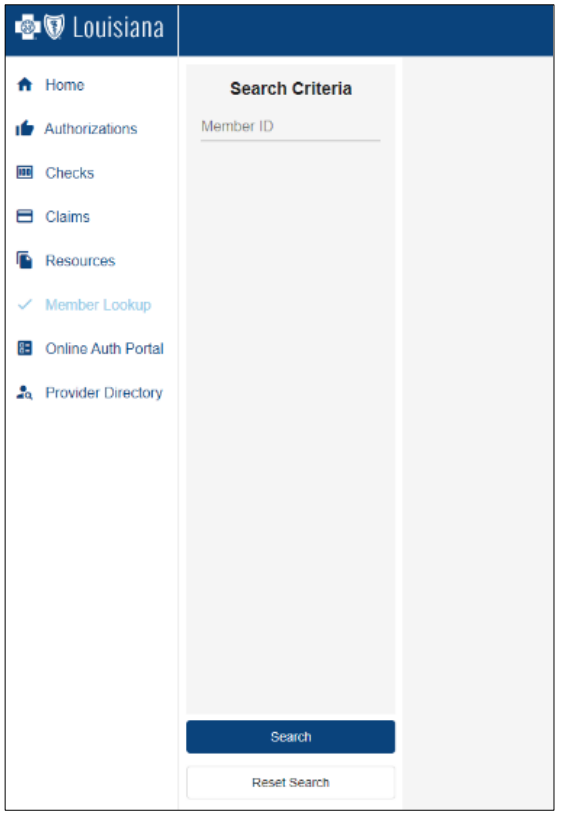
The Blue Advantage Provider Portal is available through iLinkBlue (**www.bcbsla.com/ilinkblue**) >**Blue Advantage** (under "Other Sites").

Accessing the Blue Advantage Provider Portal

Provider Portal Login

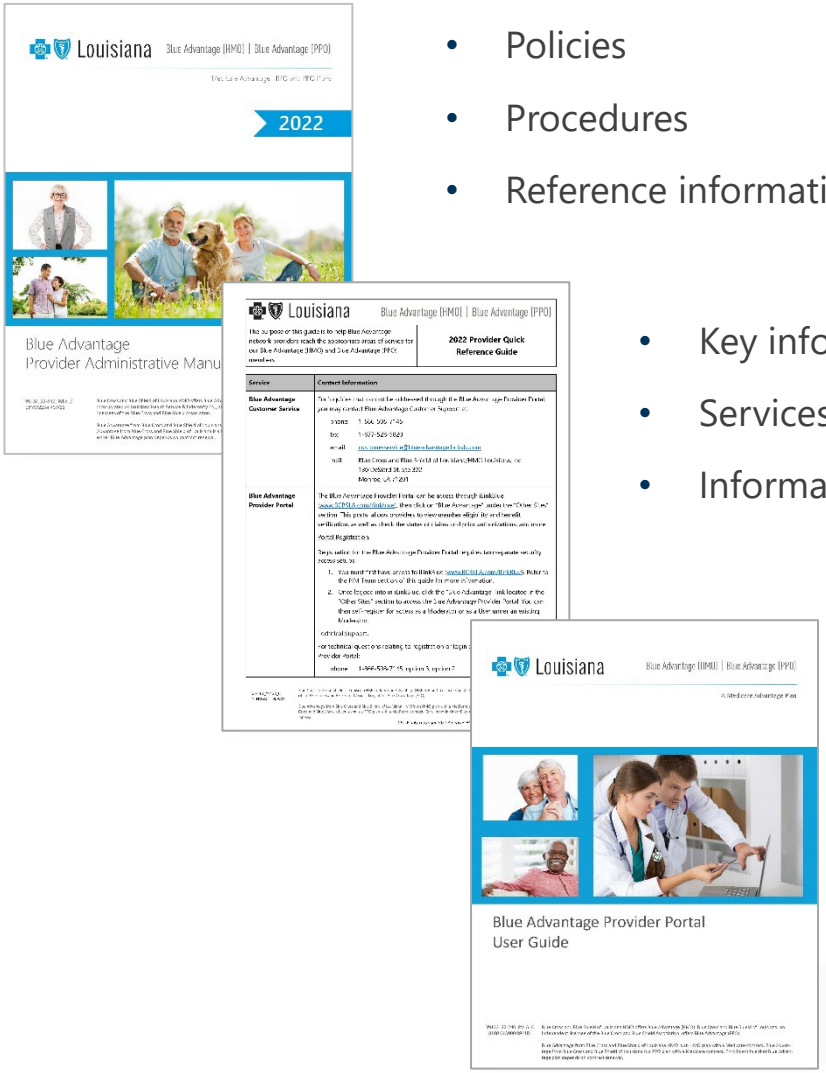


Once registration is complete, providers will be able to login and access all **available** portal features.



Provider Portal Features

Blue Advantage Manuals and Guides



- Policies
- Procedures
- Reference information required of our Blue Advantage network providers

- Key information about the Blue Advantage Networks
- Services requiring authorization
- Information on our Blue Advantage electronic tools

- How to access and register for the portal
- Overview of portal features
- Troubleshooting

Available on both the Blue Advantage resource page and Provider Portal.

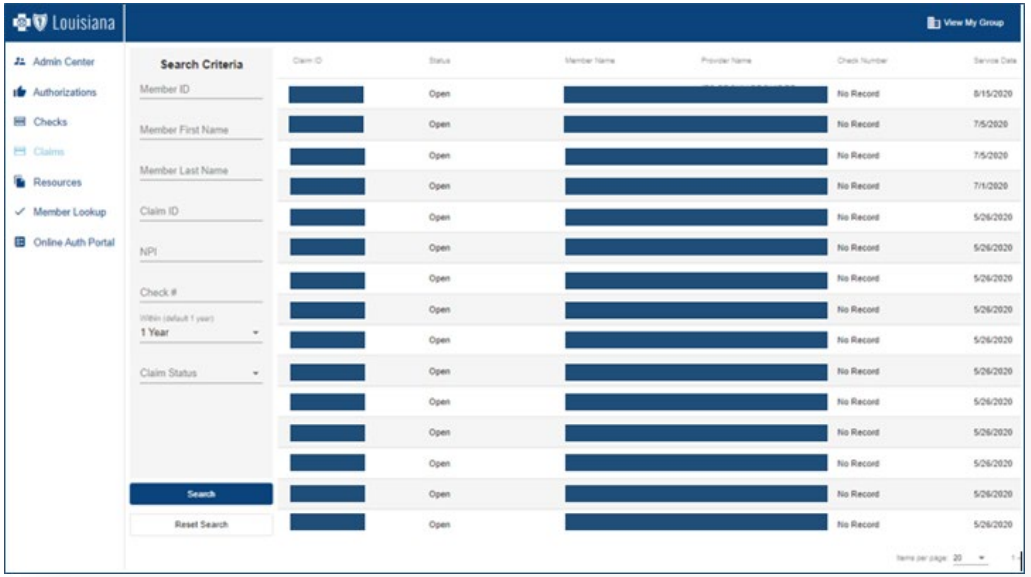
Checking Claim Status

Use the Claim Inquiry tool (available on the Blue Advantage Provider Portal) for standard claims status checks.

- There are multiple ways to inquire about a claim listed in the *Blue Advantage Provider Administrative Manual*.

For each claim listed, the portal screen will display:

- Claim number
- Date(s) of service
- Provider name
- Member name
- Claim status
- Date of claim status
- Payment amount

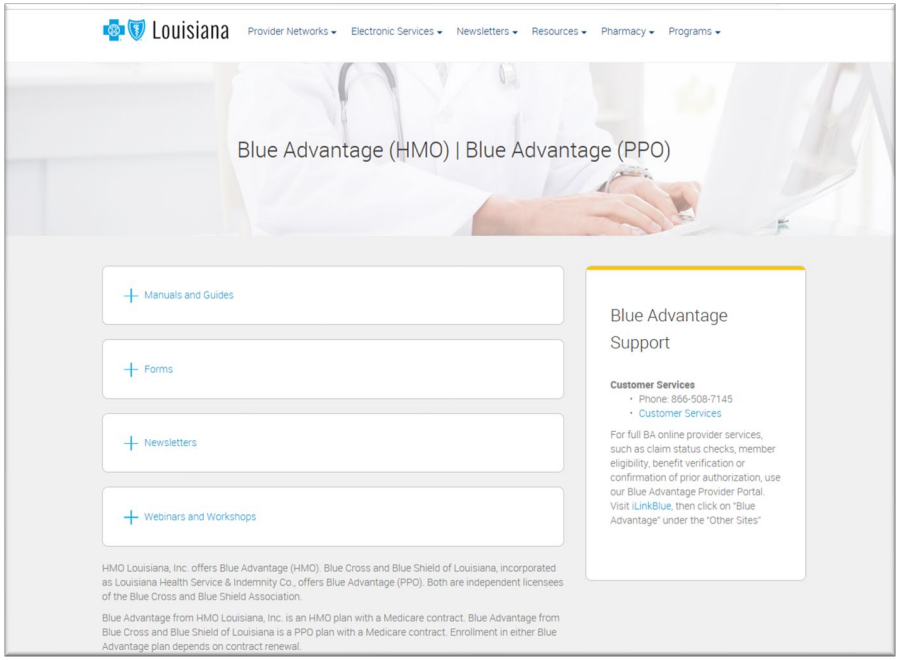


If the status of the claim is "**In Process**," you will not be able to review the summary.

Blue Advantage Resources Page

Resources that can be found on this page:

- Manual
- Authorization guide
- Forms
- Newsletters
- Webinars/workshops



Designed to give providers access to the most current Blue Advantage resources **www.bcbsla.com/providers >Blue Advantage Resources.**

Questions?

Addendum

Compliance Reminders

As a Blue Advantage provider, you are required to:

- Follow the provider guidelines in your provider manual when discussing Medicare Advantage.
- Routinely check for exclusions by the OIG/GSA (Office of Inspector General/General Services Administration).
- Report any actual or suspected compliance concerns.
- Notify us of any practice information changes.
- Verify that provider training has been completed in:
  - General compliance
  - Fraud, waste and abuse

CMS offers more information on compliance that you can access through the Blue Advantage Provider Portal. Under the "Forms & Resources" section, click on "Compliance Program," under "Helpful Links" then "CMS Medicare Compliance and Fraud, Waste and Abuse Training."

Medical Record Retention and Requests

Specific documentation requirements can be found in the *Blue Advantage Provider Administrative Manual* in the "Medical Records" section.

The guidelines for the maintenance of medical records state they must be:

- Retained for a minimum of 10 years.
- Contain consistent and complete documentation of each member's medical history and treatment.

Medical record request:

- Should be responded to within 10 days of the request.

When members change their PCP and request a transfer of their medical records, the provider has 10 business days of the request to forward the records.

Helpful Hints

- For additional details on how to register for the Blue Advantage Provider Portal, download the 2022 Blue Advantage Portal User Guide. Go to **www.bcbsla.com/ilinkblue** then click "Blue Advantage" under the "Other Sites" section.
- We recommend using Google Chrome to access the 2022 Blue Advantage Provider Portal.
- The new portal uses cookies to remember your login information and you **must** enable cookies for the portal, in order to successfully log in and access all its features.
- For additional information, please see the "Troubleshooting" section of the *Blue Advantage Provider Portal User Guide* for detailed instructions.

Case Management Services

Case management programs seek to maximize the quality of care, member satisfaction and efficiency of services through effective engagement with members and their providers.

How we do it:

- Education and support of members and family/caregivers, including self-management
- Coordination of care
- Medication adherence
- Fall prevention and safety
- Access to community resources
- Advance care planning
- Telephonic outreach

For a list of conditions and complex diseases that often benefit from the case management program, see the *Blue Advantage Provider Administration Manual*, available on the Blue Advantage Provider Portal, (**www.bcbsla.com/ilinkblue**) >Blue Advantage (under "Other Sites").

Use of CPT Category II Codes

What is a CPT Category II Code?

The American Medical Association creates and maintains CPT Category II codes to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures that are evidence-based as contributing to quality patient care.

Why use CPT II Codes?

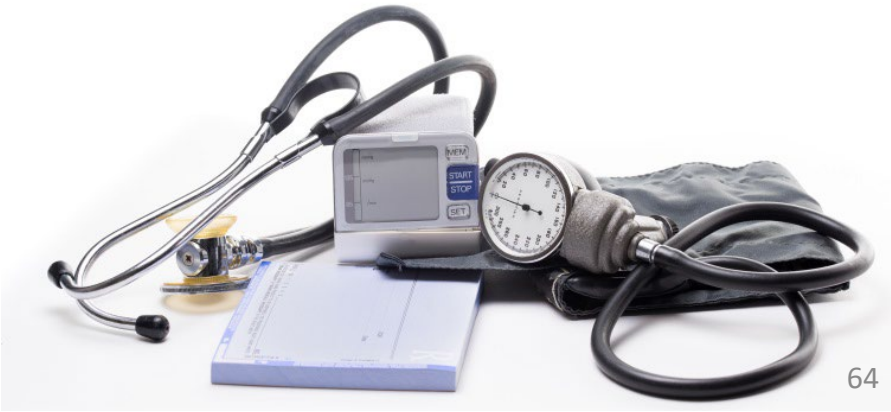
CPT II codes describe clinical components that may be typically included in evaluation and management services or other clinical services and do not have a relative value associated with them. These codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

Is there additional reimbursement when I use CPT II codes?

CPT II codes are not reimbursable and should reflect a $0 charge.

Advantage of Assigning CPT II Codes

- Lessens the administrative burden of chart review for many Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures.
- Enables organizations to monitor internal performance for key measures throughout the year, rather than once per year as measured by health plans and pay for performance.
- Identifies opportunities for improvement so interventions can be implemented to improve performance during the service year.



Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

- Targets members who meet the following criteria:
  - 3+ chronic conditions.
  - 8+ maintenance medications.
  - Spent $1,094 in the previous three months on Part D covered medications.
- Members will be invited to schedule a Comprehensive Medication Review (CMR) with an MTM-certified pharmacist which includes:
  - Review of the member's entire medication profile (including prescriptions, OTCs, herbal supplements and samples).
  - Discuss purpose and directions for the use of each medication with documentation being provided to the member after completion of the call.
  - Answer any additional questions or concerns.
- After the completion of a CMR, you and the member will receive a detailed report.
- The pharmacist performing the CMR may contact you directly in the event a significant drug therapy problem is identified.

Pharmacist Outreach Initiatives

- For additional details on how to register for the Blue Advantage Provider Portal, download the *2022 Blue Advantage Portal User Guide*. Go to **www.bcbsla.com/ilinkblue** then click "Blue Advantage" under the "Other Sites" section.
- We recommend using Google Chrome to access the 2022 Blue Advantage Provider Portal.
- The new portal uses cookies to remember your login information and you **must** enable cookies for the portal, in order to successfully log in and access all its features.
- For additional information, please see the "Troubleshooting" section of the *Blue Advantage Provider Portal User Guide* for detailed instructions.

Subrogation

- Blue Advantage subrogates with other liability carrier to recoup CMS funds.
- Conditional payments are made, which allows recoupment when a settlement is reached.
- Blue Advantage allowable charges apply.
- Claims that contain potential third-party liability (TPL) will be paid by Blue Advantage on a conditional basis, which permits us to recoup any payments if/when a settlement is reached.

Billing Reminders

- Blue Advantage ambulatory surgical center (ASC) claims must be submitted on a CMS-1500. If submitted on a UB-04 claim form, it will be denied, and must be resubmitted on a CMS-1500 claim form.
    - The ASC's NPI should be listed as the rendering provider as well.
- When a member is seen by a hospital-based provider:
    - Providers must include POS 19 **or** 22 when services are rendered in hospital-based clinic.
        - *Note: site of service reduction will be applied to the professional fee.*
    - Facilities will bill these services under revenue code 510 **or** 761.
    - Member's cost share will apply to the professional charge only.
- When billing diagnostic services on the same day as an office visit, providers should bill **both** services on the same claim form.
- When billing anesthesia services, providers must include the appropriate modifiers in accordance with CMS guidelines.
- All nurse practitioners, physician assistants and other physician extenders must be identified on the claim **with their own NPI**.

Refer to **www.cms.hhs.gov** for specific details.

Claims

Resubmission

- No payment was issued on the claim line in question.
- The incorrect or missing information on the original claim resulted in the claim denial. This would be corrected/added and resubmitted (i.e., invalid procedure code modifier combination).
- The claim can be resubmitted on paper or electronically, **not faxed**.
- The claim will be treated as an initial claim for processing purposes with no provider explanation necessary.

Corrected

- A **previously paid claim** in which the provider needs to add, remove or change a previously paid claim line.
- Providers must submit a corrected claim if all lines of the claim were previously paid, and they are wanting to add or remove a claim line or change something on a claim line. Example: date of service, procedure code, etc.
  - Examples:
    - Adding or removing a previously paid claim line where charges were billed for a service that was not rendered, or provider did not bill for a service that was rendered.
    - Changing a previously paid claim line where an incorrect date of service or an incorrect procedure code was billed.
- The corrected claim will be denied as a duplicate if the original claim number is not included.

Provider Relations

Kim Gassie Director

Jami Zachary Manager

Anna Granen Senior Provider Relations Representative

Michelle Hunt
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn, Jefferson Davis, St. Landry, Vermilion

Yolanda Trahan
Assumption, Iberia, Lafayette, St. Charles, St. James, St. John the Baptist, St. Mary, Calcasieu, Cameron, Lafourche

Mary Guy
East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana, Livingston, Pointe Coupee, St. Martin, Terrebonne

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Marie Davis
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll, Acadia

provider.relations@bcbsla.com | 1-800-716-2299, option 4

Paden Mouton, Supervisor

Provider Contracting

Jason Heck*, Director – jason.heck@bcbsla.com

Cora LeBlanc, Sr. Provider Network Development Representative – cora.leblanc@bcbsla.com
St. John The Baptist, Terrebonne, Lafourche, St. Charles, St. James, Tensas, Madison, East Carroll, West Carroll, Franklin, Richland, Morehouse, Ouachita, Caldwell, Union, Concordia, Catahoula, Lasalle parishes

Sue Condon, Lead Network Development & Contracting Representative – sue.condon@bcbsla.com
West Feliciana, East Feliciana, St. Helena, Pointe Coupee, West Baton Rouge, East Baton Rouge, Livingston, Ascension, Assumption, Iberville, Caddo, Bossier, Webster, Claiborne parishes

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Jill Taylor, Provider Network Analyst – jill.taylor@bcbsla.com
Jefferson, Orleans, Plaquemines, St. Bernard, St. Tammany, Tangi, Washington parishes

*Jason Heck works with providers in the following parishes: Desoto, Red River, Bienville, Sabine, Natchitoches, Winn, Jackson and Lincoln

provider.contracting@bcbsla.com | 1-800-716-2299, option 1

Doreen Prejean **Mary Landry** **Karen Armstrong**

Provider Credentialing & Data Management

Venessa Williams, Manager Provider Information,
vennessa.williams@bcbsla.com

Anne Monroe, Provider Information Supervisor,
anne.monroe@bcbsla.com

Mallory Trant, Provider Information Supervisor (Credentialing),
mallory.trant@bcbsla.com

If you would like to check the status on your Credentialing Application or Provider Data change or update, please contact the Provider Credentialing & Data Management Department.

1-800-716-2299 | option 2 – provider record information
PCDMStatus@bcbsla.com