Spring 2018 Professional Workshops

Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Enrollment in HMO Louisiana depends on contract renewal. HMO Louisiana is a subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

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Our Mission

To improve the health and lives of Louisianians

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

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

Agenda

Credentialing

Credentialing Process

- The credentialing process can take up to 90 days once Blue Cross receives all required information
- After 90 days you may inquire about your credentialing status by contacting our Network Operations department at 1-800-716-2299, option 2
- Required credentialing application packets are available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks
- Blue Cross credentials both professional and facility providers
- To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Blue Cross and Blue Shield Association
- Providers will remain non-participating in our networks until their application has been approved by the credentialing subcommittee. The credentialing subcommittee approves credentialing monthly
- Network providers are recredentialed every three years from their last credentialing acceptance date

NEW

New Provider File & Credentialing Policy

Effective April 9, 2018, Blue Cross implemented a new policy for credentialing and provider file maintenance requests to help ensure completed requests are processed timely

- Requests to join our networks or maintain network participation, including the credentialing and recredentialing processes, must be submitted on appropriate applications
- Requests for provider file maintenance must be submitted on the appropriate Blue Cross form

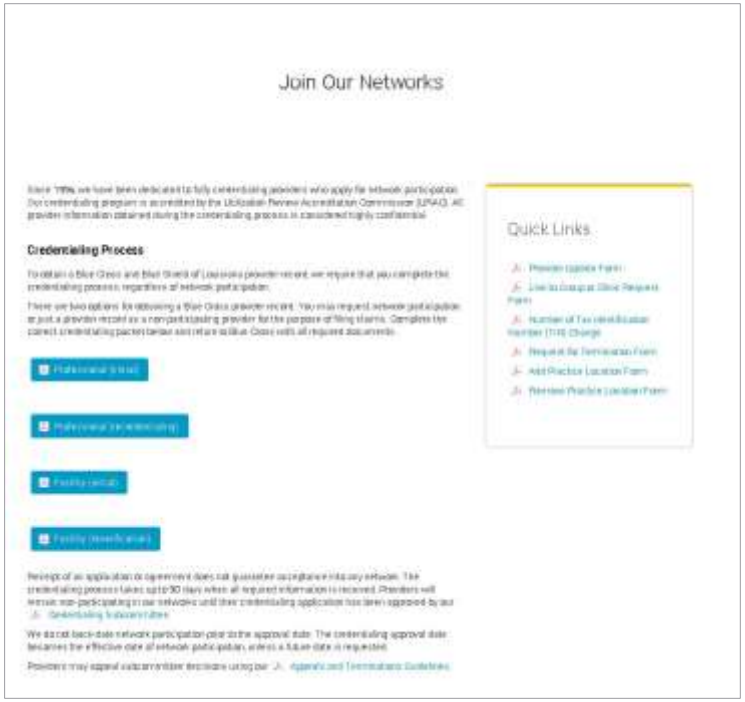
Requests that are incomplete, missing information or submitted on the incorrect form will be returned. The processing time will start over once all required information is received.

All forms and credentialing packets are available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

NEW

New Credentialing Web Page

- Credentialing Packets
- Checklists with all required documents (*submit completed checklist with all documents*)
- Quick Links to provider update forms
- Credentialing Criteria



www.BCBSLA.com/providers >Provider Networks >Join Our Networks

Act 897 Requests

Eligible physicians can request that Blue Cross reimburse their claims as if they are a network physician during the credentialing process under Louisiana Senate Bill 710 (Act No. 897). Claims for network physicians are paid directly to the provider.

The following criteria must be met:

- You must be a medical doctor (MD) or doctor of osteopath (DO)
- You must be applying for network participation to join a provider group that already has an executed group agreement on file with Blue Cross. *This provision does not apply for solo practitioners.*
- You must have admitting privileges to a network hospital. PCPs can have an arrangement with a hospitalist group to admit their patients.
- Your initial credentialing application for network participation must include a written letter of request asking Blue Cross to invoke Act 897 and an agreement to hold our members harmless for payments above the allowable amount

The Act 897 Instruction Sheet is available online at
www.BCBSLA.com/providers >Resources >Forms

Our Networks

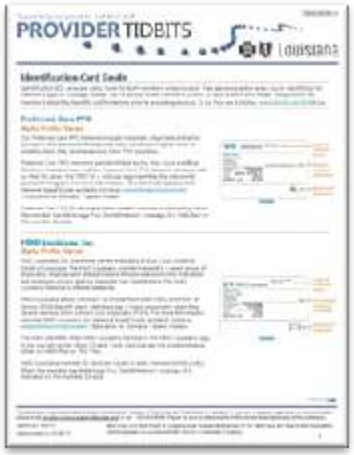
Our Provider Networks

Preferred Care PPO and **HMO Louisiana, Inc.** networks are available statewide to members

Louisiana

HMO Louisiana

We have a Provider Tidbit to help identify a member's applicable network when looking at the ID card. The Identification Card Guide is available online at **www.BCBSLA.com/providers**, then click on "Resources." Provider Tidbits can also be accessed through iLinkBlue under the "Resources" menu option.



HMO Point of Service Networks

Blue Connect

New Orleans area

Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes

Lafayette area

Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

Shreveport area

Bossier and Caddo parishes

Community Blue

Baton Rouge area

Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Effective January 1, 2018, this product is no longer offered for new sales in Bossier and Caddo parishes

Signature Blue

New Orleans area

Jefferson and Orleans parishes

Blue Advantage (HMO) Network

Blue Advantage (HMO) is our Medicare Advantage product currently available to seniors in 30 parishes.

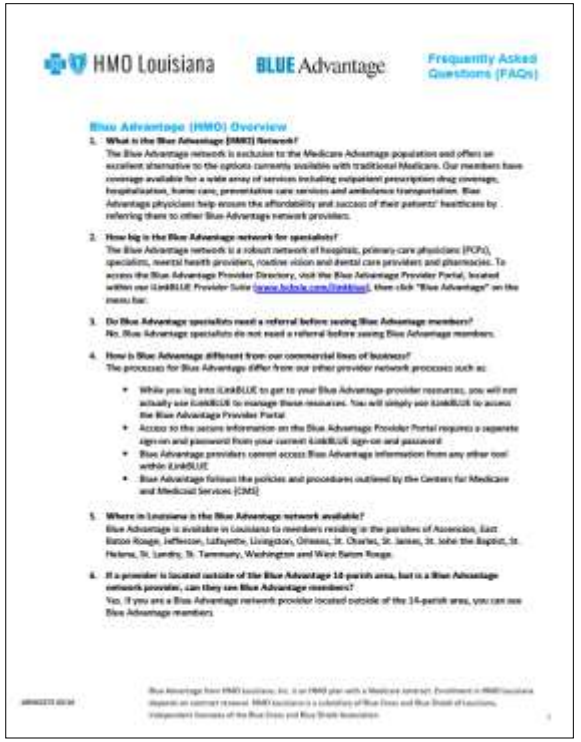
Blue Advantage Parishes

- Acadia
- Ascension
- Assumption
- East Baton Rouge
- East Feliciana
- Evangeline
- Iberia
- Iberville
- Jefferson
- Lafayette
- Lafourche
- Livingston
- Orleans
- Plaquemines
- Pointe Coupee
- St. Bernard
- St. Charles
- St. Helena
- St. James
- St. John the Baptist
- St. Landry
- St. Martin
- St. Mary
- St. Tammany
- Tangipahoa
- Terrebonne
- Vermilion
- Washington
- West Baton Rouge
- West Feliciana

Blue Advantage FAQs

Blue Advantage Frequently Asked Questions (FAQs) give you:

- A better understanding of the Blue Advantage network
- Key information on what Blue Advantage offers
- Requirements of Blue Advantage network providers



HMO Louisiana BLUE Advantage Frequently Asked Questions (FAQs)

Blue Advantage (HMO) Overview

1. **What is the Blue Advantage (HMO) Network?**
   The Blue Advantage network is exclusive to the Medicare Advantage population and offers an excellent alternative to the options currently available with traditional Medicare. Our members have coverage available for a wide array of services including outpatient prescription drug coverage, hospitalization, home care, preventative care services and ambulance transportation. Blue Advantage physicians help ensure the affordability and success of their patients' healthcare by referring them to other Blue Advantage network providers.
2. **How big is the Blue Advantage network for specialists?**
   The Blue Advantage network is a robust network of hospitals, primary care physicians (PCPs), specialists, mental health providers, routine vision and dental care providers and pharmacies. To access the Blue Advantage Provider Directory, visit the Blue Advantage Provider Portal, located within our iLinkBLUE Provider Suite (www.bcbsla.com/ilinkblue), then click "Blue Advantage" on the menu bar.
3. **Do Blue Advantage specialists need a referral before seeing Blue Advantage members?**
   No. Blue Advantage specialists do not need a referral before seeing Blue Advantage members.
4. **How is Blue Advantage different from our commercial lines of business?**
   The processes for Blue Advantage differ from our other provider network processes such as:
   - While you log into iLinkBLUE to get to your Blue Advantage provider resources, you will not actually use iLinkBLUE to manage these resources. You will simply use iLinkBLUE to access the Blue Advantage Provider Portal.
   - Access to the secure information on the Blue Advantage Provider Portal requires a separate sign-on and password from your current iLinkBLUE sign-on and password.
   - Blue Advantage providers cannot access Blue Advantage information from any other tool within iLinkBLUE.
   - Blue Advantage follows the policies and procedures outlined by the Centers for Medicare and Medicaid Services (CMS).
5. **Where in Louisiana is the Blue Advantage network available?**
   Blue Advantage is available in Louisiana to members residing in the parishes of Ascension, East Baton Rouge, Jefferson, Lafayette, Livingston, Orleans, St. Charles, St. James, St. John the Baptist, St. Helena, St. Landry, St. Tammany, Washington and West Baton Rouge.
6. **If a provider is located outside of the Blue Advantage 10-parish area, but is a Blue Advantage network provider, can they see Blue Advantage members?**
   Yes. If you are a Blue Advantage network provider located outside of the 14-parish area, you can see Blue Advantage members.

This document is available on the Blue Advantage Provider Portal, accessed through iLinkBlue at **www.BCBSLA.com/ilinkblue**

Blue Card® Program

- BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain healthcare services while traveling or living in another BCBS Plan service area.
- The main identifiers for BlueCard members are the prefix and the "suitcase" logo on the member ID card. The suitcase logo provides the following information about the member:

- The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic

- The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product

- The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product

National Alliance

(South Carolina Partnership Cases)

- National Alliance groups are administered through BCBSLA's partnership agreement with Blue Cross and Blue Shield of South Carolina (BCBSSC)
- BCBSLA taglines are present on the member ID cards; however, customer service, provider service and precertification are handled by BCBSSC
- Claims are processed through the BlueCard® program

Included in your folder is a list of member prefixes for our policies that are handled directly through the National Alliance program.

NEW

Member ID Prefixes

- As of April 15, 2018, providers may see prefixes on member ID cards that contain numeric characters
- Due to growth in the number of products being sold by Blue Cross companies nationwide, the Blue Cross Blue Shield Association has determined the need to expand the prefixes to be alpha-numeric
- Prefixes can be alpha only or a combination of alpha and numeric characters in one of the following combinations
- The prefix is the first three characters of the member number that appears on the member ID card. It is required for claims processing and is critical for member eligibility and benefit inquiries. The prefix identifies which Blue Plan and product the member has.

Example:

A2A	2AA	22A
AA2	2A2	A22

Medical Documentation

Benefits of Proper Documentation

- Allows identification of high-risk patients
- Allows opportunities to engage patients in care management programs and care prevention initiatives
- Reduces the administrative burden of medical record requests and adjusting claims for both the provider and Blue Cross
- Reduces costs associated with submitting corrected claims

Provider's Role in Documenting

Accuracy and specificity in medical record documentation and coding is critical in creating a complete clinical profile of each individual patient

- Each page of the patient's medical records should include the following for a face-to-face visit:
  - Patient name
  - Date of birth or other unique identifier
  - Date of service including the year
- Provider signature (must be legible and include credentials)
- Report ALL applicable diagnoses on claims and report at the highest level of specificity (CMS-1500 claim forms can accommodate up to 12 diagnosis codes)
- Include all related diagnoses, including chronic conditions you are treating the member for
- Medical records **must support ALL** diagnosis codes on claims

Common Errors

Common errors found in medical chart audits include:

- Illegible handwriting on paper charts
- Lack of chronic conditions included in documentation
- Lack of coding to the highest specificity
- Coding errors
- Lack of evidence of action taken for condition:
  - Condition noted in the problem list not supported in the exam
  - Monitored, Evaluated, Assessed or Treated should be noted
- Lack of clarification of whether a condition is chronic or acute
- No reference to a condition as controlled or uncontrolled
- Lack of identification for the type of diabetes
- Not documenting cause and effect relationships:
  - Notes will say Diabetes Type II and CKD Stage III; but if stated "CKD III Due to Diabetes" results in a different ICD-10 Code

Medical Record Requests

From time to time, you may receive a medical record request from us or one of our vendors to perform medical record chart audits on our behalf

- Per your Blue Cross network agreement, providers are not to charge a fee for providing medical records to Blue Cross or agencies acting on our behalf
- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a charge
- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews
- The patient's Blue Cross subscriber contract allows for the release of the information to Blue Cross or its designee

Some of the vendors Blue Cross is currently partnered with to assist us in conducting medical record reviews

- Centauri
- Health Data Vision, Inc. (HDVI)
- Inovalon
- Varis

Commercial Diagnostic Accuracy and Completion (DAC)

Commercial Diagnostic Accuracy and Completion (DAC) is a component of the Affordable Care Act (ACA)

- Encourages health plans to focus on quality improvements, efficiency and stabilization of premiums
- DAC uses diagnosis codes reported on claims to determine the disease state or illness burden (overall health) of a patient, which allows CMS to assign a risk score to each patient
- DAC medical record requests typically begin in October

Blue Cross is currently partnered with Health Data Vision, Inc. (HDVI), for in-state and Inovalon for out-of-state, to conduct DAC medical record requests

Commercial Risk Scores

Since risk scores are recalculated every year, diagnosis codes for all conditions must be documented by a provider every year

- Adhere to the proper documentation practices outlined on slide 19 of this presentation
- Blue Cross identifies those members with potential diagnostic gaps by review of claims data
- Diagnostic gaps are identified through:
  - History: prior year Dx
  - Pharmacy: prescribed medication
  - Diagnostic: lab or diagnostic test
  - Other: diagnosis with potential co-existing condition

Risk Adjustment Data Validation (RADV) Audits

Required through the ACA, framework for the risk adjustment data validation (RADV) audit process for the risk adjustment program was established

- Required audit for every insurer who sells a policy on the ACA marketplace
  - Will be used to confirm risk reported
  - To confirm providers' medical records substantiate the reported data and accurately reflect the care rendered and billed
- The Accountable Care Law mandates medical records be provided
- RADV audit requests for medical records typically begin in late July

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of healthcare performance measures developed by the National Committee for Quality Assurance (NCQA) and used by Centers for Medicare & Medicaid Services (CMS) for monitoring managed care organizations

- A subset of HEDIS measures will be collected and reported for the Marketplace (healthcare exchanges) product lines
- HEDIS results measure performance, help us to identify quality initiatives and lead us in the development of educational programs for providers and members
- HEDIS data is collected through:
  - Administrative data (claims only)
  - Hybrid data (claims data and medical record review)
  - Survey data (member and provider surveys)

Blue Cross has partnered with Health Data Vision, Inc. (HDVI) and Inovalon to conduct medical record reviews in 2018

Healthcare Effectiveness Data and Information Set (HEDIS)

- Adhere to the proper documentation practices outlined on slide 19 of this presentation
- Provide medical records upon request during the HEDIS process to help us validate the quality of care provided to our members

- Medical record requests are faxed to providers and include a member list that indicates their assigned measures and the minimum necessary information needed
- HEDIS data is collected and reviewed from February to May
- Under the HIPAA Privacy Rule, data collection for HEDIS is permitted, and release of this information requires no special patient consent or authorization
- We appreciate your cooperation in sending the requested medical record information promptly (ideally in 5 to 7 business days)

Improving Quality of Care (HEDIS®)

- Please share this information with your quality, case and disease management departments

- You can help improve quality of care by:
  - Encouraging patients to schedule preventive exams
  - Reminding patients to follow up with ordered tests and procedures
  - Making sure necessary services are being performed in a timely manner
  - Submitting claims with proper codes
  - Accurately documenting all services and results (if appropriate) in the patient's medical chart

We need to work together to improve and maintain higher quality of care. When our members are healthy, everyone benefits.

Questions related to HEDIS?

Please contact the Health and Quality Department: QualityBlue@bcbsla.com

2018 HEDIS Measurements

Controlling High Blood Pressure (CBP)
The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg

Plan All-cause Readmission (PCR)
For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

2018 HEDIS Measurements

Use of Imaging Studies for Low Back Pain (LBP)
The percentage of members ages 18-50 with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

Adult Access to Preventive/Ambulatory Health Services (AAP)
The percentage of members 20 years and older who had an ambulatory or preventive care visit:

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year

Controlling High Blood Pressure (CBP)

- **Challenge/Risk:** Uncontrolled blood pressure increases the risk of heart attacks, heart failure, stroke and kidney disease. The Centers for Disease Control and Prevention (CDC) reports heart disease as the leading cause of death in the United States.
- **Tips/Best Practices for providers:**
  - Positioning: have the patient sit quietly with feet on the floor, back supported and arm at heart level. Utilize the most appropriate cuff size.
  - Take two BP readings during the visit, one at the start of the visit and one at the end of the visit when systolic BP is greater than 140 and when diastolic BP is greater than 90 (HEDIS allows use of the lowest systolic and lowest diastolic reading taken on the same day as a representative BP)
  - Remind patients with hypertension about the importance of taking prescribed medication
  - Encourage and educate patients with hypertension on low-sodium diets
  - Encourage increased physical activity
  - Send reminders by text, email, postcard or calls to contact members who need a follow-up/annual exam prior to the end of the year (for HEDIS, the last BP reading of the measurement year is what is utilized to determine blood pressure control)
  - Ensure calibration of office BP cuffs and assist patients with calibration of home cuffs to ensure accuracy of home monitoring

Plan All-cause Readmission (PCR)

AHRQ's Hospital Guide to Reducing Readmissions

Reduce hospital-wide readmissions by 20%

- **Intervene in ED prior to re(admit)**
  - Real-time identification
  - ED staff available to coordinate
  - Use of individualized care plans
- **Reliably deliver inpatient transition of care services**
  - Conduct needs assessment
  - Engage caregiver/"learner"
  - Use customized instructions & teach-back
  - Arrange for follow-up services
- **Provider or link to transitional care services**
  - Follow-up phone calls
  - Bedside delivery of medications
  - Time-limited transitional care
  - Links to community support
- **Develop cross-setting partnerships, norms and protocols**
  - Monthly cross-continuum meetings
  - Cross-setting readmission reviews
  - Warm handoffs, "receive" oriented
  - Shared use of common tools, e.g. INTERACT

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/medicaidreadmissions.pdf

Low Back Pain

Conservative Treatment First 28 Days*

- Stay Active
- Use heat
- Take Over the Counter Medications
- Sleep on side or back
- Talk to a doctor for short-term pain medication and follow-up again if pain not relieved
- Other treatments such as physical therapy, chiropractic care, acupuncture, yoga, massage, cognitive-behavioral therapy, progressive muscle relaxation (plans vary with coverage of these benefits)

In cases where red flags are identified—such as weight loss that cannot be explained, fever over 102° F, loss of control of bowel or bladder, loss of feeling or strength in legs, problems with reflexes, and a history of cancer are present—imaging may be warranted within the first 28 days of diagnosis.* Consider coding the red flag diagnosis as primary rather than low back pain when they are present.

*Choose Wisely Initiative

Avoidance of Antibiotics in Adults with Acute Bronchitis (AAB)

- **Challenge:** Managing the patient's expectation of receiving a prescription for an antibiotic
- **Goal:** Avoid prescribing antibiotics for patients with a diagnosis of acute bronchitis without a competing diagnosis or comorbidity. Code comorbid condition or bacterial condition when present.
- **Risk:** Inappropriate use of antibiotics is the single most important factor in antibiotic resistance, C-Difficile and yeast infections
- **Interventions:**
  - Education and communication are important in managing patient expectations for medications to treat acute bronchitis symptoms
  - Careful word selection such as defining the diagnosis as a chest cold or "viral upper respiratory infection" along with offering at home treatments can also be helpful
  - Setting realistic expectations for symptom duration (cough may last about 3 weeks) gives the patient a better understanding of the disease process

Adult Access to Preventive Ambulatory Health Services (AAP)

Complete physical exam, including but not limited to: height, weight, BMI, vital signs, history & physical, review of systems, age appropriate screening tests, immunizations administered, all anticipatory guidance given, including but not limited to the following topics:

- Smoking cessation
- Avoiding alcohol and/or drugs
- Diet and nutrition
- The importance of safety belts
- Smoke detectors
- Fall prevention
- Regular dental visits/dental care
- Physical activity/fitness

Possible Interventions to Help Your Practice:

- Send reminders by text, email, postcard or calls to contact members who need an annual exam soon or new to your practice
- If you use an electronic medical record (EMR), create a flag to track members due for an upcoming preventive screening and contact them
- If you do not use an EMR, create a manual tracking method
- Complete annual health checks during sick visits; these may be missed opportunities for screenings
- Consider offering office hours into the evening, early morning or weekends to accommodate working adults

Effective primary care will provide the foundation to improve patient satisfaction and healthcare quality while reducing healthcare costs. At Blue Cross, we encourage our members to establish and maintain a relationship with a primary care provider to promote consistent and coordinated healthcare.

Billing & Claims

NEW

Chiropractic & Therapy Guidelines

- We recently made significant changes to the billing guidelines for chiropractic and therapy services
- These changes include:
  - Multiple procedure reductions
  - Bundling of hot and cold packs as well as other supplies
  - Direct patient contact requirements
  - Guidelines for timed and untimed services
  - Bundling re-evaluation codes to therapy services
  - Manual and massage therapy guidelines for chiropractic care
- For more information, see our *Professional Provider Office Manual* at **www.BCBSLA.com/providers**, then click on "Resources"

Multiple Procedure Reduction

Effective March 1, 2018, **CPT® codes 98940-98943 were added to the list of services eligible for multiple procedure reduction** when billed on the same day as codes 64550, 95831-95852, 97010-97160, 97169-97799 and G0283

If services are provided by providers in different specialties (i.e. physical therapist and occupational therapist), the multiple procedure reduction applies separately for each provider specialty

Multiple Service Reduction for Diagnostic Imaging Services

Blue Cross added multiple service reduction logic to diagnostic imaging radiology services performed for the same patient encounter:

- For professional providers, the multiple service reduction applies to the technical component of diagnostic imaging radiology services. When more than one radiology service from Medicare's diagnostic imaging family grouping is performed for the same patient encounter:
  - The technical component allowable charge for the primary radiology service is paid at 100% of the allowable charge
  - The technical component for second and subsequent services is reduced by 50%
  - The primary radiology service will be identified as the code with the highest technical component allowable charge

Applicable radiology services are identified by Medicare's diagnostic imaging family groupings as published in the *CMS National Physician Fee Schedule Relative Value File*

Global Days

- We no longer maintain a list of global days
- We now follow CMS' global day logic (except 90-day logic)
- Please refer to CMS' global days list

Example:

CMS	BCBSLA
Zero day	Zero day
10 day	10 day
90 day	45 day

UPDATED TIDBIT

Medicare Crossover Claims

- Medicare crossovers are electronically filed claims that Medicare automatically forwards or "crossover" to us when member information is available in the Medicare eligibility file
- This process includes claims where **Medicare is primary and Blue Cross and Blue Shield of Louisiana is secondary**

For more information, refer to the Medicare Crossover Claims Tidbit (**www.BCBSLA.com/providers** >Resources >Tidbits)

Member Screening Benefits

The following product enhancements are effective January 1, 2018 (and as policies renew):

Colorectal Cancer Screening

- We will cover first dollar wellness benefits for colorectal cancer (CRC) screenings (stool based tests, colonoscopies, flexible sigmoidoscopies, Cologuard® and CT colonography) when services are rendered in network. Age and frequency limitations apply.
- Policies Affected: Grandfathered fully-insured group and individual policies. Optional for grandfathered self-insured group polices.

Physician Assistant Copayment

- Office copayment (as available) will apply for physician assistant services rendered in the office
- Policies Affected: Grandfathered and non-grandfathered fully-insured group and individual policies. Optional for self-funded policies.

Refer to our 2017 4th quarter Network News for additional product enhancements, available online at **www.BCBSLA.com/providers** >Newsletters >Past Newsletters

Physician Assistant Billing

- Physician assistants (PAs) who are part of our network must submit claims for their services directly to Blue Cross using their individual NPI
- Physician assistants should use Modifier AS when billing for surgical assistant services. Modifier AS reimbursement pays at 20% of the physician assistant allowable charges.

Incident-to Billing

Blue Cross follows CMS Incident-to Guidelines

"Incident-to" means services must be furnished as an integral, although incidental, part of a physician's personal professional services in the course of diagnosis or treatment of an injury or illness

Requirements to be considered incident-to:

- Service provided must be reasonable and medically necessary
- Service must be within the practitioner's scope of practice
- Service must be performed in collaboration with a physician
- Supervising physician must be physically present in the same office and be available to render assistance if necessary
- Office must have identifiable boundaries when part of another facility and services must be furnished within those boundaries; where this office is one room, the physician must be in it to supervise
- Physician's service reflects active participation in and management of course of treatment
- The professional identity of the staff furnishing the service must be documented and legible; a counter signature alone is not sufficient to show that the incident-to requirements have been met

CPT Category II

- Blue Cross does not reimburse separately for certain codes such as, CPT Category II codes and most HCPCS Documentation, Measurement and Demonstration codes
- These codes should not be used as a substitute for any services, unless otherwise instructed by Blue Cross

Sleep Studies

Home Sleep Studies

- Blue Cross covers home sleep studies for members age 18 and older
- When benefits are available, an authorization is NOT required for home sleep studies. *Note: Authorization may be required for some self-funded groups. Always verify the member's benefits prior to rendering services*
- Home sleep study claims should be billed with HCPCS code G0398 or G0399. We will not accept HCPCS code G0400 (3 channels or less)
- Always refer members to network providers that perform home sleep studies

Facility Studies

- Blue Cross will not cover facility-based sleep studies when performed by a facility that is not specifically accredited to perform sleep studies
- Blue Cross will not cover facility-based sleep studies when the member meets the criteria to have a home sleep study instead
- An authorization is required for facility-based sleep studies

Current patient selection criteria for home and facility sleep studies are addressed in Blue Cross' medical policy for the **Medical Management of Obstructive Sleep Apnea Syndrome** (policy no. 00328)

For more information about these guidelines, see our *Professional Provider Office Manual* at **www.BCBSLA.com/providers** >Resources

Subrogation

Subrogation allows healthcare insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party. All claims submitted to Blue Cross must indicate if work-related injuries or illnesses are involved and if the services are related to an accident

Providers should:

- Not require the Blue Cross member or the member's attorney to guarantee payment of the entire billed charge
- Not require the Blue Cross member to pay the entire billed charge up front
- Not bill the Blue Cross member for amounts above the reimbursement amount/allowable charge
- Charge the member no more than is ordinarily charged other patients for the same or similar service
- Bill the member only for any applicable deductible, coinsurance, copayment and/or non-covered service

If amounts in excess of the allowable charge are collected, once identified you have 30 days to refund that amount to the member

Note: In the case of OGB claims, Blue Cross pursues recovery of claims payments and makes payments as applicable

Telemedicine

- Reimbursement for telemedicine services may be available when provided through BlueCare (our telemedicine platform) or when provided by a network physician or nurse practitioner utilizing their own telemedicine platform
- The appropriate place of service is **based on where the member is located** when the service is performed (typically, POS for home)
- The following are examples of services that are not eligible for reimbursement as telemedicine services:
  - Non-direct patient services (e.g. coordination of care rendered before or after patient interaction)
  - Services rendered by audio-only telephone communication, facsimile, email, text or any other non-secure electronic communication
  - Any services that are not eligible for separate reimbursement when rendered to the patient in person
  - Presentation/origination site facility fee
  - Services/codes that are not specifically listed in your provider manual

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

BlueCare Telehealth Services

- BlueCare is our first direct-to-consumer telehealth platform designed to let members have online doctor visits using a computer, laptop, tablet, smartphone or other internet-accessible device
- Telemedicine services through BlueCare or BCBSLA network providers are a benefit for all fully insured group and individual members. ASO groups can choose to offer telemedicine benefits to their covered members.
- BlueCare offers patients a wraparound service to supplement the care delivered in your office and can help avoid unnecessary after-hours care in an emergency room or urgent care
- BlueCare is for direct member-to-physician telehealth services. These services and related codes are detailed in the provider manual. Non-direct services, like coordination of care, are not eligible.

BlueCare Telehealth Services

- **How do my patients use BlueCare?**
  - BlueCare is at **www.BlueCareLA.com**. Patients need an internet-accessible device with audiovisual capability
  - Smartphone or tablet users can download the "BlueCare" app in the Apple App Store or Google Play
- **What kind of visits will my patients have with doctors on BlueCare?**
  - The patient and doctor will have an audiovisual "virtual encounter" office visit. Treatment and/or medicine may be prescribed if appropriate, and the BlueCare doctor may also recommend follow-up care.
  - To promote continuity of care, the patient can access records of each encounter and can share them or request that the BlueCare doctor email the record to the patient's primary care provider

Timely Filing

- **Blue Cross, HMO Louisiana, Blue Connect, Community Blue & Signature Blue:**
  - Claims must be filed within 15 months of date of service
- **FEP:**
  - Claims must be filed by December 31 of the following year after the service was rendered
- **Blue Advantage:**
  - 12 months from the date of service to file an initial claim
  - 12 months from the date the claim was processed (remit date) to resubmit or correct the claim
- **OGB:**
  - Claim must be filed within 12 months of the date of service
- **Self-insured & BlueCard®:**
  - Timely filing standards may vary so always verify the member's benefits, including timely filing standards, through iLinkBlue

For claims received after timely filing deadline and/or denied claims, member & Blue Cross are held harmless

Resolving Claims Issues

Submit an Action Request through iLinkBlue (**www.BCBSLA.com/ilinkblue**) or contact the Customer Care Center at 1-800-922-8866

- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 working days for first request
- Check iLinkBlue for a claims resolution
- Submit a second request for a review
- Allow 10-15 working days for second request

When to Contact Provider Relations for Claims Help

You may email an overview of the issue along with your two reference numbers to **provider.relations@bcbsla.com** if one of the following applies:

- You have made at least two attempts to have your claims reprocessed and have been issued two separate call reference numbers by the Customer Care Center allowing 10-15 business days after second claim attempt, or
- It is a system issue affecting multiple claims

Modifier 22

Increased Procedural Services

- When the work required to provide a service is substantially greater than typically required, it may be identified by adding Modifier 22 to the usual procedure code. Documentation must support both the substantial additional work and the reason for the additional work (ie, **what were the factors that demanded or lead to increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required**).

Note: This modifier should not be appended to an E&M, anesthesia, pathology or radiology service

Level of Office Visit for E&M Services

In a recent review of claims billed, a trend of Evaluation and Management (E&M) codes being billed at higher levels was identified

- When billing for any procedure, your medical records must prove medical necessity. In addition, for E&M codes 99201-99215, the required components of the level of service coded must also be documented in the medical record.
- The correct code for an E&M visit should be chosen based on the complexity of the visit
- This is determined by the extent of history and examination required to determine a diagnosis and the complexity of medical decision making as documented in the record
- **Medical decision making** should be the **key component** used to select the level of E&M code
- Complexity of medical decision making is based on number of problems treated, amount of data reviewed, and risk of associated management decisions
- Upon audit, providers found to have a lack of medical decision making documented in the medical record, for the billed E&M services, will be contacted and risk recoupment of all overpaid amounts
- Providers must follow 1995 or 1997 documentation guidelines for coding all E&M services
- For your convenience, these guidelines can be found at the CMS website: **www.cms.gov**

Pharmacy

Closed Formulary

- The change began **January 1, 2017**
- Blue Cross has a list of covered drugs—or closed formulary—to support safe, effective, lower-cost drugs
- The closed formulary drug list includes thousands of generic and brand drugs identified by independent Louisiana doctors and pharmacists, along with input from Blue Cross clinical staff
- Please check to see if a drug is covered before prescribing it
- Key Changes to Drug Coverage include:
  - Non-formulary drugs will not be covered
  - Select drugs with over-the-counter options will not be covered
  - Select drug kits that include or are packaged with a non-prescription product will not be covered, but the prescription drug may be covered when purchased alone

You and your patients can check the 2018 Covered Drug List and find up-to-date information about drug coverage at **www.BCBSLA.com/covereddrugs**

Formulary Exceptions

- You may ask for an exception if your patient has a medically necessary need for a non-formulary drug
- Formulary exceptions will be similar to the prior authorization process, which is explained at **www.BCBSLA.com/providers** >Pharmacy >Drug Authorization

Coverage eligibility for non-formulary drugs that do NOT have a dedicated medical policy are addressed in Blue Cross' medical policy no. 00543 for the **Formulary Exception Process/Non-Formulary Drug Review Process Standard Criteria (Closed Formulary)**. Medical policies are available through iLinkBlue.

NDC Billing Guidelines

Use the following billing guidelines to report required NDCs on professional CMS-1500 claims and outpatient facility UB-04 claims:

- NDC code editing will apply to any clinician-administered drugs billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter "A").
- Each clinician-administered drug must be billed on a separate line item
- Claims that do not meet the requirements will be rejected and returned on your "Not Accepted" report. Units indicated would be "1" or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs
- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim:
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

Failure to report NDCs on claims will result in automatic rejections

Reporting NDCs on Professional Claims

Electronic Clearinghouse Claims 837

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

Hard Copy Claims

On the CMS-1500 claim form, report the NDC in the shaded area of Box 24A. We follow the CMS guidelines when reporting the NDC. NDCs should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g. N49999999999. The drug quantity and measurement/qualifier should be included.

iLinkBlue Claims Entry (Professional Only)

Select 24K to expand the claim line to report the NDC, Quantity and Measurement:

- NDC Code Field: Enter the 11-digit NDC code. No alpha characters, spaces or hyphens can be present
- Quantity: Numeric value of quantity
- Measurement: Select the appropriate measurement from the drop down menu
  - F2 – International Unit
  - GR – Gram
  - ME – Milligram
  - ML – Milliliter
  - UN – Unit

NDC Reporting Clarification

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format.

How should the NDC be entered on the claim? See the examples below:

10-Digit Format on Package	10-Digit Label Format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-22	5-4-2	09999-9999-99
5-3-2	99999-999-99	5-4-2	99999-0999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-09

If the NDC is not submitted in the correct format, the claim will reject

CII and CIII Opioid Coverage Policy

#6	Louisiana has the 6th highest opioid prescription per capita rate, making the state 1 of only 8 that have more opioid prescriptions dispensed in a year than they have residents.
861	More than 800 Louisiana residents died from opioid overdoses, both prescription and illicit, in 2015. From 2014 to 2015, opioid overdoses increased by 12% in the state, according to the Louisiana Department of Health.
2M	In 2015, 20.5 million Americans 12 or older had a substance use disorder. Two million of them had a substance use disorder involving prescription pain relievers.

New Opioid Louisiana Laws in Effect

Among the bills that the Louisiana legislature passed during the 2017 Regular Session that addressed the opioid epidemic in Louisiana were 2 that affect prescribing:

Act 82 (House Bill 192)

- Effective August 1, 2017, implements a 7-day prescription limit for first-time fills on opioid drugs to treat pain. The bill exempts the limit for people with certain conditions like cancer or chronic pain, and allows doctors to override the limit in certain cases, such as for medical necessity.

Act 76 (Senate Bill 55)

- Provisions effective beginning January 1, 2018, tightens Louisiana's Prescription Monitoring Program, which is a database doctors and pharmacists can check to make sure patients do not have dispensing records that indicate potential abuse. The law requires healthcare providers to check the database before prescribing opioids to a patient and recheck it every 90 days, if the prescription continues beyond that period.

References: The Associated Press | The Center for Public Integrity | American Society of Addictions Medicine | National Safety Council

Prescribing Opioids

3.7%	Opioids account for 3.7% of prescription claims
21%	21% of members with our pharmacy benefits had at least one claim for an opioid prescription in 2016
94%	94% of opioid prescriptions are for short-acting opioids
	Top prescribing specialties include (in no particular order): primary care specialties, pain management, orthopedists, dentists/oral surgeons and others

Based on Blue Cross 2016 Claims Data. Excludes opioids prescribed by oncologists.

NEW

2018 Opioid Policy

In order to set appropriate coverage guidelines, Blue Cross developed this policy after considering a breadth of:

- clinical guidelines
- industry best practices
- state regulatory requirements
- our own member population

The policy:

- places safety edits for acetaminophen, ibuprofen and aspirin on all short-acting opioid prescriptions
- requires prior authorization for short-acting opioids more than a certain days' supply, within a set period of time
- requires prior authorization for new users of long-acting opioids
- provides certain exceptions or adjusted limitations for existing users within a set time and members with cancer or receiving end-of-life care based on claims history and/or provider information

NEW

2018 Opioid Policy Goals

Our Goals

- Decrease the amount of opioids in the community
- Minimize the number of patients becoming chronic opioid users

NEW

2018 Opioid Policy

DRUG CLASS	POLICY
ACETAMINOPHEN (TYLENOL) SAFETY EDIT	▪ Limits all Tylenol® containing medications to 3 grams or less of Tylenol per day ▪ No exceptions ▪ Applies to opioid and non-opioid drugs
IBUPROFEN SAFETY EDIT	▪ Limits all ibuprofen/short-acting opioid combination medications to 5 tabs or less per day ▪ No exceptions
ASPIRIN SAFETY EDIT	▪ Limits all aspirin/short-acting opioid combination medications to 4 grams or less of aspirin per day ▪ No exceptions
SHORT-ACTING OPIOIDS (examples: Percocet® and generics, Lortab® and generics, codeine, oxycodone)	▪ Prior authorization required for fills longer than 7-day supply ▪ Prior authorization required for fills longer than 21-day supply within 60 days' time ▪ Existing users who filled short-acting opioid prescriptions in the previous 130 days will be grandfathered ▪ Certain exceptions will apply for members with cancer or receiving end-of-life care based on claims history and/or provider information
LONG-ACTING OPIOIDS (examples: Butrans®, fentanyl patch, OxyContin®, MS Contin®, morphine ER, oxycodone ER)	▪ Prior authorization required for new users ▪ Existing users who filled long-acting opioid prescriptions in the previous 130 days will be grandfathered ▪ Certain exceptions will apply for members with cancer or receiving end-of-life care based on claims history and/or provider information

Opioid Prescribing Toolkit

- The toolkit and coverage policy were developed by Blue Cross clinical pharmacists and physicians and approved by its Pharmacy and Therapeutics Committee, a group of Louisiana doctors and pharmacists who guide coverage decisions
- The resources were compiled from a number of sources including the Louisiana Department of Health, Centers for Disease Control and Prevention (CDC) and others

The toolkit can be found at **www.BCBSLA.com/providers** >Pharmacy

Opioid Prescribing Toolkit

The toolkit includes a compilation of best practices to plan and execute various tactics to help you and your patients manage pain safely and reduce risk. The toolkit includes:

- Drug Alert: Blue Cross Opioid Coverage Policy
- CDC Guidelines for Prescribing Opioids for Chronic Pain
- CDC Assessing Benefits and Harms of Opioid Therapy
- Opioid Screening Risk Assessment Tool and Opioid Safety Survey
- Sample Treatment Plan Outline, Definitions and Agreement
- Sample Pain Treatment with Opioid Medications Patient Agreement
- Louisiana Prescription Monitoring Program (PMP) Overview
- Behavioral Health Services Information from New Directions
- Prescription Drug Safety Saves Lives Patient Information

Referrals

Member Referrals

Network providers should ALWAYS refer members to CONTRACTED providers

- Referrals to out-of-network providers result in significantly higher cost-shares to our members and it is a breach of your Blue Cross provider contract
- Providers who consistently refer to out-of-network providers will be audited and may be subject to a REDUCTION in their network reimbursement

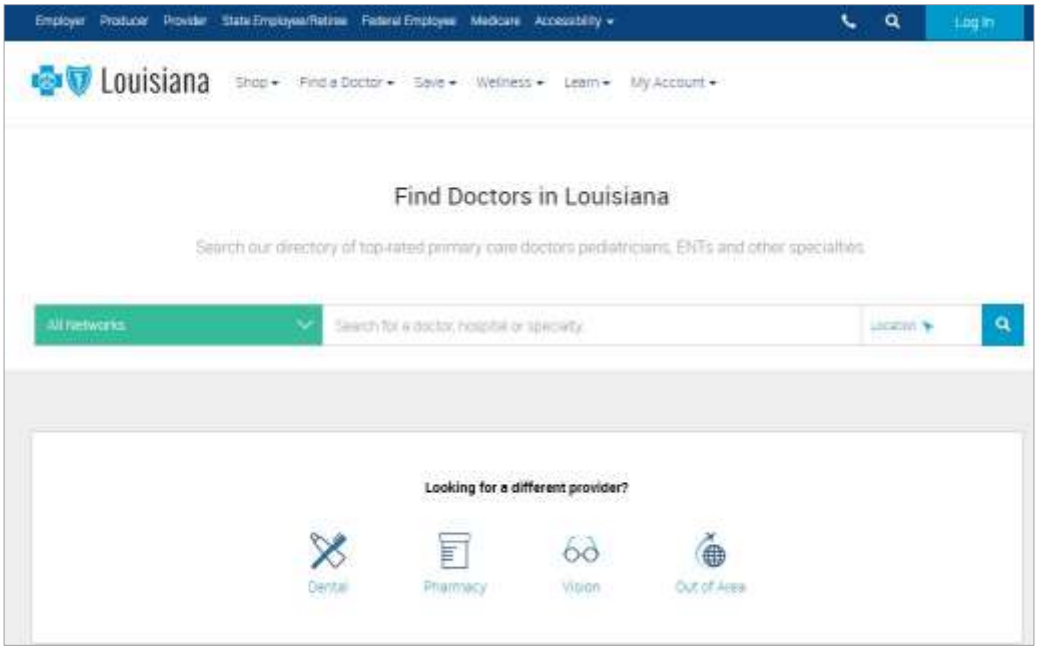
Out-of-network Referrals

The impact on your patients when you refer Blue Cross members to out-of-network providers:

- Out-of-network member benefits often include higher copayments, coinsurances and deductibles
- Some members may have no benefits for services provided by non-participating providers
- Non-participating providers can balance bill the member for all amounts not paid by Blue Cross

Finding Participating Providers

You can find network providers to refer members to in our online provider directories at **www.BCBSLA.com** >Find a Doctor



Laboratory Referrals

- All of our network providers should refer members to preferred reference lab vendors when lab services are needed and are not performed in your office
- If you perform laboratory testing procedures in your office, we require a copy of your Clinical Laboratory Improvement Act (CLIA) certification
- HMO Louisiana, Blue Connect, Community Blue and Signature Blue physicians may perform a selection of lab tests from our In-office Lab List

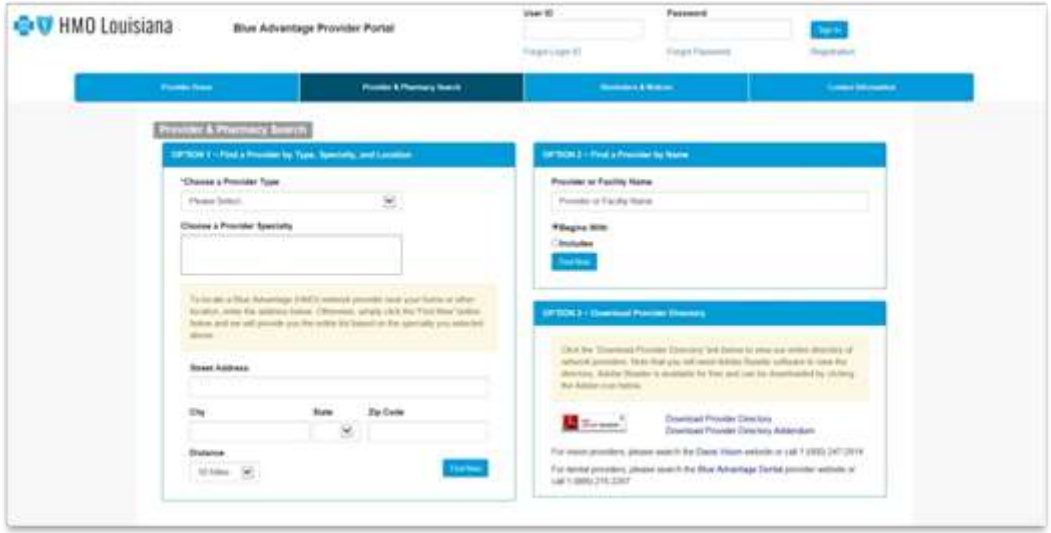
The ordering/referring provider NPI is required on all laboratory claims. Place the NPI in the indicated blocks:

- CMS-1500: Block 17B
- 837P: 2310A loop, using the NM1 segment and the qualifier of DN in the NM101 element

The In-office Lab List is in our network speed guides, available online at **www.BCBSLA.com/providers** >Resources

Finding Blue Advantage (HMO) Providers & Lab Services

To refer Blue Advantage (HMO) members to other providers, use the "Provider & Pharmacy Search" feature of the Blue Advantage Provider Portal (accessed through iLinkBlue)



Preferred laboratories for all specimens for the Blue Advantage network

- Clinical Pathology Labs (CPL)
- Quest Diagnostics
- Lab Corp

Quality Blue Programs

Quality Blue Primary Care (QBPC)

- We have implemented a cost-savings incentive for members when services are performed by a QBPC provider
- Blue Cross reduces the member's office copayment for office visits with a QBPC-enrolled primary care doctor (this benefit applies for office visits with a nurse practitioner who works with the enrolled primary care doctor)
- We have a newer QBPC claims-based program that is also included under the QBPC umbrella and the reduced copay benefit
- To determine a member's QBPC cost share, visit iLinkBlue (**www.BCBSLA.com/ilinkblue**)

How do doctors become part of QBPC?

- We target network primary care physicians—family medicine, internal medicine, geriatricians or general practice
- Providers enrolled in QBPC have their performance measured against established program clinical quality and efficiency measures
- To learn more about the QBPC Program, visit **www.BCBSLA.com/QBPC**

Blue Distinction Specialty Care

- Blue Distinction Specialty Care Centers are part of a national designation program that recognizes facilities demonstrating expertise in delivering quality specialty care, safely and effectively. These designations are only awarded to the specific facility and specific location.
- Two designation levels:

Blue Distinction® Center

Blue Distinction® Center+

The list of Blue Distinction Centers is available online at **www.BCBSLA.com/providers** >Programs >Quality Blue >Blue Distinction

Blue Distinction Level Comparison

Evaluation Criteria for Participation Focused on:	Blue Distinction® Center Healthcare facilities recognized for their **expertise** in delivering specialty care	Blue Distinction® Center+ Healthcare facilities recognized for their **expertise** and **efficiency** in delivering specialty care
Identifying those facilities that demonstrate **expertise in delivering quality specialty care** – safely and effectively	✓	✓
Nationally **established quality measures** with emphasis on **proven outcomes**	✓	✓
Cost of care calculated on procedures, using episode-based allowable amounts		✓

Specialty Care Insight Program

- Our Specialty Care Insight Program makes information about efficiency and effectiveness more transparent to specialty providers in our network
- Blue Cross provides reports to network physicians in the following specialties:
  - Cardiology
  - Gastroenterology
  - General Surgery
  - Obstetrics and Gynecology
  - Orthopedics
  - Otolaryngology (ENT)
  - Urology

Reports are mailed to providers biannually

- The Specialty Care Insight Report provides analytical data that allows practices to see how they compare to peers on cost of care and effectiveness (process measures for medical conditions that physicians in that specialty commonly treat) measures

Specialty Care Insight Program

- Blue Cross is sharing data from these reports with network primary care physicians enrolled in our Quality Blue Value Partnerships
- The overall effectiveness and efficiency data in these specialties for the seven practices to which that PCP practice most often refers patients will be shared
- Blue Cross is continuing to meet with the Louisiana societies and professional chapters for the specialties currently included in the Specialty Care Insight program to get ongoing feedback on the measures included in these reports
- For more information on the Specialty Care Insight initiative, visit **www.BCBSLA.com/SCI**
- If you have questions about the Specialty Care Insight Reports, contact Provider Relations at **provider.relations@bcbsla.com** or 1-800-716-2299, option 4

Care Management

Care Management Team

Blue Cross has a clinical care team of more than 200 doctors, nurses, dietitians, pharmacists and social workers to help our members achieve their health and wellness goals

Our care team supports your relationship with your patients (our members) and helps them stick to the treatment plans you recommend

In our Case and Disease Management programs:

- Patients get health coaching to help them stay on top of their health conditions, work toward wellness goals and practice good self-care between appointments
- Care is better coordinated between Blue Cross and your office, which helps improve quality and boost the patients' health outcomes
- The focus is on the whole person, using a proactive, patient-centered, population health improvement model that looks at each patient's individual needs, including health status and social determinants

Case Management Programs

Our Case Management programs work with your Blue Cross patients to develop and implement care plans to overcome or reduce barriers to getting needed care, focusing on boosting health outcomes and choosing cost-effective care

Case managers look for and work with members to address gaps in care, wellness opportunities or transitions

Current Case Management Programs:

- Transplant Care Management
- Healthy Blue Beginnings (high-risk pregnancy)
- Oncology Management
- Complex Case Management
- High Utilizers/High Cost (ER use, hospital discharge)
- Care Coordination

Disease Management Programs

Our Disease Management programs help improve the self-care and health of your Blue Cross patients with chronic health conditions

Our aim is to improve the physical and psycho-social well-being of Blue Cross members through cost-effective, personalized solutions that enable them to stick to the care plans recommended by their physicians

Current Disease Management Programs Offered:

- End Stage Renal Disease
- Chronic Kidney Disease 
- Congestive Heart Failure
- Diabetes 
- Pre-diabetes/metabolic syndrome
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease/Hypertension 
- Asthma

Some of these conditions are also targeted in our Quality Blue programs

If a member is eligible for more than one program, he or she gets assigned according to a hierarchy process to address the most urgent need first.

Quality Navigators

- As part of the Quality Blue programs, Blue Cross has clinical staff who serve as direct liaisons to the enrolled primary care practices
- These staff, called Quality Navigators, work with the practices to review their patients' records and identify gaps in care
- This lets Blue Cross and providers work together to improve health outcomes, particularly for patients who have chronic conditions, and refer eligible patients to Case and Disease Management programs

How to Refer Blue Cross Patients

Contact the Blue Cross Clinical Staff

- Phone: 1-800-317-2299
- M-F, 8 a.m. – 5 p.m.
  (except office holidays)
- Providers can call on behalf of a Blue Cross patient
- Blue Cross patients can self-refer
- Blue Cross members can refer an immediate family member

There is no added cost for Blue Cross members to participate in our Case and Disease Management programs. Our Case Management programs are offered as a member benefit on most of our individual and group plans (this benefit varies for some ASO groups).

Patients can call Blue Cross at the customer service number on the back of their member ID card to find out if this program is covered

NEW

Obesity Benefit Updates

- Starting July 1, 2018, childhood obesity treatment (ages 6-18) will be extended from 6 months to 12 months of lifetime treatment for eligible population
- Starting January 1, 2019, obesity treatment will be expanded for eligible population and ages

ALLIANCE FOR A HEALTHIER GENERATION

For more information, visit **www.BCBSLA.com/providers** >Childhood Obesity

Obesity Provider/Member Engagement

Place an order for obesity treatment journals for your practice. Journals include:

- Goal guidance
- Nutrition resources
- Physical activity resources
- Tracking sheets

For questions, email **wellnessinfo@bcbsla.com**

Our Secure Online Services

Accessing Our Secure Online Services

We offer many online services that require secure access. These services include applications such as:

- iLinkBlue
- BCBSLA Authorizations
- Behavioral Health Authorizations
- Pre-Service Review for Out-of-Area Members (BlueCard® members)
- and more (as we develop new services)

We require that each provider organization must designate at least one administrative representative to self-manage user access to our secure online services

Administrative Representative

- An administrative representative is a person at your organization who has registered with Blue Cross to designate user access to our secure online tools
- They only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities
- If you do not have an administrative representative registered with Blue Cross, please fill out and submit the Administrative Representative Registration Packet, which can be found on our Provider page (**www.BCBSLA.com/providers**)

NEW

Enhanced Security Protocol

- Beginning August 1, 2018, iLinkBlue and Sigma accounts that have not been accessed in 90 days will be suspended
- iLinkBlue/Sigma users and their administrative representative will receive an email once their account has not been accessed in 60 days, alerting them the account will be suspended after 90 days of inactivity
- More information will be mailed to administrative representatives and iLinkBlue users on May 1, 2018

Provider Identity Management Team

Need help?

- The Provider Identity Management (PIM) Team is a dedicated team to help you establish and manage system access to our secure electronic services
- If you have questions regarding the administrative representative setup process, please contact our PIM Team
  - Email: **PIMTeam@bcbsla.com**
  - Phone: 1-800-716-2299, option 5

What they will do for you:

- Set up administrative representatives
- Educate and assist administrative representatives
- Outreach to providers without administrative representatives to begin the setup process

Common issues the PIM Team is asked to help with:

- How do I change my administrative representative's phone number?
  - This can be done with a phone call to the PIM team
- How do I change my administrative representative's email address?
  - Because your email address is your username, you must submit a new Administrative Representative Registration Packet
- How do I terminate my administrative representative?
  - This requires a written notification be sent to the PIM team

NEW

Provider Self-service Initiative

- Effective March 1, 2018, providers are required to use our self-service tools for:
  - member eligibility
  - claim status inquiries
  - professional allowable searches
  - medical policy searches
- These services will no longer be handled directly by our Customer Care Center
- Self-service tools available to providers:
  - iLinkBlue (**www.BCBSLA.com/ilinkblue**)
  - Interactive Voice Recognition (IVR) (1-800-922-8866)
    - The *Automated Benefits & Claim Status (IVR Navigation Guide) Tidbit* will help you navigate the IVR system and is available at **www.BCBSLA.com/providers** >Resources >Tidbits
  - HIPAA 27x transactions

iLinkBlue

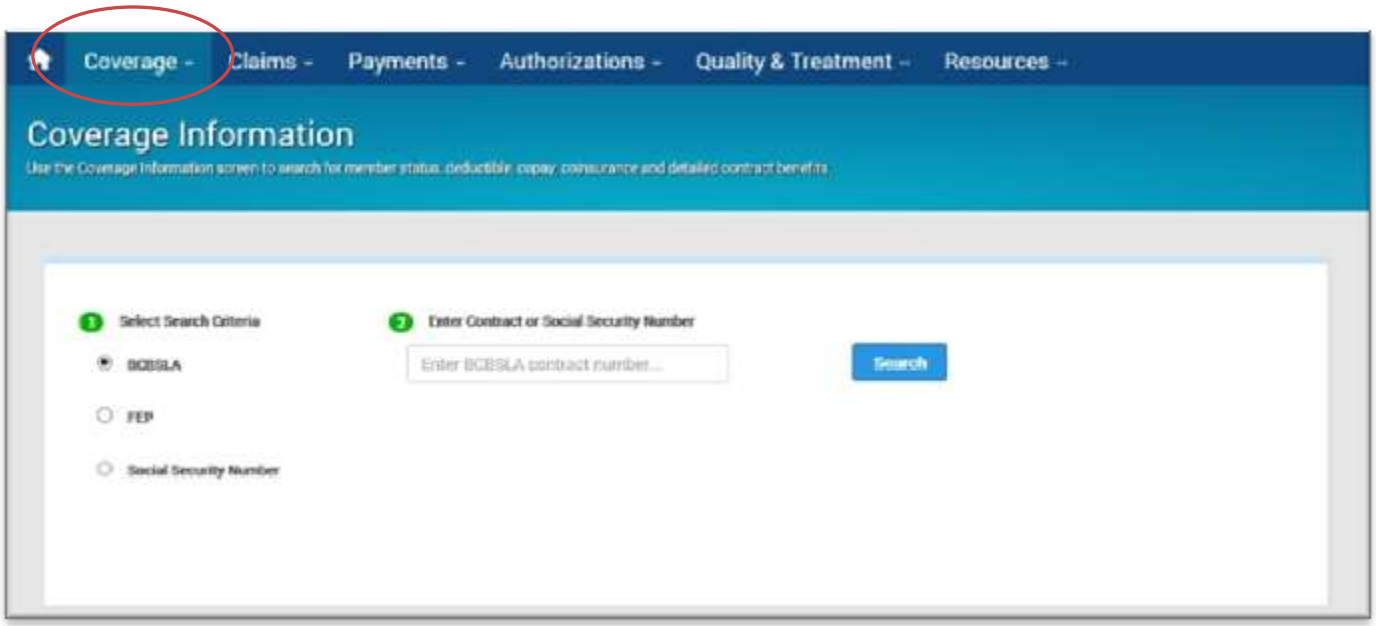
- iLinkBlue offers user-friendly navigation to allow easy access to many secure online tools:
  - Coverage & Eligibility
  - Benefits
  - Coordination of Benefits (COB)
  - Claims Status (BCBSLA, FEP and Out of Area)
  - Medical Code Editing
  - Payment Registers/EFT Notifications
  - Allowables Search
  - Authorizations
  - Medical Policy
  - 1500 Claims Entry
- UB-04 claims entry is no longer available

For iLinkBlue training and education, contact **provider.relations@bcbsla.com**

www.BCBSLA.com/ilinkblue

iLinkBlue – Coverage & Eligibility

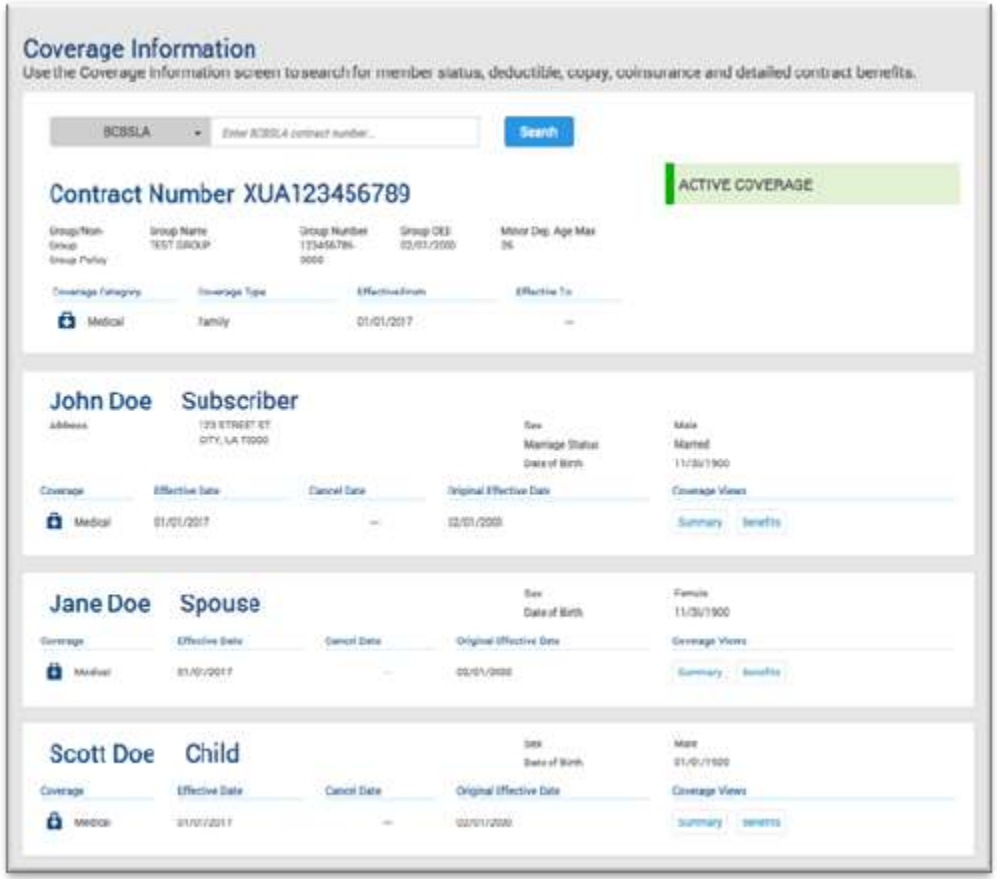
1.



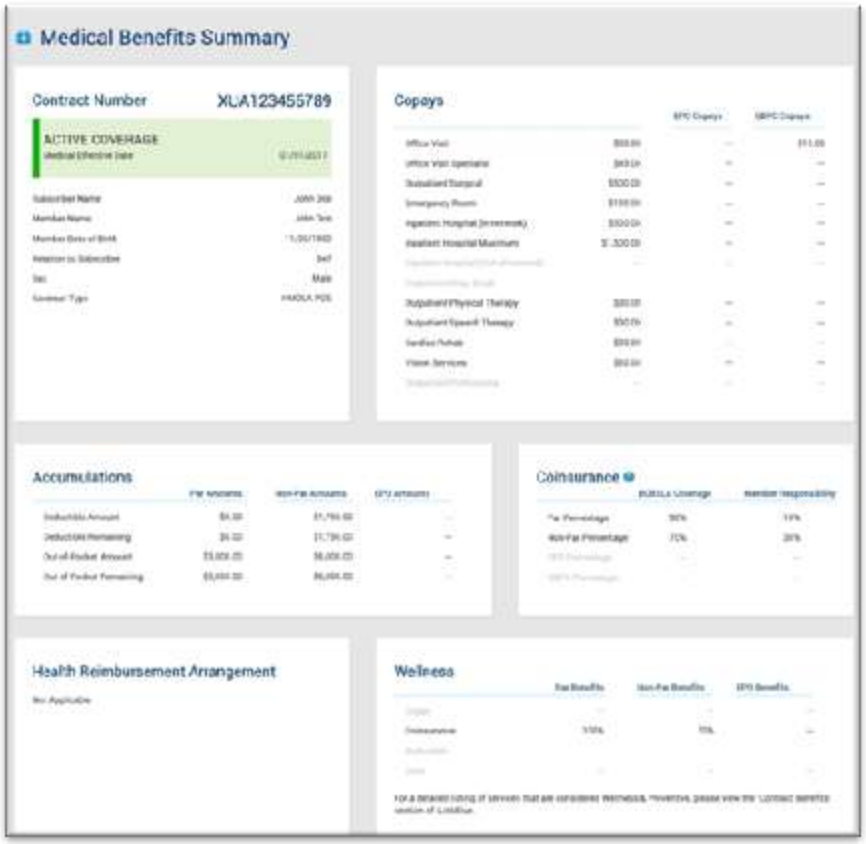
Use the "Coverage" menu option to research Blue Cross and Federal Employee Program (FEP) member eligibility, copays, deductibles and detailed contract information

iLinkBlue – Coverage & Eligibility

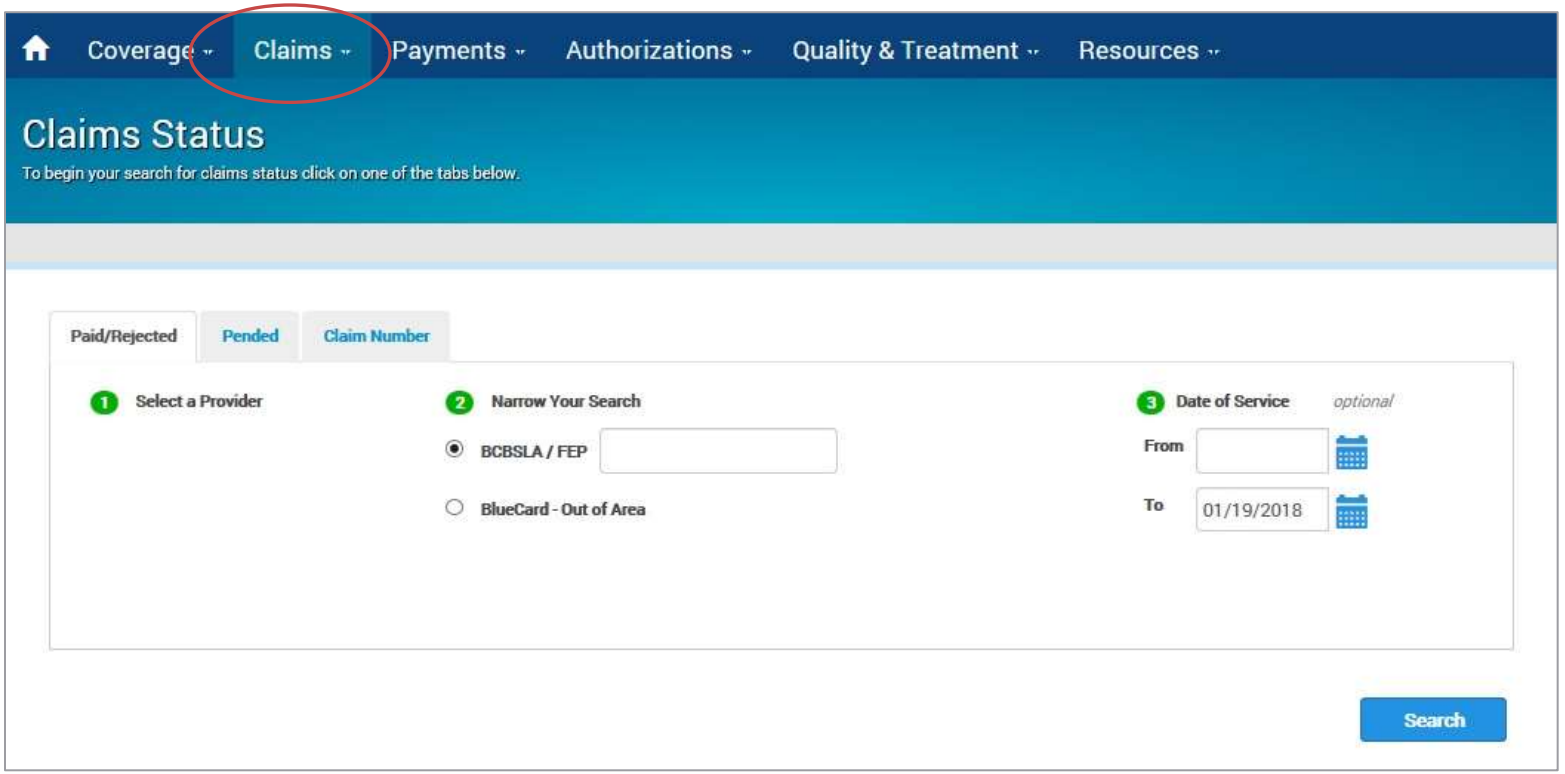
2.



iLinkBlue – Coverage & Eligibility

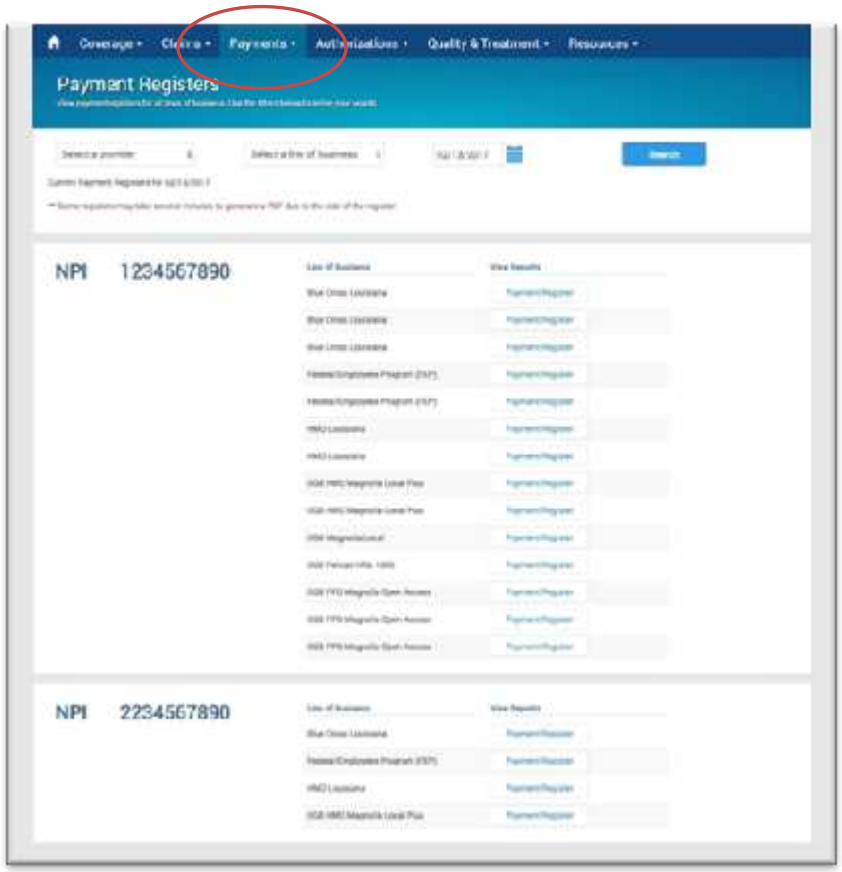
3. 

iLinkBlue – Claims Research



- Use the "Claims" menu option to research paid, rejected and pended claims
- You can research BCBSLA, FEP and Out-of-area claims submitted to Blue Cross for processing

iLinkBlue – Payment Registers



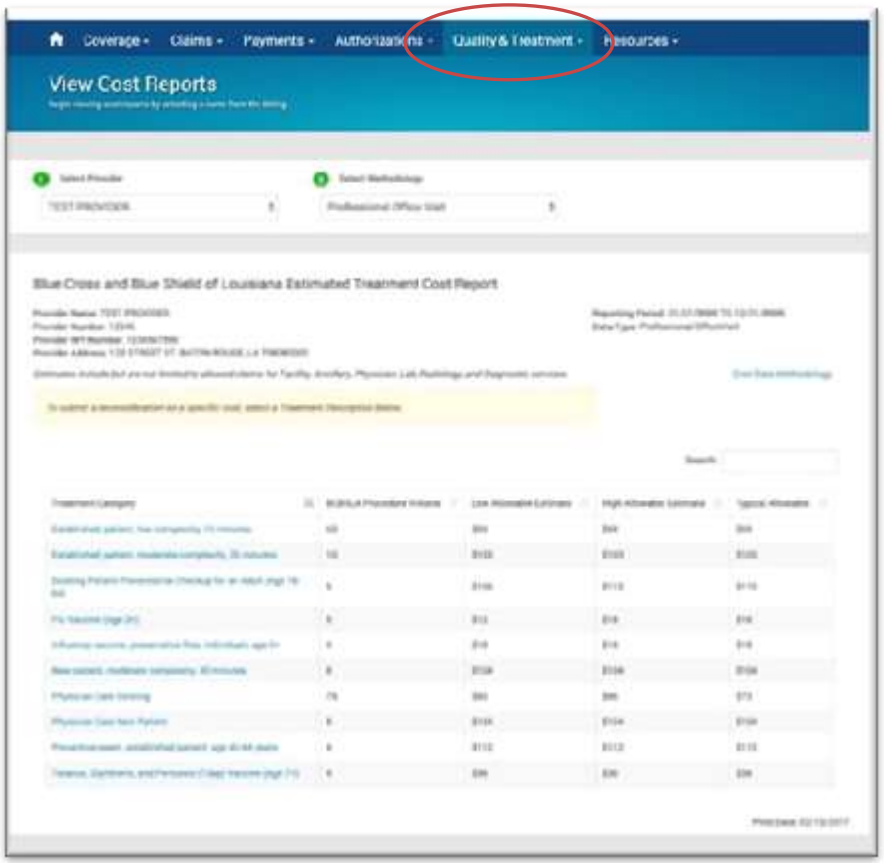
- Use the "Payments" menu option to find your Blue Cross payment registers
- Payment registers are released weekly on Mondays
- Notifications for the current week will automatically appear on the screen
- You have access to a maximum of two years of Payment Registers in iLinkBlue
- If you have access to multiple NPIs, you will see registers for each

iLinkBlue – Authorizations

- Use the "Authorizations" menu option to access our authorization tools
- An administrative representative must grant each user security access to the following applications:
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Pre-Service Review

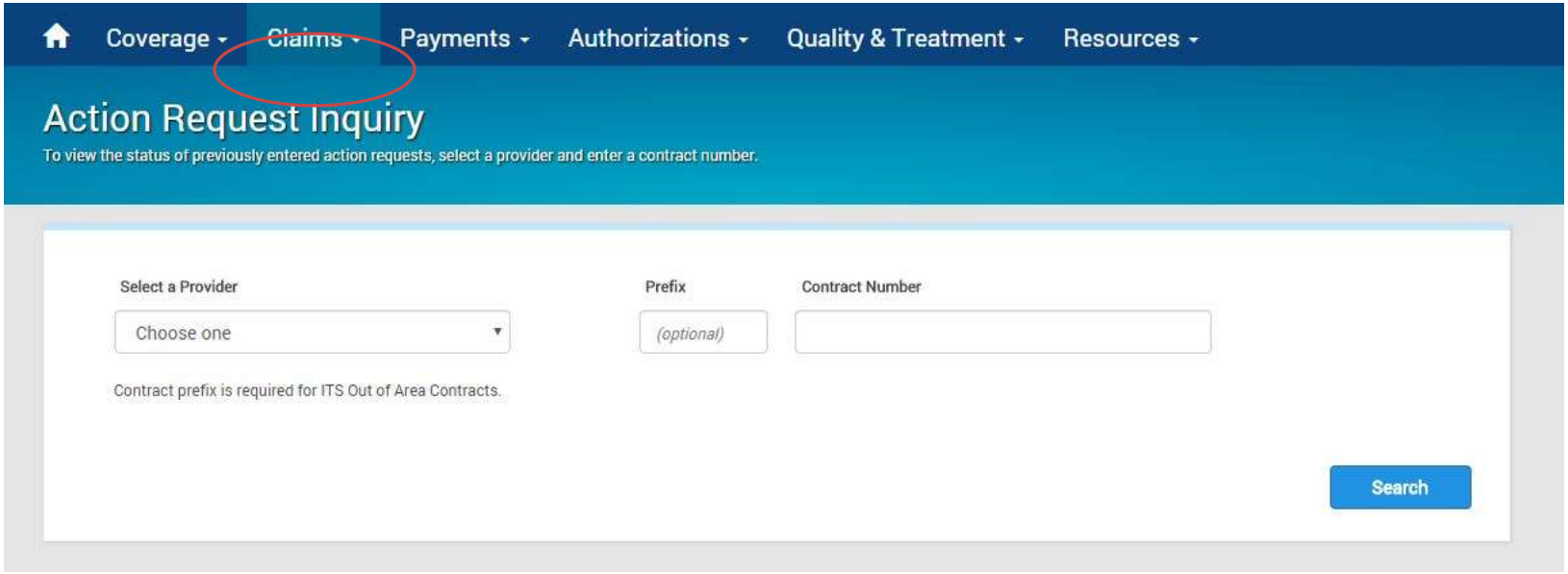
NOW UNTIL MAY 11

iLinkBlue – Estimated Treatment Cost Reports



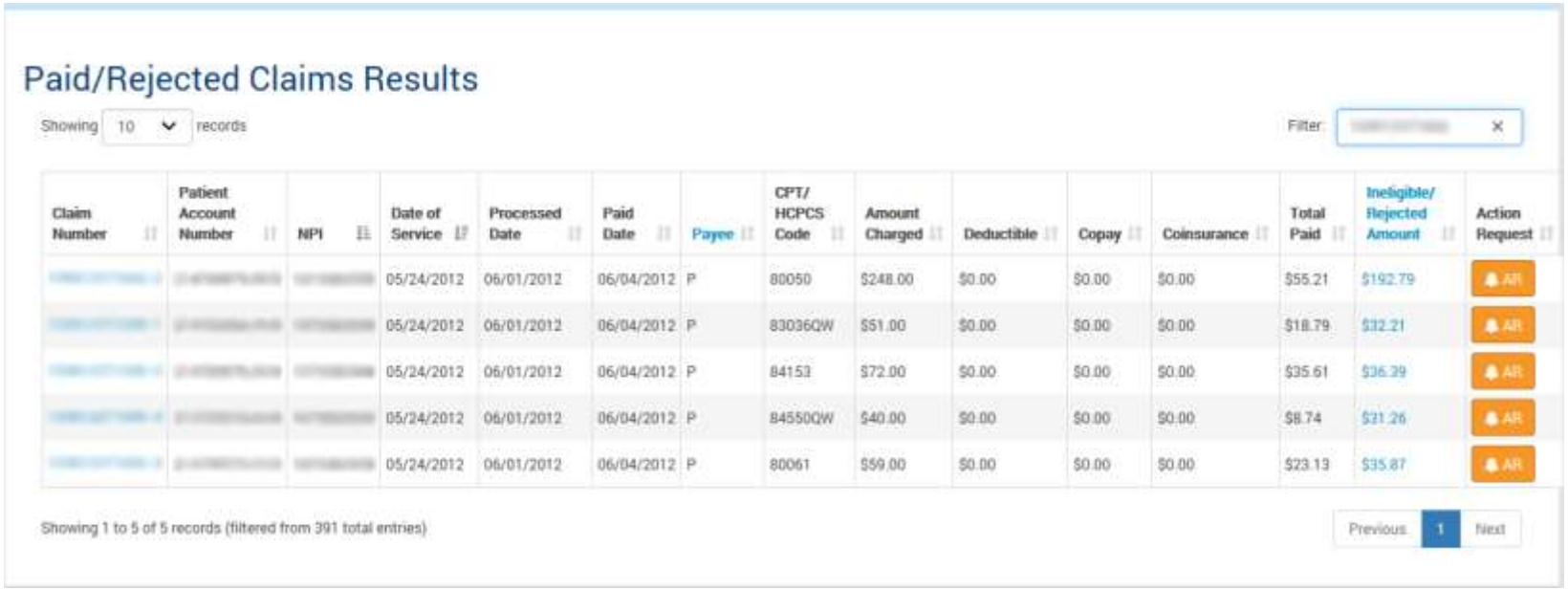
- Twice a year (spring and fall), Blue Cross refreshes the Estimated Treatment Cost Tool with updated provider costs to enable our members to be more active in managing their own healthcare choices
- When this occurs, providers are sent a letter advising them they have 30 days from the date of notice to review their cost reports and request a reconsideration, if needed
- Use the "Quality & Treatment" menu option to find your **Estimated Treatment Cost Reports**
- The **View Reports** option allows you to view the most recent reports calculated for your facility or professional provider
- The **Electronic Reconsideration Form** for a treatment will be available to providers only during the reconsideration period

iLinkBlue – Action Requests



Use the **action request inquiry** to electronically communicate with Blue Cross on specific claims.

iLinkBlue – Action Requests



Paid/Rejected Claims Results

Showing 10 records

Filter

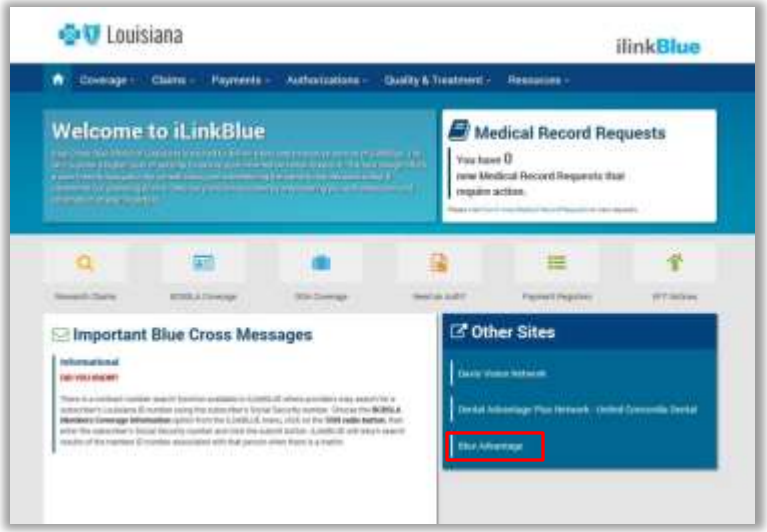
Claim Number	Patient Account Number	NPI	Date of Service	Processed Date	Paid Date	Payee	CPT/ HCPCS Code	Amount Charged	Deductible	Copay	Coinsurance	Total Paid	Ineligible/ Rejected Amount	Action Request
			05/24/2012	06/01/2012	06/04/2012	P	80050	$248.00	$0.00	$0.00	$0.00	$55.21	$192.79	AR
			05/24/2012	06/01/2012	06/04/2012	P	83036QW	$51.00	$0.00	$0.00	$0.00	$18.79	$32.21	AR
			05/24/2012	06/01/2012	06/04/2012	P	84153	$72.00	$0.00	$0.00	$0.00	$35.61	$36.39	AR
			05/24/2012	06/01/2012	06/04/2012	P	84550QW	$40.00	$0.00	$0.00	$0.00	$8.74	$31.26	AR
			05/24/2012	06/01/2012	06/04/2012	P	80061	$59.00	$0.00	$0.00	$0.00	$23.13	$35.87	AR

Showing 1 to 5 of 5 records (filtered from 391 total entries)

Previous 1 Next

You may click the **AR** icon from the Claims Results screen or the **Action Request** button from the Claim Details screen to open a form that prepopulates with the claim information. Please include your contact information.

Accessing the Blue Advantage Provider Portal



- The processes for Blue Advantage (HMO) differ from our other provider network processes
- We have created a separate portal for these contracted providers to access those processes
- You can access the Blue Advantage Provider Portal through iLinkBlue
- The Blue Advantage Provider Portal also requires a higher level of security access that must be assigned to users by your organization's security administrative representative
  - Contact the PIM Team to set up an administrative representative (1-800-716-2299, option 5)

Various Authorizations

NEW

Spine Pain Management & Spine Surgeries

- We now require an authorization for spine pain management and spine surgery services through the AIM ***Provider****Portal*$_{SM}$ on iLinkBlue (**www.BCBSLA.com/ilinkblue**)
- AIM Specialty Health$_{®}$ administers, for Blue Cross, medical necessity reviews
- Services that do not meet criteria will be denied and are not billable to the member
- Criteria are available at **www.aimspecialtyhealth.com** >Resources >Clinical Guidelines >Musculoskeletal

For a listing of codes, contact **provider.relations@bcbsla.com**

NEW

Radiation Oncology

- We now require an authorization for radiation therapy for oncology through the AIM ***Provider****Portal*$_{SM}$ on iLinkBlue (**www.BCBSLA.com/ilinkblue**)
- AIM Specialty Health$_{®}$ administers, for Blue Cross, medical necessity reviews
- Services that do not clearly meet criteria will be reviewed by board-certified-like specialists. These reviews will be based on AIM appropriate-use criteria.
- Services that do not meet criteria will be denied and are not billable to the member
- Criteria are available at **www.aimspecialtyhealth.com** >Resources >Clinical Guidelines >Radiation Oncology

For a listing of codes, contact **provider.relations@bcbsla.com**

Approval Letters Now Faxed

- Our Care Management team has begun sending all approval of service notification letters via fax. Approval letters will no longer be mailed
- Professional providers and facilities may receive up to three separate batches of faxes: inpatient, outpatient and recertification
- Batches are sent Monday-Saturday beginning at 4 a.m.
- Each batch will include all of the members who were approved for services from the previous business day
  - e.g. if there were 15 outpatient services authorized for your facility, the outpatient batch fax will include all 15 approval letters


Louisiana

Utilization Management
Approval and Denial Fax Form

LOCATION INFORMATION

INDIVIDUAL PROVIDER INFORMATION

SUBMISSION INFORMATION

RETURN INFORMATION

Update or change your fax number for approval and denial letters through our **Utilization Management Approval and Denial Fax Form**, available online at **www.BCBSLA.com/providers** >Resources >Forms

Prior Authorizations

- Services that require prior authorization can be found in our provider manuals and network speed guides. Both are available online at **www.BCBSLA.com/providers** >Resources
- Authorization requirements may vary by product
- The provider must initiate the authorization process at least 48 hours prior to the service by:
  - Using iLinkBlue to access our online authorization portal, or
  - Calling the authorization number on the member ID card

Top reasons for claim denials related to authorizations:

- Place of treatment and/or date of service does not match authorization
- Diagnosis and/or procedure code does not match authorization
- Servicing provider does not match authorization

Process for Changing an Authorization

You can ask our authorization department to change or add a code to an already approved authorization when all of the following conditions are met:

- There is an approved authorization on file
- Provider states a claim has not been filed
- The requested code is surgical or diagnostic
- The requested code is not on a Blue Cross medical policy or a non-covered benefit
- If the above criteria is met, an authorization can be changed within seven calendar days of the services being rendered

If the procedure being added or changed on the authorization is on a Blue Cross medical policy or is a non-covered benefit, it cannot be updated on the authorization.

Once the claim is filed, fax medical records to (225) 298-2906 or 1-800-515-1150.

Failure to Obtain an Authorization

Failure to obtain a prior authorization can result in:

- A 30 percent penalty imposed on PPO and HMO POS network providers for failing to obtain authorization prior to performing an outpatient service that requires authorization
- The denial of payment for services for Office of Group Benefits (OGB) members

Authorization penalty amounts or services that are denied for no authorization are not billable to the member

OGB Authorization


OGB Plan Services Requiring Authorization

INPATIENT

OUTPATIENT

Louisiana

OGB has different authorization requirements

- Failure to obtain an authorization will result in denied services that are not billable to the member
- The list of OGB authorization requirements can be found on Page 8 of Section 4 of our *Professional Provider Office Manual*
- The list also appears on the OGB Speed Guide
- Both are available at **www.BCBSLA.com/providers** >Resources

Urgent Authorizations

- The initial request for authorization of an urgent illness is processed as soon as possible based on the clinical situation, or within 72 hours of the request regardless of whether all information is received
- If the request is approved, the contact person/practitioner is notified by telephone and a confirmation letter is sent to the member, physician and hospital, as applicable
- If the request is denied, the contact person is notified by telephone and is given the reason for the denial and the procedure for initiating the expedited appeal process. A letter listing appeal rights is sent to the member, physician and hospital, if applicable, within one business day of the determination

The authorization process is designed only to evaluate the medical necessity of the service and is not a guarantee of payment or a confirmation of coverage for benefits

Blue Advantage (HMO) Inpatient Admissions and Discharges

- Blue Advantage network providers are required to provide notification for Blue Advantage members' inpatient admissions and discharges
- Blue Advantage providers must submit clinical documentation to Blue Advantage within one business day of admission to complete the notification process and receive an authorization
- Blue Advantage providers can report inpatient admissions to the Blue Advantage Medical Management team:
  - Phone: 1-866-508-7145
  - Fax: 1-877-528-5818
- The phones are forwarded to a voice mail system during non-business hours and the fax is available 24 hours a day, 7 days a week

Notifications submitted via phone or fax will be confirmed by Blue Advantage Medical Management staff with a reference number. This reference number does not guarantee payment

Providers who are denied payment because notification was not received, may not bill the member

Imaging Authorizations

- The ordering physician should always use the AIM ***Provider****Portal*$_{SM}$ in iLinkBlue to set up an authorization (**www.BCBSLA.com/ilinkblue** >Authorizations >AIM Specialty Health Authorizations)
- AIM Specialty Health$_{®}$ – allows you to submit and receive pre-authorizations over the Web on a real-time basis eliminating the need to call AIM for the following outpatient high-tech diagnostic services:
  - Computerized Tomography (CT) Scans
  - Computerized Tomographic Angiography (CTA)
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Nuclear Cardiology Procedures
  - Positron Emission Tomography (PET) Scans
- Blue Advantage (HMO) providers only use AIM for their Blue Advantage members' authorizations for advanced radiological imaging or radiation therapy services

Top reasons for claim denials related to outpatient imaging authorizations:

- No authorization on file
- Facility location (place of treatment) does not match authorization
- Servicing provider does not match authorization

Medical Appeals

Medical Necessity Appeals

- Blue Cross receives large volumes of medical necessity appeals
- We require network providers to disclose ineligible services to members prior to performing or ordering services
- Investigational or experimental procedures are not considered medically necessary according to our policy
- Please remember to check the medical policies section on iLinkBlue to view the most current medical policies. Benefit determinations are made based on the medical policy in effect at the time of the provision of services.
- You can easily search for medical policies using the index within iLinkBlue
- Our medical policies include:
  - coverage eligibility
  - background information related to technology
  - devices and treatments
  - technology assessments
  - literature sources
  - the rationale for coverage determinations

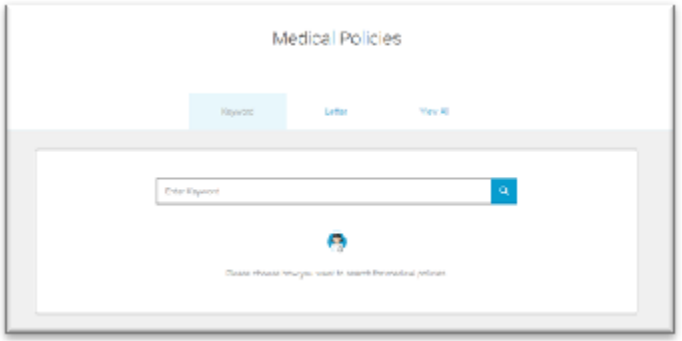
For medical necessity appeals, providers must send a written request to:

BCBSLA – Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022
Fax (225) 298-1837

Accessing our Medical Policies

1.

2.



- From the iLinkBlue menu, select "Authorizations" then "Medical Policy Guidelines" to open the **Medical Policy Index**
- Policies are listed in alpha order or you may search by policy number or procedure code

Medical policies are reviewed, updated and developed every month. We publish these updates in our quarterly *Provider Network News* newsletters, available online at **www.BCBSLA.com/providers** >Newsletters.

Submitting Research to Evidence Street

- Healthcare product manufacturers with new procedures or devices that may influence medical policy should consider submitting their research to the Blue Cross Blue Shield Association Evidence Street®
- Visit the Evidence Street® website at **https://app.evidencestreet.com** to monitor when BCBSA is reviewing particular medical categories and learn when to submit peer-reviewed evidence for consideration during scheduled submission periods
- Research should be submitted to **evidencestreet@bcbsa.com**
- If outside of a submission period, it is collected for review during the next submission period for that medical category

Correcting or Disputing Claims

Electronic Claims Adjustments for Corrected Claims

Clearly indicate that your CMS-1500 claim is a corrected claim as follows:

- EDI/1500/Professional claim forms submitted as "corrected claims" can be submitted electronically
- In Loop 2300 ~ CLM05-03 must contain a "7" or "8"
- REF01 must contain an "F8"
- REF02 must contain the Original Reference Claim Number
- 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

Correcting Claims Tidbit

- Submitting corrected claims can be easy when the appropriate steps are followed
- Use the "Submitting Corrected Claims" tidbit as a guide to properly adjust or void a claim so it does not deny as duplicate or process incorrectly
- The tidbit outlines the steps for submitting a corrected claim by paper or electronically (via clearinghouse or iLinkBlue)


PROVIDER TIDBITS

Louisiana

Submitting Corrected Claims

Available online at **www.BCBSLA.com/providers** >Resources

Disputing Claims Tidbit

- We recognize that disputes may arise between providers and Blue Cross regarding covered services
- Use the "Disputing Claims" tidbit as a guide to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross

Examples of issues that qualify as disputes include:

- Claims issues related to authorizations
- Claims based on adverse determinations of medical necessity or benefit determinations
- Reimbursement reviews

Available online at **www.BCBSLA.com/providers** >Resources

Claims Dispute Form

- Use the Claims Dispute Form to properly request a review of your claim
- Be sure to place the form on top of your claim when submitting for review to ensure it is routed to the appropriate area of the company
- Use the Claims Dispute Form when:
  - Claim rejected as duplicate
  - Claim denied for bundling
  - Claim denied for medical records
  - Claim denied as investigational or not medically necessary
  - Claim payment/denial affects the provider's reimbursement
  - Claim payment affects the member's cost share
  - Claim denied for a BlueCard® member


Louisiana

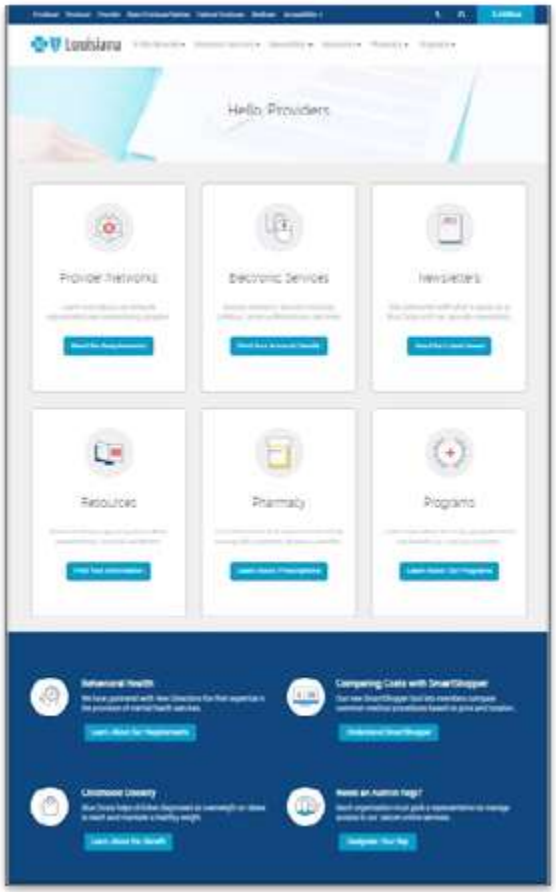
Claims Dispute Form

Available online at **www.BCBSLA.com/providers** >Resources

Note: This form replaced our Reimbursement Review Form, which we no longer accept

Support & Resources

Provider Page



www.BCBSLA.com/providers

The Provider Page is home to online resources such as:

- Provider manuals
- Network speed guides
- Newsletters
- Provider forms
- And more

Manuals & Newsletters

Our provider **Manuals** are extensions of your network agreement(s). The manuals are designed to provide the information you need as a participant in our networks.

www.BCBSLA.com/providers >Resources

Our provider **Newsletters**, contain information and tips on changes to processes, such as claims filing procedures or reimbursement changes, along with a number of featured articles

www.BCBSLA.com/providers >Newsletters

Speed Guides & Tidbits

Our **Speed Guides** offer quick reference to network authorization requirements, policies and billing guidelines

Provider Tidbits are quick guides designed to help you stay informed of our current business processes

www.BCBSLA.com/providers >Resources

Forms for Providers

It is important we always have your most current information in our files. The Provider File team manages demographic changes to your provider record. Below are the required forms for making the indicated changes to your record:

Use our **Provider Update Form** if you have an address, phone, fax, email address or hours of operation change

Use our **Link to Group or Clinic Request Form** when an individual provider is linking to a provider group or clinic

Use our **Notice of Tax Identification Number (TIN) Change Form** to report a change in your tax ID number

www.BCBSLA.com/providers >Resources >Forms

Forms for Providers

Below are the required forms for making the indicated changes to your record:

Use our **Request for Termination** to request termination from one or more of our networks

Use our **Add Practice Location Form** when an individual provider is adding a practice location(s)

Use our **Remove Practice Location Form** when an individual provider is removing a practice location(s)

www.BCBSLA.com/providers >Resources >Forms

Continuing Medical Education

- We are offering our network physicians, nurse practitioners and physician assistants free continuing medical education (CME) credits directly through the Washington University CME portal
- More than 30 courses are available on a variety of topics
- Please be sure to take advantage of these free CME credits before this opportunity ends on **December 31, 2018**
- Accessing the Washington University CME Portal:
  1. Go to **https://cmeonline.wustl.edu/bcbsl/**
  2. Click "New Account"
  3. Enter registration information (* indicates required information)
  4. Click "Sign Up"

Call Centers

Customer Care Center	**1-800-922-8866**
FEP Dedicated Unit	**1-800-272-3029**
OGB Dedicated Unit	**1-800-392-4089**
Blue Advantage	**1-877-250-9167**

For information NOT available on iLinkBlue

Other Provider Phone Lines

BlueCard Eligibility Line® – 1-800-676-BLUE (1-800-676-2583)
for out-of-state member eligibility and benefits information

Fraud & Abuse Hotline – 1-800-392-9249
Call 24/7 and you can remain anonymous as all reports are confidential

Network Administration – 1-800-716-2299

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding credentialing/recredentialing
- **option 3** – for questions regarding your provider file record
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding administrative representative setup

Provider Relations

Provider Education & Onsite Training

Kim Gassie
director

Jami Zachary
supervisor

Mary Guy
East Baton Rouge, East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana

Marie Davis
Assumption, Iberia, Lafayette, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn

Patricia O'Gwynn
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll

Kelly Smith
Acadia, Ascension, Calcasieu, Cameron, Iberville, Jefferson Davis, Livingston, Pointe Coupee, St. Landry, St. Martin, Vermilion, West Baton Rouge

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard

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

Darnell Kling **Angela Jackson**

Network Development

Provider Contracting

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manager

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network.development@bcbsla.com | 1-800-716-2299, option 1

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

Network Operations

Provider Network Setup, Credentialing & Demographic Changes

Wendy Barber
provider file manager

Gloria Burns
credentialing manager

The **network.administration@bcbsla.com** email address should be used by providers as an electronic option for submitting contracts, applications and forms

This email address should not be used to submit general inquiries

If you would like to check the status on your Credentialing Application or Provider File change or update, please contact the Network Operations Department by calling 1-800-716-2299

1-800-716-2299 • option 2 – credentialing • option 3 – provider file
Fax: 225-297-2750 • network.administration@bcbsla.com

Questions?