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 chat feature at the top of your screen to type your question related to today's training webinar
- In the "Send to" field, select "Webinar Host"
- Once your question is typed in, hit the "Send" button to send it to the presenter
- We will address submitted questions at the end of the webinar

# NEW TO BLUE ADVANTAGE (HMO) AND BLUE ADVANTAGE (PPO) WEBINAR

## July 22, 2020

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

# Welcome to the Blue Advantage Network!

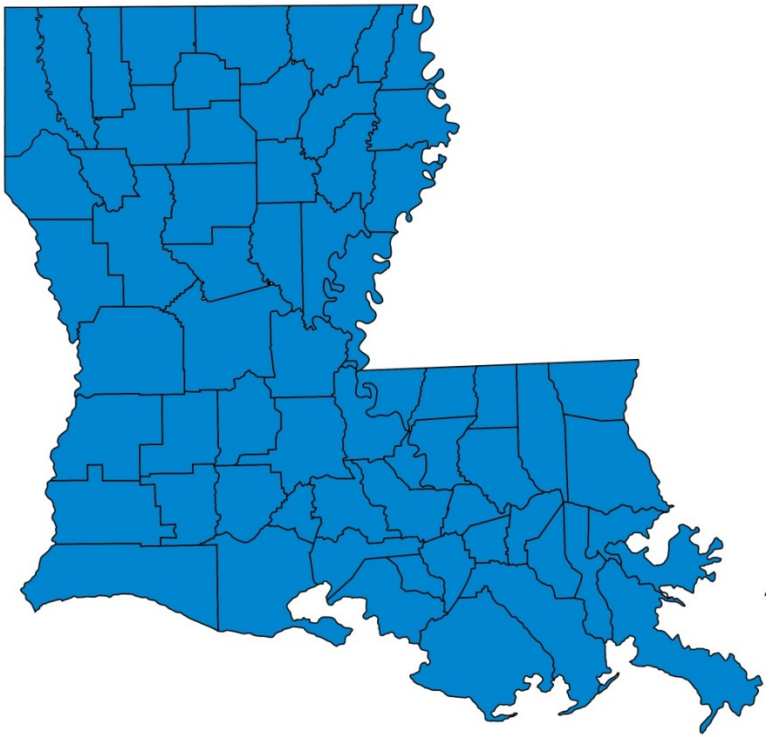
- Thank you for participating in our Blue Advantage (HMO) and Blue Advantage (PPO) provider networks
- You play an important role
- You are one of the select providers chosen to be in our Blue Advantage networks
  - High-quality medical care and efficient services

# 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.

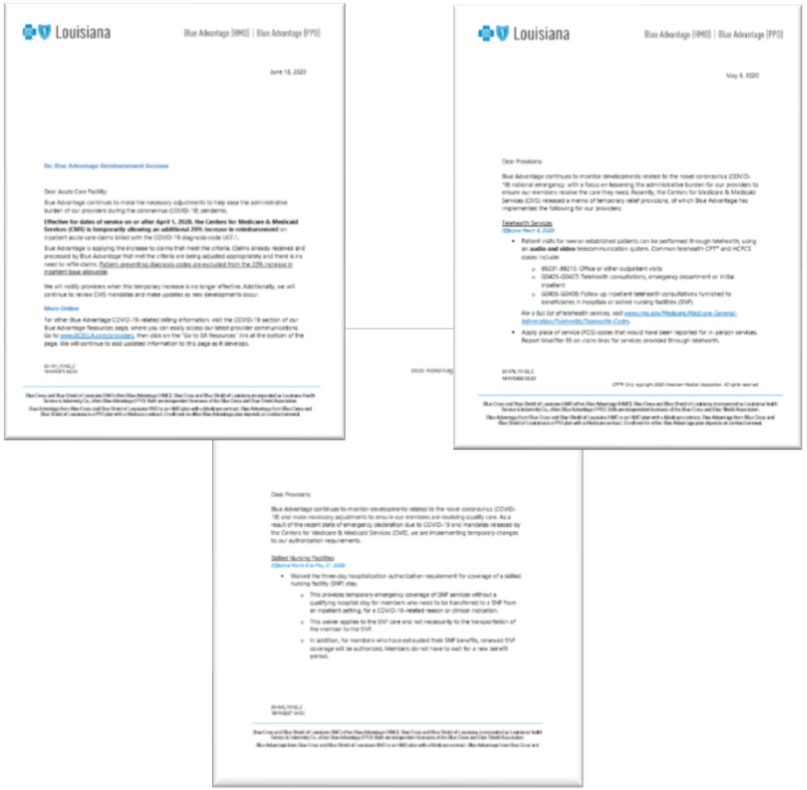


# COVID-19 Relief Provisions

Blue Advantage continues to make the necessary adjustments to help ease the administrative burden of providers during the coronavirus (COVID-19) pandemic.

Visit the COVID-19 section of the Blue Advantage Resources page to access a copy of the provider communications regarding these provisions.

Go to www.BCBSLA.com/providers, then click on the “Go to BA Resources” link at the bottom of the page.



# Lumeris Partnership

## Why partner with Lumeris?

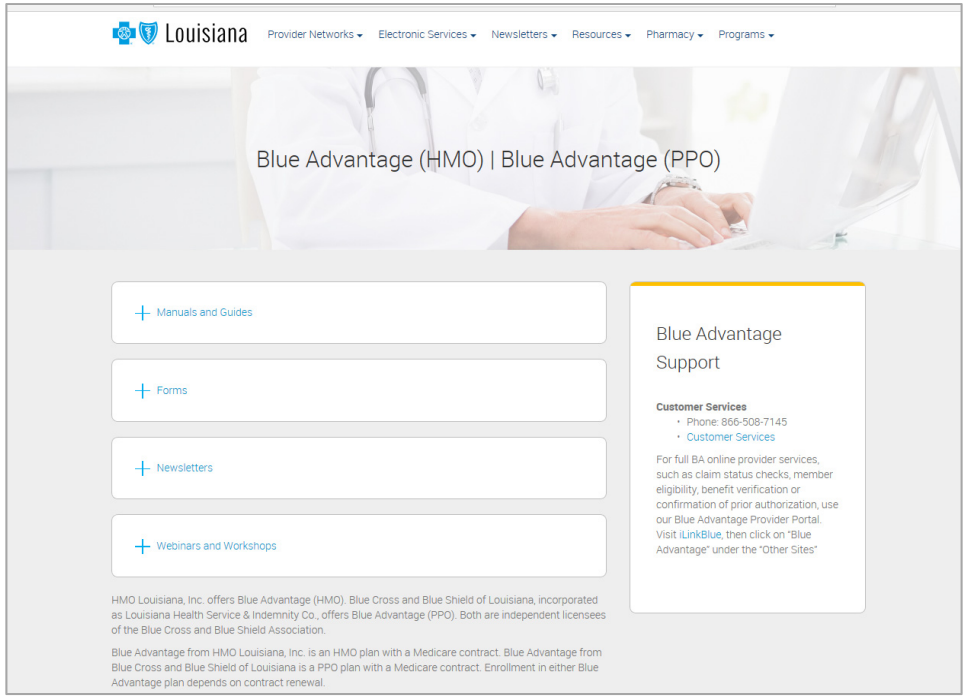
- Experts in Medicare Advantage plan management
- Pioneers in population health management solutions

## Lumeris assists with:

- Customer service, claims and medical management
- Improvement in quality of care measures
- Better coordination, transition of care and self-management

Information on this slide provided by Lumeris.

# Blue Advantage Resources Page




Resources that can be found on this page:

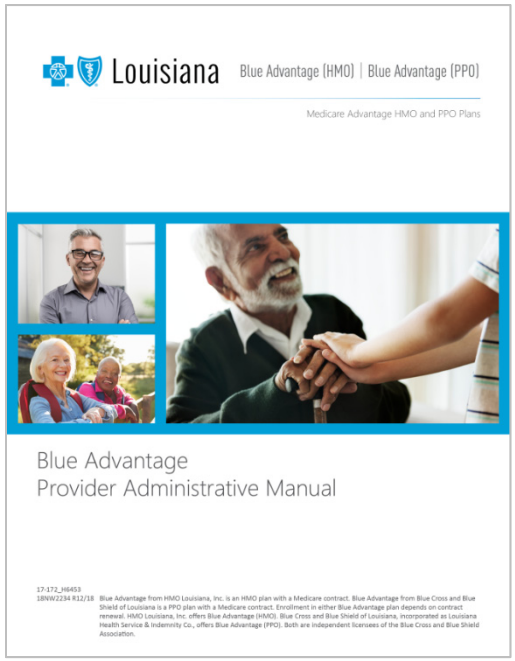
- Manual
- Authorization guide
- Forms
- Newsletters
- Webinars/workshops

Designed to give providers access to the most current Blue Advantage resources

**www.BCBSLA.com/providers >Blue Advantage Resources**

# Blue Advantage Provider Administrative Manual

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

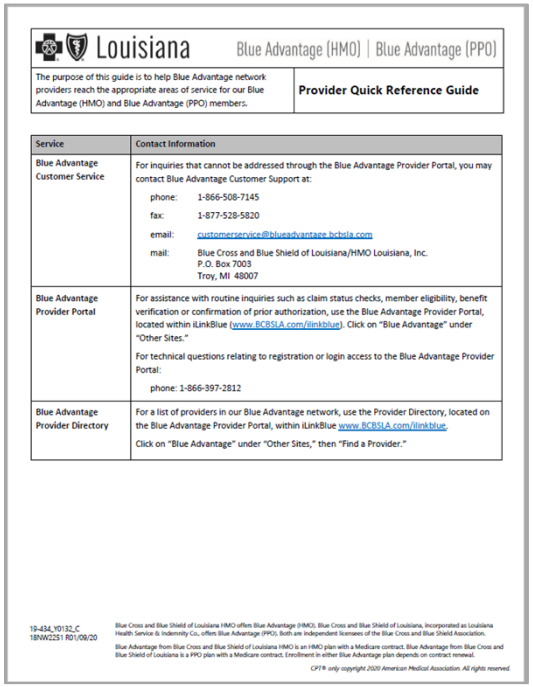



Available on the Blue Advantage resource page at

**www.BCBSLA.com/provider >Blue Advantage Resources >Manuals and Guides**

# Provider Quick Reference Guide

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



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

The purpose of this guide is to help Blue Advantage network providers reach the appropriate areas of service for our Blue Advantage (HMO) and Blue Advantage (PPO) members.

**Provider Quick Reference Guide**

| Service | Contact Information |
|---|---|
| Blue Advantage Customer Service | For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Support at:<br>phone: 1-866-508-7145<br>fax: 1-877-528-5820<br>email: customerservice@blueadvantagela.bcbsla.com<br>mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.<br>P.O. Box 7003<br>Troy, MI 48007 |
| Blue Advantage Provider Portal | For assistance with routine inquiries such as claim status checks, member eligibility, benefit verification or confirmation of prior authorization, use the Blue Advantage Provider Portal, located within iLinkBlue (www.BCBSLA.com/ilinkblue). Click on "Blue Advantage" under "Other Sites."<br>For technical questions relating to registration or login access to the Blue Advantage Provider Portal:<br>phone: 1-866-397-2812 |
| Blue Advantage Provider Directory | For a list of providers in our Blue Advantage network, use the Provider Directory, located on the Blue Advantage Provider Portal, within iLinkBlue www.BCBSLA.com/ilinkblue.<br>Click on "Blue Advantage" under "Other Sites," then "Find a Provider." |

19-434_Y0132_C
18NW2251 R01/09/20

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO); Blue Cross and Blue Shield of Louisiana, Incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

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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Available on the Blue Advantage Resources page at

**www.BCBSLA.com/provider >Blue Advantage Resources >Manuals and Guides**

# 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." See slide 25 for how to access the portal.

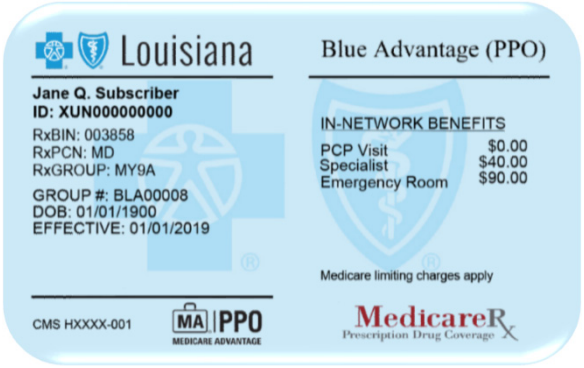
# Member ID Cards

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

- Demographic information about covered member
- Copayment or coinsurance responsibilities
- Important phone numbers


***XUM prefix***

*Note: HMO member ID cards will also include PCP name and phone number*

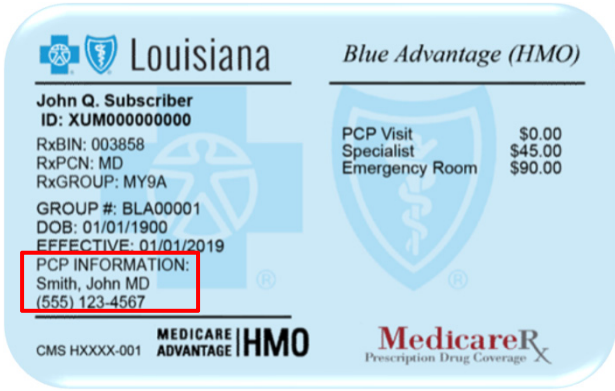



***XUN prefix***

*Note: Though PPO member ID cards do not display PCP information, we recommend that PPO members choose a PCP*

# Member ID Cards

- Primary care provider (PCP) offices should confirm they are the member's PCP of record prior to a member's appointment
- The date on the Blue Advantage member ID card represents the **effective date with the plan**, not the effective date with the PCP
- If your name is not listed on the member ID card as the PCP, you can still see members in the HMO network only, and we will pay the claim. The member should contact Blue Advantage Customer Service to change the PCP of record.
- The member ID card is used for all types of coverage such as Medicare Part A, Part B and Part D (pharmacy)




Providers may confirm member eligibility, PCP of record, deductible, maximum out-of-pocket and COB information via our online Blue Advantage Provider Portal at **www.BCBSLA.com/ilinkblue >Blue Advantage**

# Blue Advantage Customer Service

Blue Advantage Customer Service representatives are available to assist members once they have enrolled

Members may contact customer service for questions concerning:

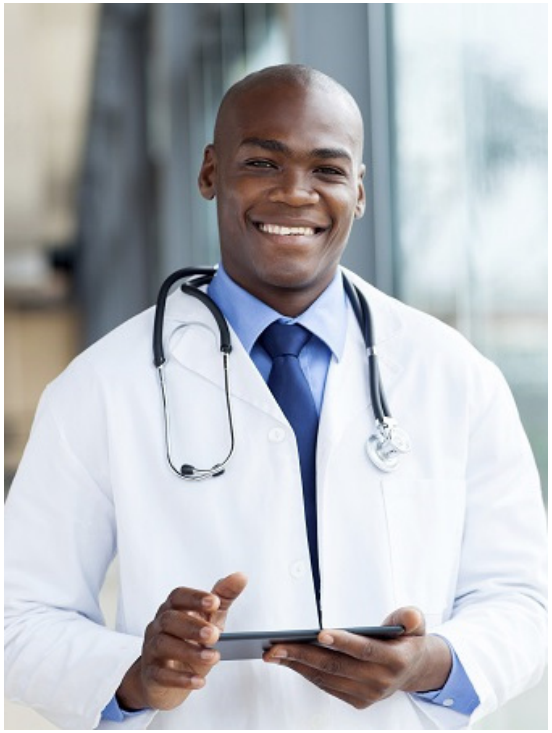
- The role of the PCP
- How to access a specialist
- Criteria for emergency room coverage
- Use of their member ID card
- Medical and prescription drug benefits

**1-866-508-7145**

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

# Role of the Primary Care Provider

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



- Oversees, coordinates, discusses and directs the member's care in a coordinated approach 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 member medically necessary services

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

# ADSP: Online Tool for the PCP

Need training? Email provider.relations@bcbsla.com with subject line "ADSP training"

Blue Advantage has a tool—the Accountable Delivery System Platform (ADSP)—that can assist PCPs in coordinating the care of members assigned to them

The ADSP is accessible through the Blue Advantage Provider Portal:

**www.BCBSLA.com/ilinkblue**

Click "Blue Advantage" under the "Other Sites" section. Once on the Blue Advantage Provider Portal, click "ADSP."

**Access to the ADSP requires an additional level of security**

# Annual Wellness Coupon Program

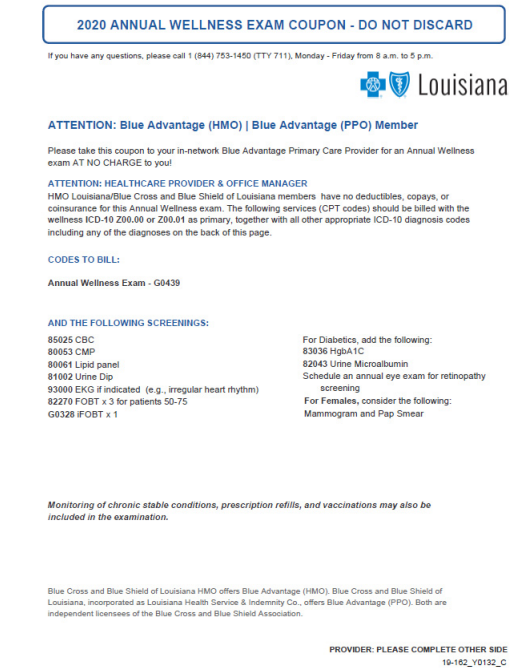
- Blue Advantage members will receive a paper coupon in the mail as part of our new Annual Wellness Coupon Program
- The coupons are for the member's annual wellness exam, which should be provided by a primary care provider
- The current coupon program is limited to only Blue Advantage members

# What are the Goals of the Program?

To help facilitate wellness visits by providing the member's primary care provider with:

- Pertinent details about the member's previously documented chronic conditions/current diagnoses
- Relevant clinical tests for the member
- Commonly overlooked conditions/ diagnoses that may be applicable to the member
- Suspected conditions based on claims history

# What Does the Coupon Look Like?



**2020 ANNUAL WELLNESS EXAM COUPON - DO NOT DISCARD**

If you have any questions, please call 1 (844) 753-1450 (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**

HMO Louisiana/Blue Cross and Blue Shield of Louisiana members have no deductibles, copays, or coinsurance for this Annual Wellness exam. The following services (CPT codes) should be billed with the wellness ICD-10 **Z00.00** or **Z00.01** as primary, together with all other appropriate ICD-10 diagnosis codes including 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 (e.g., irregular heart rhythm)
82270 FOBT x 3 for patients 50-75
G0328 iFOBT x 1

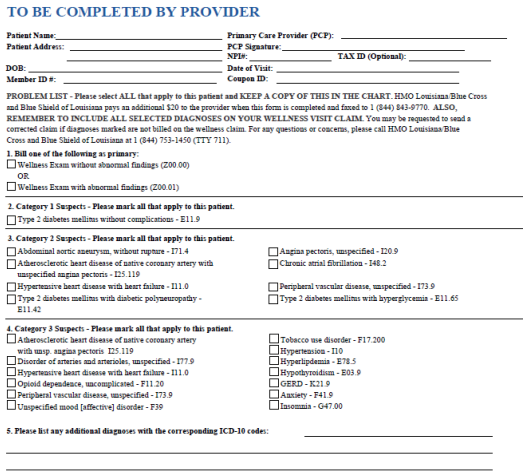
For Diabetics, add the following:
83036 HgbA1C
82043 Urine Microalbumin
Schedule an annual eye exam for retinopathy screening

For **Females**, consider the following:
Mammogram and Pap Smear

***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, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

**PROVIDER: PLEASE COMPLETE OTHER SIDE**
19-162_Y0132_C



**TO BE COMPLETED BY PROVIDER**

**Patient Name:**_____ **Primary Care Provider (PCP):** _____
**Patient Address:** _____ **PCP Signature:**_____
_____ **NPI#:**_____ **TAX ID (Optional):** _____
**DOB:** _____ **Date of Visit:** _____
**Member ID #:** _____ **Coupon ID:** _____

**PROBLEM LIST - Please select ALL that apply to this patient and KEEP A COPY OF THIS IN THE CHART.** HMO Louisiana/Blue Cross and Blue Shield of Louisiana pays an additional $20 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 HMO Louisiana/Blue Cross and Blue Shield of Louisiana at 1 (844) 753-1450 (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.**
☐ Type 2 diabetes mellitus without complications - E11.9

**3. Category 2 Suspects - Please mark all that apply to this patient.**
☐ Abdominal aortic aneurysm, without rupture - I71.4
☐ Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris - I25.119
☐ Hypertensive heart disease with heart failure - I11.0
☐ Type 2 diabetes mellitus with diabetic polyneuropathy - E11.42
☐ Angina pectoris, unspecified - I20.9
☐ Chronic atrial fibrillation - I48.2
☐ Peripheral vascular disease, unspecified - I73.9
☐ Type 2 diabetes mellitus with hyperglycemia - E11.65

**4. Category 3 Suspects - Please mark all that apply to this patient.**
☐ Atherosclerotic heart disease of native coronary artery with unsp. angina pectoris I25.119
☐ Disorder of arteries and arterioles, unspecified - I77.9
☐ Hypertensive heart disease with heart failure - I11.0
☐ Opioid dependence, uncomplicated - F11.20
☐ Peripheral vascular disease, unspecified - I73.9
☐ Unspecified mood [affective] disorder - F39
☐ 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 additional diagnoses with the corresponding ICD-10 codes:** _____

**Front**

**Back**

# What are Diagnosis Categories?

Diagnosis categories are provided to allow easy reference and visibility during the wellness visit

| | |
|---|---|
| Category 1 | Includes diagnoses that have been previously submitted on claims |
| Category 2 | Includes diagnoses that are possible, given the member's claims history |
| Category 3 | Includes commonly overlooked diagnoses |

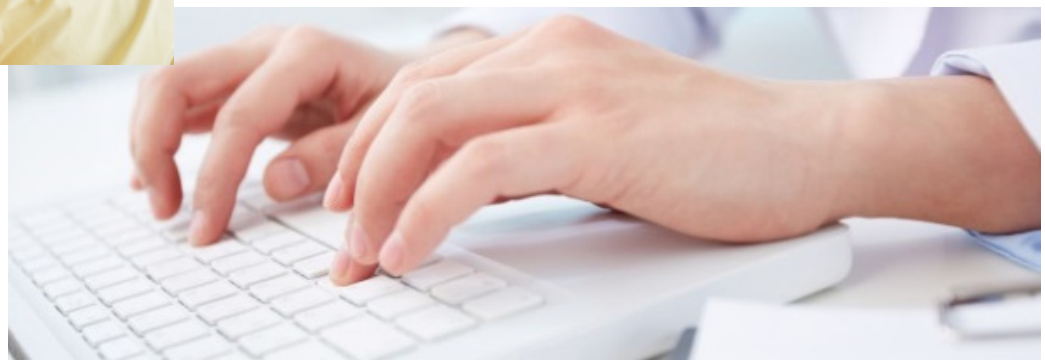
# What Should Providers do when they Receive a Coupon?

- When presented with a coupon, the provider should 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 electronic medical record.
- Providers should sign the coupon to attest to the accuracy of the notes and diagnoses, then send the completed coupon via fax to **1-844-843-9770**

Providers will be compensated $20 per coupon for the additional administrative work associated with documentation and billing, in addition to the fee for services

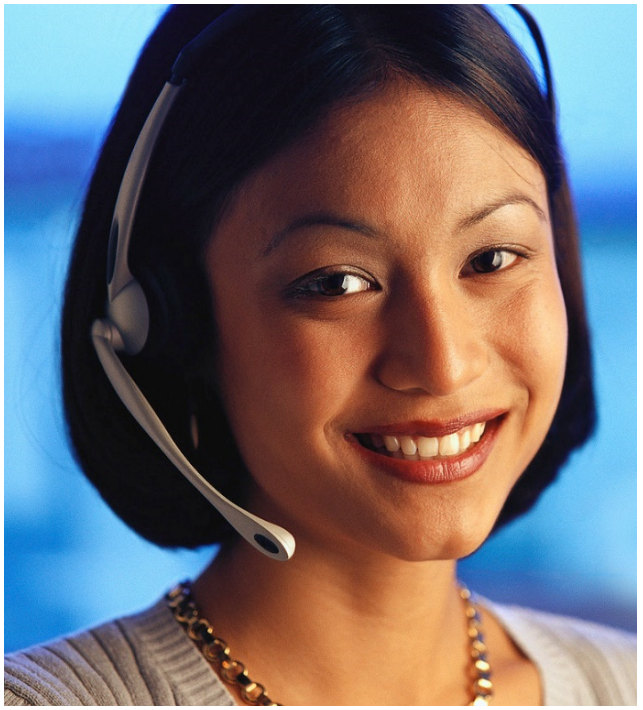
# What if the Member has Already had a Wellness Visit this Year?

Providers can bill a second wellness visit in the year even if they have already billed one and still get the $20. We will pay for the additional wellness visit at no charge to the member. Please bill the claim as you normally would.



# What if the member loses their coupon or needs an extra copy?

- Coupons are personalized and unique to each member. Only the customized coupons that are received by members will be processed (not photocopied coupons). Duplicated coupons will not be accepted.
- Personalized copies may be requested by calling **1-844-753-1450**



# 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**<br>**Third trimester within three days**<br>**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** |

# Health Risk Assessments (HRA)

## New member HRA

- Paper-based questionnaire sent to each new member upon confirmation of the member's effective date
- Analyzed to identify members who have complex or serious medical conditions

All members with a "high-risk" HRA score are contacted by the Case Management staff for proactive intervention and potential enrollment into the Complex Case Management Program


**PCP of record is notified of high-risk status with a copy of the member's care plan or actual completed HRA**

# The Blue Advantage Provider Portal

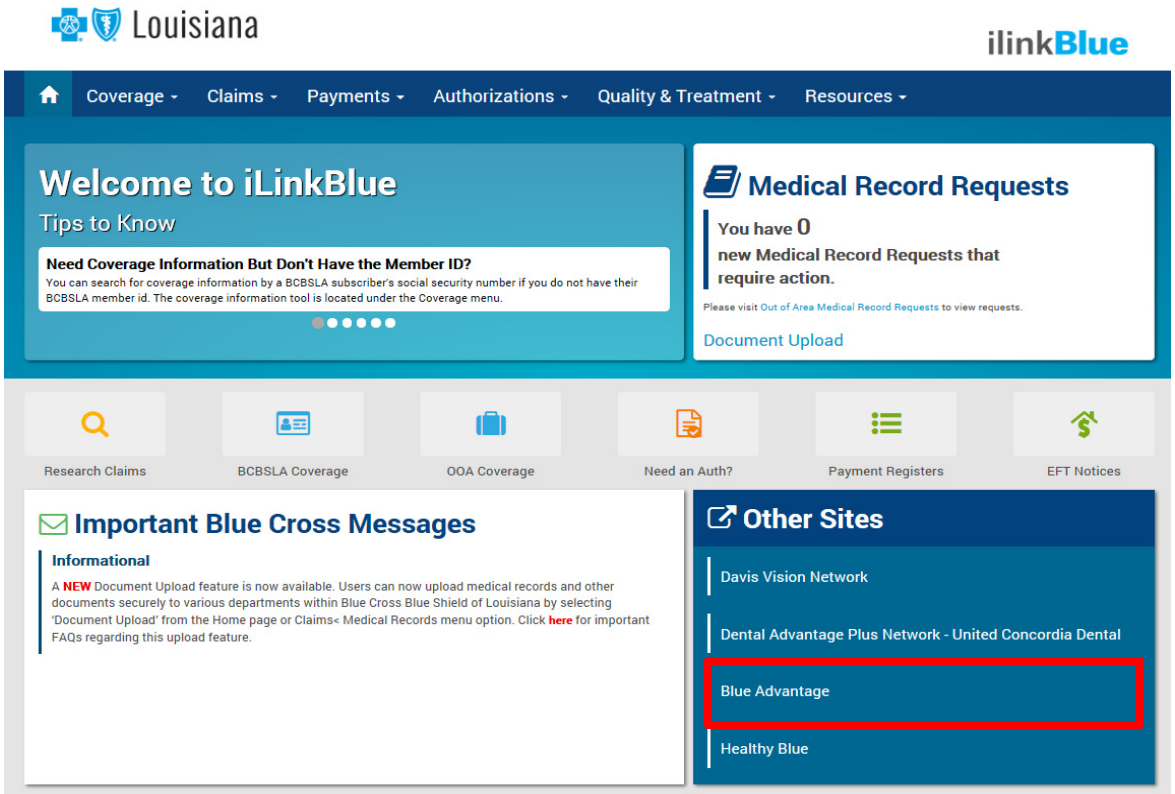
Providers in our Blue Advantage network can access the **Blue Advantage Provider Portal** through iLinkBlue (**www.BCBSLA.com/ilinkblue**)> Blue Advantage (under Other Sites)

- Features that must be accessed through the Portal:
  - Eligibility
  - Claims
  - Authorization Inquiry
  - Lumeris ADSP

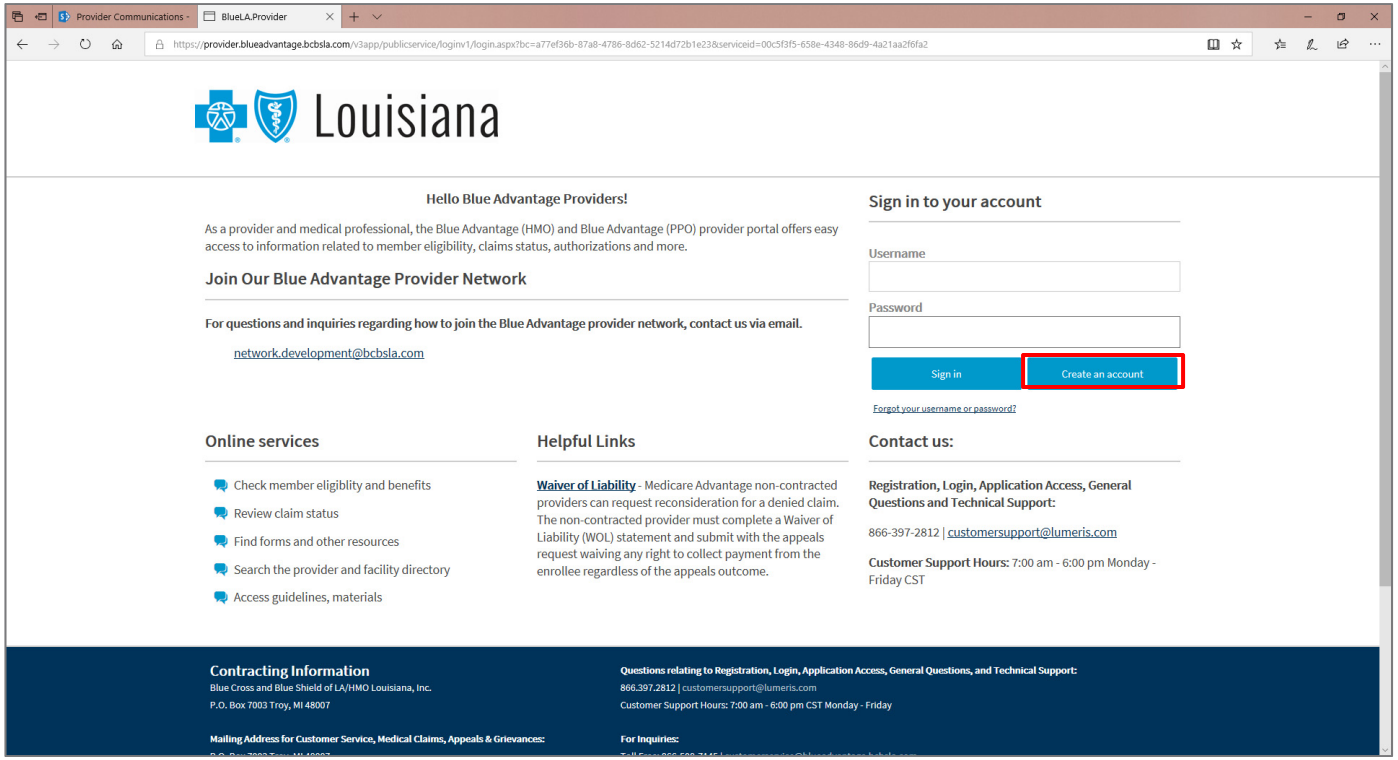
**New users will need to create an account to access all portal features**

# Accessing the Blue Advantage Provider Portal

**www.BCBSLA.com/ilinkblue**



# Blue Advantage Provider Portal Registration




For access to the Blue Advantage Provider Portal, click "**Create an account**"

# 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

# The 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

# Medical Record Documentation, Audits & Reviews

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

<u>The guidelines for the maintenance of medical records state they must be</u>:

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

<u>Medical record request</u>:

- 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**

# Authorization & Benefit Determinations

**Inpatient Admission:**

Plan requires notification within **one business day** of inpatient admission

**Observation:**

Plan requires notification within **one business day** of observation admission

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

**Nurses conduct reviews for the appropriateness of the level of care and discharge planning**

**Medical Necessity Criteria:**

- InterQual (IQ)
- Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD)

# Authorization & Benefit Determinations

## Hospital Admissions:

- Providers can report inpatient admissions to the Medical Management team by:
  - Phone: 1-866-508-7145
  - Fax: 1-877-528-5818 *(available 24 hours a day)*
- Phones are forwarded to a secure voicemail system during non-business hours
- 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 at **www.BCBSLA.com/providers >Blue Advantage Resources**

# Authorization & Benefit Determinations

**The notification process serves to:**

- Confirm the admission is authorized by the PCP, if applicable
- Verify member eligibility, coverage/benefit exclusions
- Identify if the facility is a Blue Advantage contracted provider
- Notify the appropriate hospital case manager of the admission to begin review of continued stay appropriateness and early identification of potential discharge needs

# Prior Authorization

**Requests submitted to Plan via fax, letter or phone**

- Requests can originate from the ordering physician, the member, his/her PCP or representative
- Medical necessity criteria applied

CMS requires multiple provider outreach attempts to obtain necessary clinical information, upon which to make organization determinations

**Provision of robust clinical info upon initial submission is key**

Services requiring authorization are listed in the *Provider Quick Reference Guide* that is available on the Blue Advantage Resources page at **www.BCBSLA.com/providers >Blue Advantage Resources**

# Prior Authorization

**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 verbal 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

When services are partially or fully denied, members are sent a **Notice of Right to an Expedited Grievance** form

# Behavioral Health Authorizations

**New Directions:**

Administers authorizations for the following services for Blue Advantage members:

Facility Authorizations

Inpatient and outpatient behavioral health services including ECTs, Mental Health and Substance Abuse Inpatient Treatment, Psychological Testing, Residential Treatment Center (RTC), Intensive Outpatient Program (IOP) and Partial Hospital Program (PHP)

**online:** New Directions WebPass Portal through iLinkBlue

**phone:** 1-877-250-9167

Once on iLinkBlue (**www.BCBSLA.com/ilinkblue**), click on the "Authorizations" menu option and select "Behavioral Health Authorization"

# Other Authorizations

## AIM Specialty Health:

Administers authorizations for the following outpatient services for Blue Advantage members:

### Radiation Oncology Program

Prior authorizations for radiation therapy services including advanced radiological imaging or radiation therapy services

### High-tech Radiology

Prior authorizations for services including CT, MRI/MRA, Nuclear Cardiology and PET

### Outpatient Musculoskeletal (MSK) Services

Prior authorizations for non-emergency treatment and procedures for spine surgery, joint surgery and interventional pain management

### Cardiology Services

Prior authorizations for select office and outpatient non-emergency procedures

*Note: Authorizations required for inpatient procedures are still handled by Lumeris*

**online:** AIM ***Provider****Portal*$_{SM}$ through iLinkBlue | **phone:** 1-866-455-8416

Once on iLinkBlue (**www.BCBSLA.com/ilinkblue**), click on the "Authorizations" menu option and select "AIM Specialty Health Authorizations"

# Transition of Care

## 100% of members with a high-risk discharge diagnosis are identified for outreach

**Overall Program Goals Using the Coleman Care Transitions Intervention Model©**

- Assist in reducing avoidable hospital readmission and related costs to the member and health plan
- Improve provider follow-up after hospital discharge *(PCP offices are notified via fax of inpatient admissions/ discharges and should schedule a patient follow-up visit within seven days of discharge)*

# 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

# 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, have the member sign and mail to the Social Security Administration office

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

# Outpatient Lab Tests

Blue Advantage network providers can:

- Perform lab work in the office if they are CLIA certified for test(s) being performed
- Draw specimen and send to one of our preferred labs

Blue Advantage Preferred Labs:

**Clinical Pathology Laboratories (CPL)**

**LabCorp**

**Quest Diagnostics**

# 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 1-800-247-2814

# Other Services

- **United Concordia**

  administers routine dental services

- **Express Scripts**

  administers pharmacy benefit management

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

# Part B vs. Part D Overview

B/D

**Some drugs may be covered under Part B or Part D depending on what they treat or where/how they are given**

- If a drug qualifies for coverage under Part B, it **cannot** be covered under Part D
- Drugs that are eligible for coverage under Part B or D may require a prior authorization to ensure correct adjudication

B

**Part B Covered Drugs**

- Primarily drugs covered "Incident To" a physician's service
  - Drug is usually not considered self-administered and must be furnished by the physician's office
- Some drugs are covered at a pharmacy under specific circumstances
- Member cost share is their Part B coinsurance

D

**Part D Covered Drugs**

- Most prescription medications dispensed by a pharmacy
- Outpatient administered drugs that are dispensed by a pharmacy to be given in a provider office (aka "brown bagging" and "white bagging")
  - Exception: those covered under part B or excluded per CMS regulations
- Member cost share depends on the drug's assigned tier

# Overview of Drug Coverage Rules

*Exceptions and Exclusions to Part D Drug Coverage*

B

**Drugs filled or administered at a pharmacy but covered under Part B instead of Part D (not exhaustive)**

- Drugs that require a medical device to administer (ex. albuterol from a nebulizer)
- Select oral chemotherapy drugs that contain the same active ingredient as not self-administered chemotherapy drug
- Immunosuppressive drugs following a Medicare-covered transplant (ex. prednisone – will require prior authorization to determine Part B vs. D)
- Select vaccines such as influenza or pneumococcal
- Hemophilia clotting factors

D

**Part D Exclusions**

- Drugs used for cosmetic purposes, weight loss or weight gain (unless used for AIDS wasting, 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

# Preferred Value Pharmacy Network

## Benefits of Preferred Network

**Cost-savings for member**

- Copayments are now the same at both preferred retail pharmacies and mail order
- Free standard shipping is included for mail order

**Enhanced programs to improve adherence**

- Improve engagement with patient and physician outreach

**Connect members to pharmacies that support Clinical Star measures**

- Preferred network pharmacies are assessed on Part D Clinical Star measures – consistent performance is incentivized

# Preferred Value Pharmacy Network

- The retail **Preferred Value Pharmacy Network** is anchored by Walgreens; however, it also includes other chains and many independent pharmacies
- CVS Pharmacies and some independent pharmacies **are not in** the preferred network
- Members may use non-preferred network pharmacies, but will pay higher copayments on drugs in Tiers 1-3 compared to a preferred pharmacy

**Louisiana chain pharmacies include:**

Walgreens + Albertson's
Costco
Fred's
Kmart
Kroger
Rite Aid
Sam's Club
Sav-On Pharmacy
Walmart

**Many independent pharmacies also participate**

# Benefits of Home 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 home

# 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

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

**TO BE SAFE:**
When setting up first mail-order prescription of a drug, members should make sure to have a 30-day supply of medication on hand to allow processing time

# Diabetic Testing Supplies

- Can receive free OneTouch® (LifeScan) and Freestyle® (Abbott) meters
- $0 coinsurance for covered diabetic test strips
- Available at a network pharmacy or can be delivered to the member's home

**Find complete information online:**

1) www.BCBSLA.com/myblueadvantage
2) Documents
3) 2020 Diabetes Testing Supplies Coverage at Network Pharmacies

**Two ways members may get a FREE meter:**

1) **Go to a Blue Advantage network pharmacy**
   - Members can take their prescription for a covered meter to a Blue Advantage network pharmacy
   - All of the covered meters are available through network pharmacies
2) **Call to get a meter delivered at home**
   - Call Abbott or LifeScan and give the code provided to have a covered meter delivered at home
   - Strips are available at network pharmacies

# ABNs Not Used for Blue Advantage

## CMS does not allow use of Advanced Beneficiary Notices (ABNs) in 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 providers know or have 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** IDN has been issued, the provider may collect from the member for the specific services outlined in the IDN after services are rendered

# 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
- All nurse practitioners, physician assistants and other physician extenders must be identified on the claim **with their own NPI**

**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

# Electronic Claim Submission

- Providers submitting directly to Change Healthcare must make the system changes necessary to send their Blue Advantage claims with the Payer ID **84555**
- Providers who do not send directly to Change Healthcare, please notify your clearinghouse of the new Payer ID **84555** for Blue Advantage claims
- Blue Advantage routine dental should be filed to United Concordia Dental (UCD)
- Blue Advantage routine eye exams and eyewear should be filed to Davis Vision
- Blue Advantage pharmacy claims should be filed to Express Scripts

NOTE: iLinkBlue is not available for submission of claims for Blue Advantage members

# Paper Claims

## Direct all paper claims to:

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
P.O. Box 7003
Troy, MI  48007

# Checking Claim Status

Participating providers should use the online Claim Inquiry tool on the Blue Advantage Provider Portal for standard claims status checks

- Once a claim has been submitted, it can be found online by going to the Blue Advantage Provider Portal. Providers can inquire about a claim by date range or by a specific claim ID.
- For each claim listed, the portal screen will display:
  - Claim number
  - Dates of service
  - Provider name
  - Member name
  - Claim status
  - Date of claim status
  - Payment amount

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

# Resolving Claims Issues

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

- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 working days for first request
- Check Blue Advantage 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 your claims issue is still unresolved after the second request, you may email an overview of the issue along with documentation of your two requests to Provider Relations at:

**provider.relations@bcbsla.com**

# Claims Resubmission

This is a resubmittal of a previously denied Blue Advantage claim line or entire claim and would be used if:

- 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

If an amount was paid on the claim line in question, the provider should not use the claim resubmission process

Note: We added CARC/RARC code **MA130** on all claim lines that are rejected for incorrect billing. The provider should correct and resubmit the claim as a new claim.

# Corrected Claims

A previously paid claim in which the provider needs to add, remove or change a 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.
  - Example: adding or removing a previously paid claim line where charges were billed for a service that was not rendered or the provider did not bill for a service that was rendered
  - Example: changing a previously paid claim line where an incorrect date of service or an incorrect procedure code was billed
- All requests must be submitted and clearly identified as a **corrected claim**

# CMS-1500 Corrected Claims

- EDI/CMS-1500/Professional claims can be submitted electronically as "Corrected Claims"
  - In 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
- CMS-1500 paper claim forms can be submitted as "corrected claims"
  - The paper CMS-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.

The correction will be rejected if the Original Reference Claim Number is not correct either in format or for the member and date of service

# UB-04 Corrected Claims

- EDI/UB-04/Facility corrected claims can be submitted electronically as "Corrected Claims"
  - The TOB must indicate a Frequency "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, and
  - Reason for the correction in Block 80

The correction will be rejected if the Original Reference Claim Number is not correct either in format or for the member and date of service

# Billing Ambulatory Surgical Center (ASC) Claims

**Effective on and after October 1, 2020**, Blue Advantage ASCs must begin filing claims on a CMS-1500 form for all Medicare Advantage members. Beginning January 1, 2021, ASC claims received on the incorrect claim form will be denied.

# Timely Filing Disputes

If disputing a timely filing denial of a claim and the claim is filed:

## Electronically

The only acceptable proof of timely filing is the second level acceptance report from the clearinghouse that indicates the claim was accepted by Blue Advantage

## Paper

The provider must submit supporting documentation from their practice management system including the applicable field descriptions since the documentation is specific to your system

**OR**

A UB-04/CMS-1500 with the original date billed AND documentation supporting the claim was submitted within the timeframe specified in your contract agreement from the date of service, **AND** follow-up was done at a minimum of every 60 days

- If there is no documentation supporting the follow-up activity (i.e., filed second submission MM/DD/YYYY or contacted plan and spoke with_, on MM/DD/YYYY) the timely filing denial will stand. This documentation is required for any CMS audits.

# Provider Pay Disputes

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

1. The claim must be filed within the timeframe specified in your contract agreement from the date the claim was processed to dispute the payment amount

2. Participating providers are not allowed to seek additional compensation from members other than copayments, deductibles, coinsurance and payment for non-covered services

3. The dispute should be submitted in writing and include the basis for the dispute and documents supporting your position

# Provider Pay Disputes Cont'd

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

4. Blue Advantage will communicate the decision either verbally or in writing if it is determined the correct amount was previously paid

5. If payment is corrected, it will appear on a remittance advice to the requesting provider

*The review is by Blue Advantage and determination is final*

To initiate the general dispute resolution process, providers should send a written notice with a brief description of the dispute to:

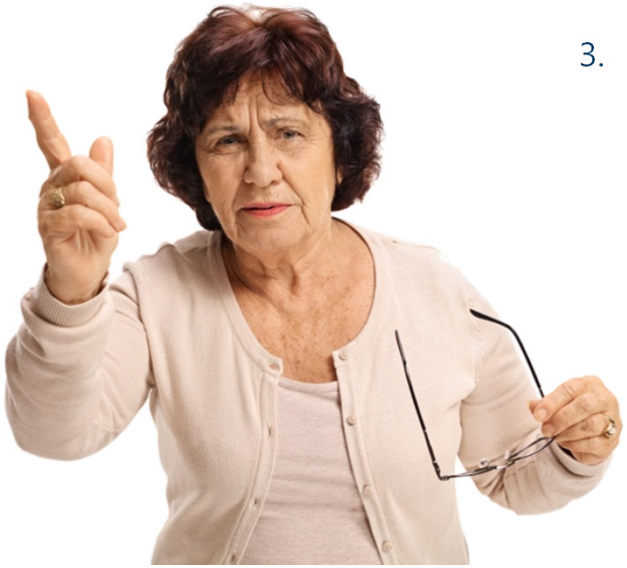
**Blue Cross and Blue Shield of Louisiana / HMO Louisiana, Inc.**
**Provider Disputes**
**P.O. Box 7003**
**Troy, MI 48007**

# 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

# Adjustments, Additional Payments, Overpayments & Voluntary Refunds

Blue Advantage will perform adjustments upon discovery of an incorrectly processed claim

- Adjustment claims can be identified on provider remits as ending in:

  "**01**" "**02**" "**03**" etc.

- If an adjustment results in additional payment, it will appear on the provider's remittance

- If an adjustment results in an overpayment, an overpayment letter will be issued to the provider

- If a refund is not received timely, the overpayment will be withheld from the provider's next remittance

# 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

# Transition to Vantage

- Beginning January 1, 2021, Blue Advantage will be transitioning our business operations from Lumeris Healthcare Outcomes to Vantage Health Plan
- Vantage has extensive Medicare Advantage experience
- This partnership allows BA to:
  - Further innovate and impact cost and quality of care
  - Continue to deliver exceptional customer services
  - Continue to improve the health and lives of Louisianians

Additional details will be provided in the coming months. If you have questions about this transition, email Provider Relations at provider.relations@bcbsla.com and include “BA transition” in the subject line

# Provider Relations



**Your Blue Cross and Blue Shield of Louisiana Provider Relations Team**

Left to right: Marie Davis, Melonie Martin, Anna Granen, Patricia O'Gwynn, Jami Zachary, Mary Guy, Kelly Smith, Lisa Roth

# Provider Relations

*provider education & onsite training*

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Director

**Jami Zachary**
Manager

**Anna Granen**
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**Kelly Smith**
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**Marie Davis**
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**Mary Guy**
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**Melonie Martin**
East Baton Rouge

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

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

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# Network Development

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# Provider Credentialing & Data Management (PCDM)

## Provider Network Setup, Credentialing & Demographic Changes

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**Mary Reising** Manager – mary.reising@bcbsla.com
**Anne Monroe** Provider Data Supervisor - anne.monroe@bcbsla.com
**Rhonda Dyer** Credentialing Supervisor - rhonda.dyer@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 by emailing **PCDMstatus@bcbsla.com** or by calling 1-800-716-2299

1-800-716-2299 | option 2 – credentialing | option 3 – provider data management
Fax: 225-297-2750 • **pcdmstatus@bcbsla.com**

# EDI Contact Information

## iLinkBlue

**www.BCBSLA.com/ilinkblue**
1-800-216-2583
EDIServices@bcbsla.com

## Electronic Funds Transfer

Provider Credentialing & Data Management (PCDM)
1-800-716-2299, option 3
network.administration@bcbsla.com

# Questions