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 "Panelists"
- 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

Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Blue Advantage Network Workshop

December 2020

An educational presentation from the Provider Relations Department of Blue Cross and Blue Shield of Louisiana

20-185_Y0132_C
18NW2606 R12/20

Last reviewd on 12/22/2020

Our Mission

To improve the health and lives of Louisianians

Our Core Strategies

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

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

Agenda

Welcome to our Blue Advantage Networks

Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

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

Vantage Health Plan

Beginning January 1, 2021, Blue Advantage (BA) 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

If you have questions about this transition, email Provider Relations at provider.relations@bcbsla.com and include "BA transition" in the subject line

Transition Highlights

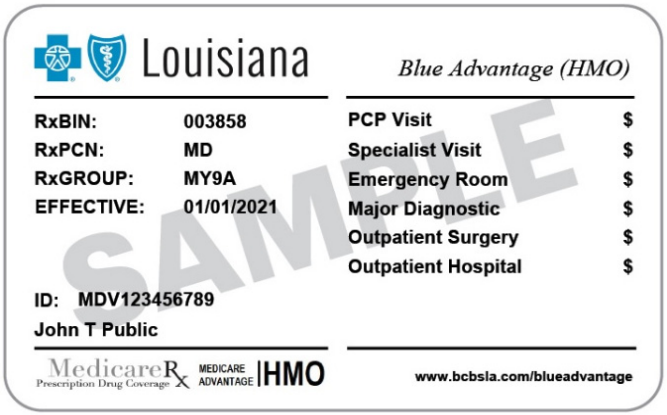
New Member ID Cards

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

- Name of the covered member
- Copayment or coinsurance responsibilities
- Important phone numbers
- The member ID card is used for all types of coverage such as Medicare Part A, Part B and Part D (pharmacy)

Note: Blue Advantage member ID cards with prefixes XUM and XUN will not be valid for 2021 dates of service

PMV prefix



MDV prefix

New

Accessing Our Secure Online Services

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

- iLinkBlue
- Blue Advantage Provider Portal*

Access to these applications are granted by your organization's Administrative Representative or Group Moderator

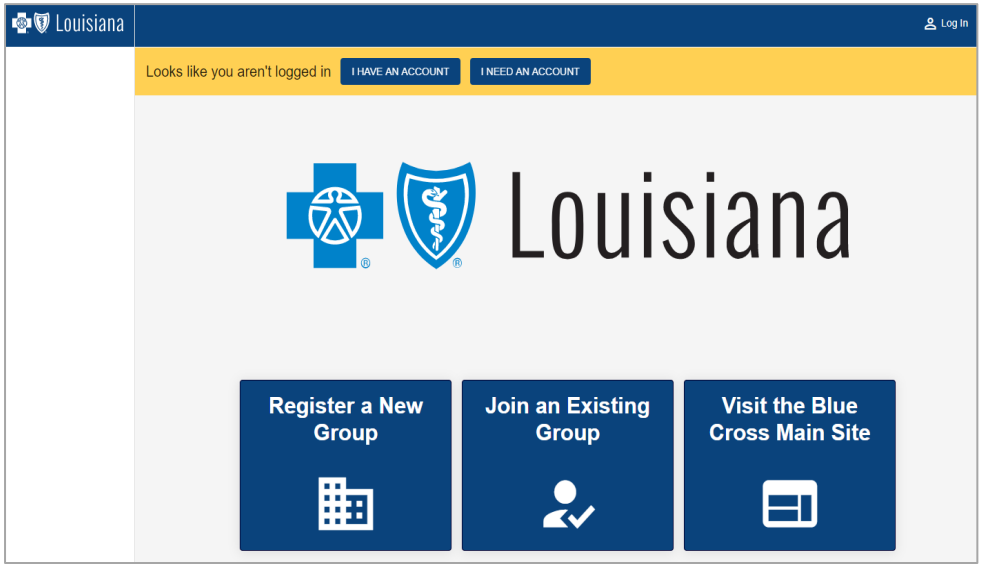
**For additional information on the new Blue Advantage Provider Portal please attend one of our Blue Advantage Portal webinars on Wednesday December 2 or 9. There will be a morning and afternoon session on both days, 10 a.m. or 2 p.m.*

New

2021 Blue Advantage Provider Portal

As a part of this transition, providers will need to access the new Blue Advantage Provider Portal for 2021 resources such as:

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



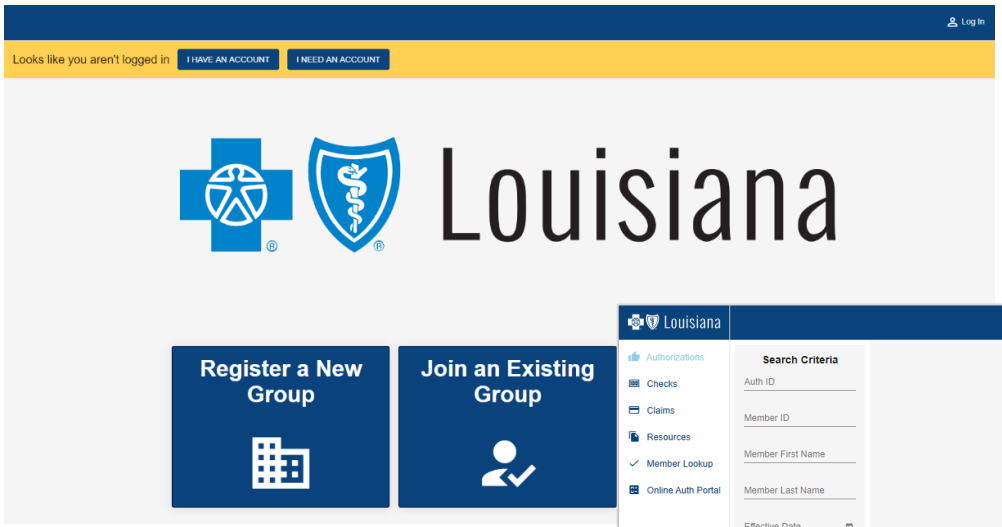
All 2021 portal features will be available on December 15, 2020

The new Blue Advantage Provider Portal will soon be available through iLinkBlue (**www.BCBSLA.com/ilinkblue**) >Blue Advantage (under Other Sites)

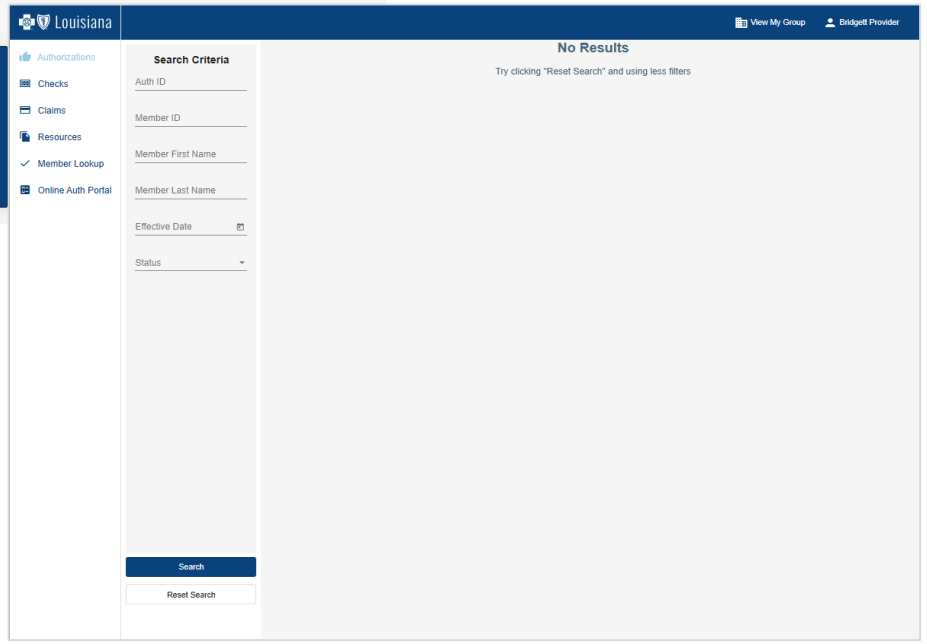
New

Accessing the Blue Advantage Provider Portal

Provider Portal Login



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



Provider Portal Home Page

New Prior Authorization

Providers may submit prior authorization requests for 2021 dates of service by using one of the following authorization forms:

- Behavioral Health Authorization Form
- Home Health Authorization Form
- Inpatient Authorization Form
- Outpatient Authorization

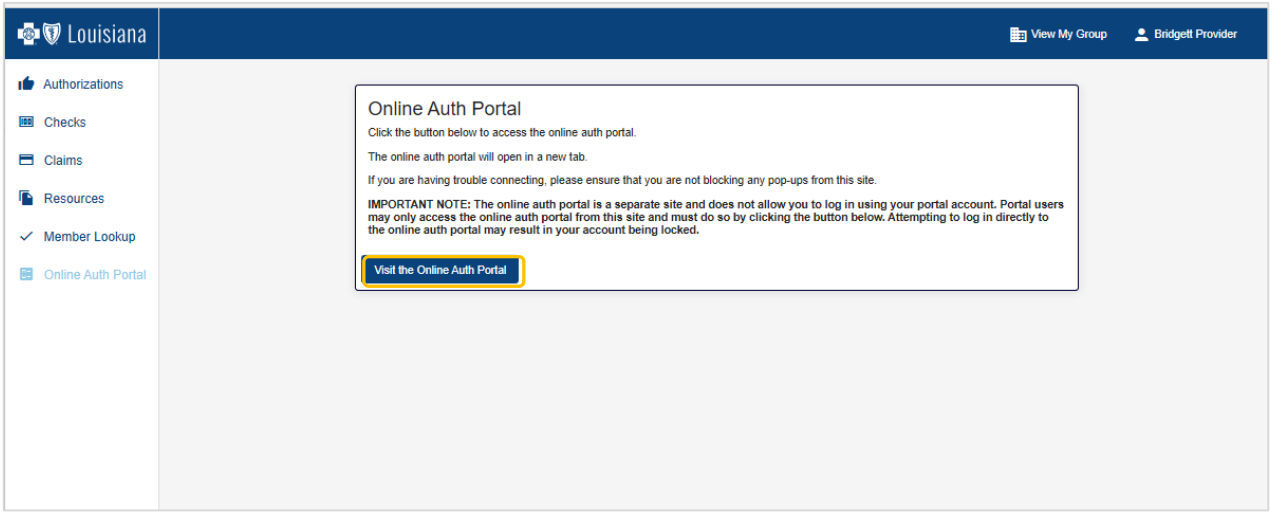
The 2021 *Provider Quick Reference Guide* includes the list of 2021 services requiring prior authorization. It is available on the Blue Advantage Resources Page, **www.BCBSLA.com/providers**, then click "Go to BA Resources" at the bottom of the page.

New

Prior Authorization

Coming soon, providers can use the "Online Auth Portal" to request a prior authorization for the following services on the 2021 provider portal:

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



New

Authorization Administration Changes

Prior Authorization Type	Dates of Service **before** January 1, 2021	Dates of Service on or **after** January 1, 2021
Behavioral Health	New Directions	Vantage
High-tech Radiology	AIM	Vantage
Home Health	Lumeris	Vantage
Inpatient Services	Lumeris	Vantage
Office and Outpatient Cardiology	AIM	Vantage
Outpatient Musculoskeletal	AIM	Vantage
Outpatient Services	Lumeris	Vantage
Radiation Oncology	AIM	Vantage

New

Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)

2021 EFT/ERA processes will be managed by RedCard

- Providers who are currently set up for both EFT and ERA services with Blue Advantage are being automatically set up with RedCard for 2021
- Providers will receive an email from RedCard to verify that they have been successfully set up to receive EFT payments and ERAs in 2021
  - A link will be included to access and confirm your information and password setup
  - If you have not received this email by December 10, 2020, please contact RedCard directly at 1-844-292-4066 or send an email to support@ach835.com
- Providers will continue to receive EFT payments and ERAs for 2020 dates of services from Lumeris that are processed through June 30, 2021

Providers who are not set up with RedCard by the first check run in 2021 will receive paper checks

The estimated date for the first check run is the second or third week of January

New

Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)

If it is determined that you are not set up for EFT and ERA services, complete the following steps:

1. Download the *Provider EFT/ERA Enrollment Form* from the Blue Advantage Resources page. Go to **www.BCBSLA.com/providers**, then click on "Go to BA Resources" at the bottom of the page and choose "Forms."

2. Submit the completed form directly to RedCard by fax or mail:

   fax: (314) 567-4503

   mail: RedCard Systems, Attn: EFT/ERA Enrollment
   744 Office Pkwy
   Creve Coeur, MO 63141

If you have questions about EFT/ERA enrollment, contact RedCard at 1-844-292-4066

New

2021 Billing Changes

Effective January 1, 2021:

- Medicare Advantage ambulatory surgical center (ASC) claims must be submitted on a CMS-1500. If submitted on a UB-04 claim form, it will be denied, and must be resubmitted on a CMS-1500 claim form
- When a member is seen by a hospital-based provider
  - Providers must include POS 19 **or** 22 when services are rendered in hospital-based clinic

    Note: site of service reduction will be applied to the professional fee
  - Facilities will bill these services under revenue code 510 **or** 761
  - Member's cost share will apply to the professional charge only

New

2021 Billing Reminders

- When billing diagnostic services on the same day as an office visit, providers should bill **both** services on the same claim form
- When billing anesthesia services, providers must include the appropriate modifiers in accordance with CMS guidelines. Refer to **www.CMS.gov**.
- All nurse practitioners, physician assistants and other physician extenders must be identified on the claim **with their own NPI**

New

Claims Runout Process

Inpatient

(Acute, Psych, SNF, Substance Abuse, Rehab, LTCH)

Date of Service	Submit to Lumeris	Submit to Vantage
2020 admission submitted before June 30, 2021	✓	
2020 admission submitted after June 30, 2021		✓

Outpatient ER

Date of Service	Submit to Lumeris	Submit to Vantage
2020 begin DOS submitted before June 30, 2021	✓	
2020 begin DOS submitted after June 30, 2021		✓

New

Claims Runout Process

Outpatient Observation

Date of Service	Lumeris	Vantage
2020 begin DOS submitted before June 30, 2021	✓	
2020 begin DOS submitted after June 30, 2021		✓

Home Health

Date of Service for 30-day episode	Lumeris	Vantage
2020 begin date of episode submitted before June 30, 2021	✓	
2020 begin date of episode submitted after June 30, 2021		✓

New

Claims Runout Process

Professional, Ancillary and Other Outpatient Claims

Providers will need to split bill for the following services that span the benefit year:

- Partial hospitalization (PHP and IOP)
- Mental Health/Behavioral Health/ Substance Abuse counseling
- Nutritional counseling
- Supervised exercise therapy (SET)
- Cardiac & intensive rehabilitation
- Pulmonary rehabilitation
- DME & supplies
- Chemotherapy/radiation
- Dialysis
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Other therapies

Date of Service	Submit to Lumeris	Submit to Vantage
2020 dates of service submitted before 6/30/2021	✓	
2020 dates of service submitted after 6/30/2021		✓

Network Information

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 "Resources" section, click on "Compliance." See Slide 9 for how to access the Blue Advantage Provider Portal.

Role of the Primary Care Provider (PCP)

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

- Oversee, coordinate, discuss and direct the member's care with the member's care team, specialists and hospital staff
- Develop and grow the provider-member relationship while being proactive and cost effective
- Responsible for coordinating members' medically necessary services
- When a member changes to a new PCP, upon request, the prior PCP has 10 business days of request to submit records to new PCP

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

Appointment Scheduling & Wait Times

All Blue Advantage network providers must use their best effort to adhere to the following standards for appointment scheduling and wait times

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

Providers should make every effort to see the patient within an average of one hour from the patient's scheduled appointment

Annual Wellness Coupon Program

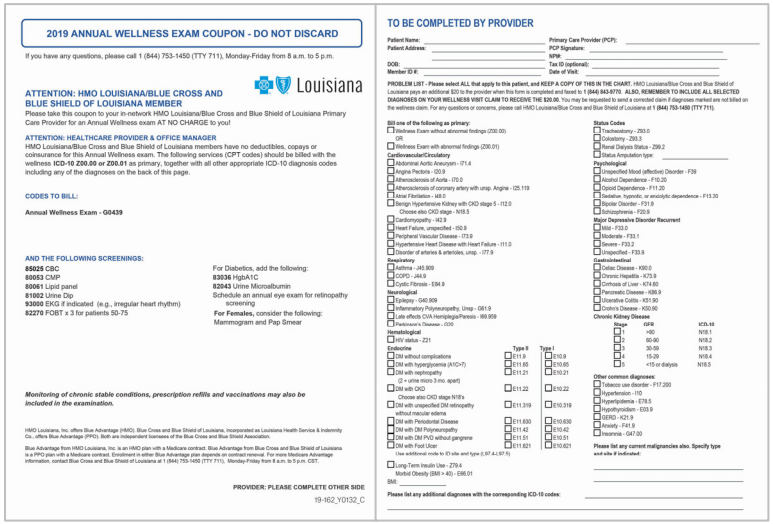
- Members will receive a paper coupon in the mail for their annual wellness exam, which should be provided by their PCP
- The goal is to help facilitate wellness visits by providing:
  - Pertinent details about the member's previously documented chronic conditions/current diagnoses
  - Relevant clinical tests for the member
  - Commonly overlooked conditions/diagnoses that may be applicable to the member
  - Suspected conditions based on claims history

Annual Wellness Coupon Program

- 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 on 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

What will the coupon look like?



2019 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: HMO LOUISIANA/BLUE CROSS AND BLUE SHIELD OF LOUISIANA MEMBER

Please take this coupon to your in-network HMO Louisiana/Blue Cross and Blue Shield of Louisiana 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

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.

HMO Louisiana, Inc. 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 HMO Louisiana, Inc. 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. For more Medicare Advantage information, contact Blue Cross and Blue Shield of Louisiana at 1 (844) 753-1450 (TTY 711), Monday-Friday from 8 a.m. to 5 p.m. CST.

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#: _____
DOB: _____ Tax ID (optional): _____
Member ID #: _____ Date of Visit: _____

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) 843-9370**. **ALSO, REMEMBER TO INCLUDE ALL SELECTED DIAGNOSES ON YOUR WELLNESS VISIT CLAIM TO RECEIVE THE $20.00.** 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).**

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

Cardiovascular/Circulatory
- ☐ Abdominal Aortic Aneurysm - I71.4
- ☐ Angina Pectoris - I20.9
- ☐ Atherosclerosis of Aorta - I70.0
- ☐ Atherosclerosis of coronary artery with unsp. Angina - I25.119
- ☐ Atrial Fibrillation - I48.0
- ☐ Benign Hypertensive Kidney with CKD stage 5 - I12.0
  Choose also CKD stage - N18.5
- ☐ Cardiomyopathy - I42.9
- ☐ Heart Failure, unspecified - I50.9
- ☐ Peripheral Vascular Disease - I73.9
- ☐ Hypertensive Heart Disease with Heart Failure - I11.0
- ☐ Disorder of arteries & arterioles, unsp. - I77.9

Respiratory
- ☐ Asthma - J45.909
- ☐ COPD - J44.9
- ☐ Cystic Fibrosis - E84.9

Neurological
- ☐ Epilepsy - G40.909
- ☐ Inflammatory Polyneuropathy, Unsp. - G61.9
- ☐ Late effects CVA Hemiplegia/Paresis - I69.959
- ☐ Parkinson's Disease - G20

Hematological
- ☐ HIV status - Z21

Endocrine

	Type II	Type I
☐ DM without complications	☐ E11.9	☐ E10.9
☐ DM with hyperglycemia (A1C>7)	☐ E11.65	☐ E10.65
☐ DM with nephropathy (2 + urine micro 3 mo. apart)	☐ E11.21	☐ E10.21
☐ DM with CKD Choose also CKD stage N18's	☐ E11.22	☐ E10.22
☐ DM with unspecified DM retinopathy without macular edema	☐ E11.319	☐ E10.319
☐ DM with Periodontal Disease	☐ E11.630	☐ E10.630
☐ DM with DM Polyneuropathy	☐ E11.42	☐ E10.42
☐ DM with DM PVD without gangrene	☐ E11.51	☐ E10.51
☐ DM with Foot Ulcer Use additional code to 1) site and type (L97.4-L97.5)	☐ E11.621	☐ E10.621

- ☐ Long-Term Insulin Use - Z79.4
- ☐ Morbid Obesity (BMI > 40) - E66.01

BMI: _____

Please list any additional diagnoses with the corresponding ICD-10 codes:

Status Codes
- ☐ Tracheostomy - Z93.0
- ☐ Colostomy - Z93.3
- ☐ Renal Dialysis Status - Z99.2
- ☐ Status Amputation type: _____

Psychological
- ☐ Unspecified Mood (affective) Disorder - F39
- ☐ Alcohol Dependence - F10.20
- ☐ Opioid Dependence - F11.20
- ☐ Sedative, hypnotic, or anxiolytic dependence - F13.20
- ☐ Bipolar Disorder - F31.9
- ☐ Schizophrenia - F20.9

Major Depressive Disorder Recurrent
- ☐ Mild - F33.0
- ☐ Moderate - F33.1
- ☐ Severe - F33.2
- ☐ Unspecified - F33.9

Gastrointestinal
- ☐ Celiac Disease - K90.0
- ☐ Chronic Hepatitis - K73.9
- ☐ Cirrhosis of Liver - K74.60
- ☐ Pancreatic Disease - K86.9
- ☐ Ulcerative Colitis - K51.90
- ☐ Crohn's Disease - K50.90

Chronic Kidney Disease

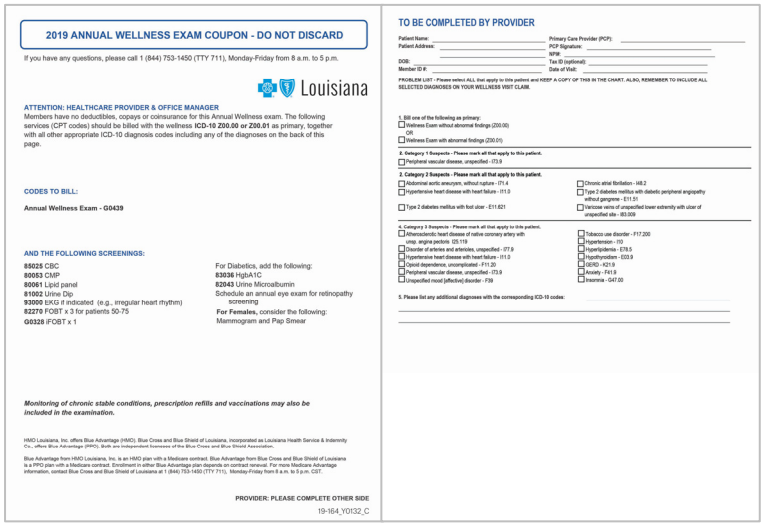
Stage	GFR	ICD-10
☐ 1	>90	N18.1
☐ 2	60-90	N18.2
☐ 3	30-59	N18.3
☐ 4	15-29	N18.4
☐ 5	<15 or dialysis	N18.5

Other common diagnoses:
- ☐ Tobacco use disorder - F17.200
- ☐ Hypertension - I10
- ☐ Hyperlipidemia - E78.5
- ☐ Hypothyroidism - E03.9
- ☐ GERD - K21.9
- ☐ Anxiety - F41.9
- ☐ Insomnia - G47.00

Please list any current malignancies also. Specify type and site if indicated:

_____
_____
_____

Option 1:
Members who have claims history



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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.

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PROVIDER: PLEASE COMPLETE OTHER SIDE

19-164_Y0132_C

TO BE COMPLETED BY PROVIDER

Patient Name: _____ Primary Care Provider (PCP): _____
Patient Address: _____ PCP Signature: _____
_____ NPI#: _____
DOB: _____ Tax ID (optional): _____
Member ID #: _____ Date of Visit: _____

PROBLEM LIST - Please select ALL that apply to this patient and KEEP A COPY OF THIS IN THE CHART. ALSO, REMEMBER TO INCLUDE ALL SELECTED DIAGNOSES ON YOUR WELLNESS VISIT CLAIM.

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.
- ☐ Peripheral vascular disease, unspecified - I73.9

3. Category 2 Suspects - Please mark all that apply to this patient.
- ☐ Abdominal aortic aneurysm, without rupture - I71.4
- ☐ Hypertensive heart disease with heart failure - I11.0
- ☐ Type 2 diabetes mellitus with foot ulcer - E11.621
- ☐ Chronic atrial fibrillation - I48.2
- ☐ Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene - E11.51
- ☐ Varicose veins of unspecified lower extremity with ulcer of unspecified site - I83.009

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:

_____
_____

Option 2:
Members who do NOT have claims history

Medical Documentation

Medical Records 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
- Varis and Inovalon are approved vendors for these requests

Medical Records Signature Requirements

Guidelines regarding signatures on medical records are found in your *Blue Advantage Provider Administrative Manual*

Electronic Signatures

Acceptable:

- Chart "Accepted by" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed by" with provider's name
- "Signed: John Smith MD"

Unacceptable:

- Dictated but not read
- Signed but not read
- Auto-authentication
- Generated by

Medical Management

Role of Medical Management

Nurses, clinical pharmacists, social workers, physicians who coordinate:

- Prior authorization, concurrent review, discharge planning and assistance with referrals
- Notify PCP offices of acute discharges for PCP follow-up
- Case and Disease Management programs (please see manual for complete program list)

Authorization and Benefit Determinations

Inpatient Admission:

Plan requires notification within one business day of inpatient (IP) admission

Observation:

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

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

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

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

Medical Necessity Criteria:

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

Prior Authorization

Submit request via fax, letter, phone or portal

- Originate from member, their provider or representative
- Apply medical necessity criteria

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

Provision of robust clinical information upon initial submission is key

The *Provider Quick Reference Guide* includes the list of services requiring prior authorization. It is available on the Blue Advantage Provider Portal.

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 oral communication

Expedited

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

*Contracted providers can submit an appeal **only** when it involves a pre-service request*

Member sent written Notice of Right to an Expedited Appeal

Notice of Discharge from an Inpatient Facility

The Important Message (IM) from Medicare:

- Statutorily required notice
- Informs Medicare beneficiaries that their covered hospital care is ending
- The IM must be given to the member within two days of discharge

The Notice of Medicare Non-Coverage (NOMNC):

- Notifies Medicare beneficiaries that their skilled nursing facility (SNF), home health care (HHC) or comprehensive outpatient rehabilitation facility (CORF) services are ending
- Must be given to the member and/or their identified representative a minimum of two days prior to discharge
- A signed NOMNC must be faxed to Blue Advantage Medical Management at **1-877-528-5816**

Samples of these forms are located in the Sample of Forms section of the *Blue Advantage Provider Administrative manual*. The member's appeal rights are included on both the IM and NOMNC forms.

Transition of Care

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

Overall Program Goals Are To:

- 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 discharges and should schedule patient follow-up visits 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

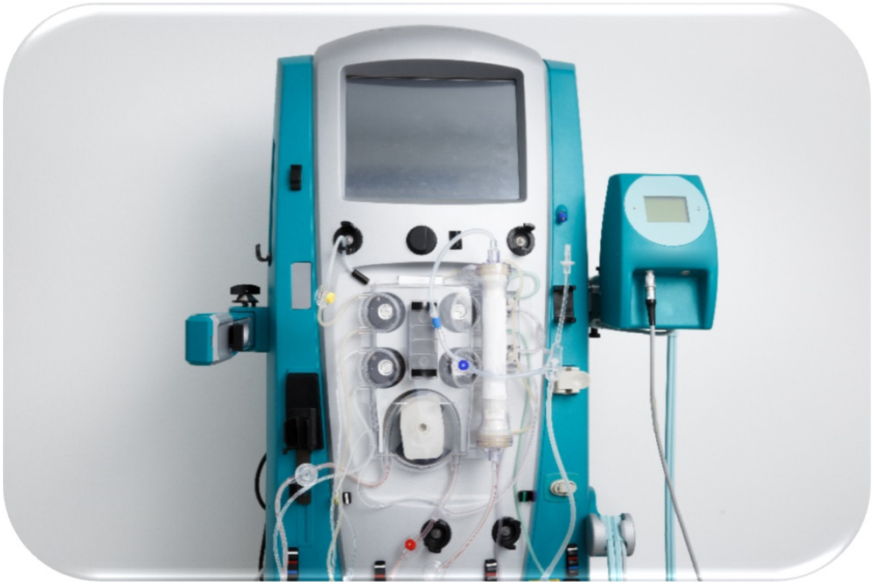
How we do it:

- 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

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

Dialysis Patients

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



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

Other Services

Outpatient Lab Tests

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

Blue Advantage Preferred Labs:

- Clinical Pathology Laboratories (CPL)

  www.cpllabs.com

- Laboratory Corporation of America (LabCorp)

  www.labcorp.com

- Quest Diagnostics

  www.questdiagnostics.com

Refractions

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

Other Services

- **United Concordia**

  administers routine dental services

  phone: 1-866-445-5825

- **Express Scripts**

  administers pharmacy benefit management

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

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

Pharmacy

Part B vs Part D Overview

B

Part B Covered Drugs

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

D

Part D Covered Drugs

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

B/D

Part B or Part D Covered Drugs

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

Overview of Drug Coverage Rules

B

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

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

D

Part D

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

Part D Exclusions

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

**There is currently no FDA approved vaccine for coronavirus disease (COVID-19). However, if and when a vaccine is available, Blue Advantage will provide coverage to members in accordance with CMS guidance.*

Preferred Value Pharmacy Network

Benefits of Preferred Network

Cost-savings for member

- Members will pay less for drugs in Tiers 1–3
- Copays are now the same at both preferred retail and mail order pharmacies
- Free standard shipping is included with Express Scripts 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**

Members may use standard network pharmacies but will pay higher copays on drugs in Tiers 1 – 3 compared to a preferred pharmacy

CVS Pharmacies and some independent pharmacies **are not in** the Preferred Network

Louisiana chain pharmacies include:

Walgreens
Kroger
Sam's Club
Walmart

Many independent pharmacies also participate

Pharmacy network changes are common, and our network is undergoing a few extra changes in 2021.

We encourage members to double check that their selected pharmacy is participating in the way they expect

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 member's 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 your 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

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

Members can find the following information online at www.BCBSLA.com/blueadvantage:

1) Documents
2) 2021 Diabetes Testing Supplies Coverage at Network Pharmacies

Call Abbott toll free at 1 (866) 224-8892 and use the code **MWXODF9F**

Call LifeScan toll free at: 1 (877) 764-5393 and use the code **151btn002**

Pharmacist Outreach Initiatives

Medication Adherence

Provider Outreach

Our Academic Detailing Pharmacist may contact your office for assistance with members who we have identified as possibly having a medication-related gap in care:

- Non-adherent to certain medications for diabetes, hypertension or hyperlipidemia
- Diagnosis of Rheumatoid Arthritis without a claim for a disease modifying drug
- Established cardiovascular disease or diabetes with no claim for a statin

Member Outreach

- Refill reminders to members who are determined to be at-risk of becoming non-adherent to certain medications
- Pharmacists will call members directly who are a single day late to fill targeted medications
- Pharmacists will answer questions, offer helpful tips, provide members with reminder tools or help transfer their prescriptions to mail-order if desired

Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

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

Billing and Claims Requirements

COVID-19 Billing

For current and future billing guidelines related to the novel coronavirus (COVID-19), providers should access the COVID-19 section for the Blue Advantage Resources page

www.BCBSLA.com/providers
>click on "Go to BA Resources" at the bottom of the page

ABNs Not Used for Blue Advantage

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

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

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

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

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

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

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

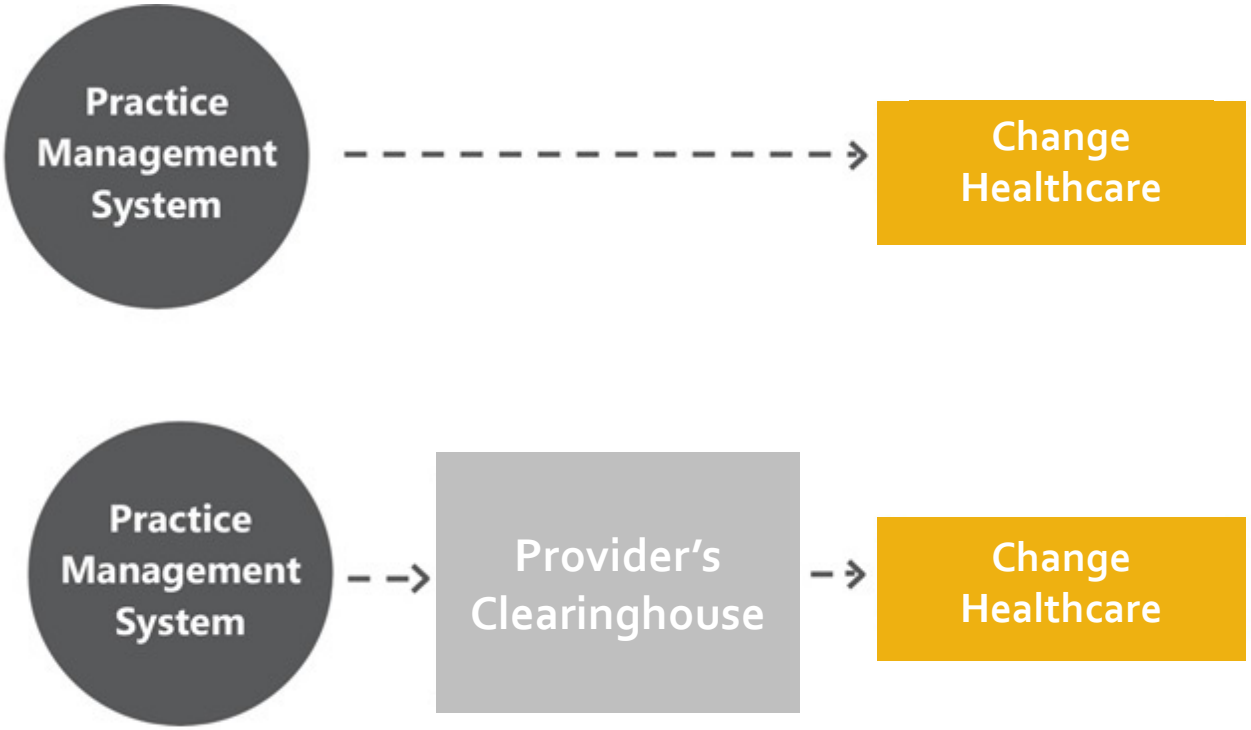
OR

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.

Electronic Claim Submission

All electronic claims must be received via Change Healthcare (professional and facilities/UBs). Blue Advantage is unable to receive claims filed directly from any other source.



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 **72107**
- Providers who do not send directly to Change Healthcare, please notify your clearinghouse of the new Payer ID **72107** 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

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

Paper Claims

Mail all paper claims to new address:

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

Faxed claims are **not** accepted

Reimbursement Guidelines for Facilities

Multiple Surgeries

The following are payment guidelines for a facility when billing multiple surgical procedures performed at the same operative session:

Primary Procedure	lesser of charges or 100% of fee schedule*
Secondary Procedure	lesser of charges or 50% of fee schedule*
Third-Fifth Procedures	lesser of charges or 50% of fee schedule*

** minus copayments and deductibles, as applicable*

Reimbursement Guidelines for Physicians

Multiple Surgeries

The following are CMS payment guidelines for physician/practitioner when billing for multiple surgical procedures performed at the same operative:

Primary Procedure – lesser of charges or 100% of fee schedule*

Secondary Procedure – lesser of charges or 50% of fee schedule*

Third-Fifth Procedures – lesser of charges or 50% of fee schedule*

** minus copayments and deductibles, as applicable*

Endoscopies

Blue Advantage follows Medicare pricing for endoscopy procedures by reducing a multiple, same family, endoscopy claim by the base scope allowable and applying the applicable multiple surgery reductions to different family endoscopy claims

The following are CMS payment guidelines for assistant surgeons (if an assistant surgeon is warranted based upon the surgery performed):

- **For Physicians**, 16% of total amount paid to the surgeon minus copayments and deductibles, as applicable

Multiple surgery restrictions apply

Reimbursement Guidelines

Subset Procedure

- Overpayments can result from procedural unbundling. This occurs when two or more procedures are used to bill for a service when a single, more comprehensive procedure exists that more accurately describes the complete service.
- When this occurs the component procedures will be denied and rebundled to pay the comprehensive procedure

Examples:

- If the comprehensive procedure has been submitted along with the component procedures, either on a single claim or on multiple claims, all component codes will be denied and rebundled to the comprehensive code
- If only the component codes are billed either on a single claim or on multiple claims, all component codes will be denied, and the comprehensive code will be added to the claim for payment

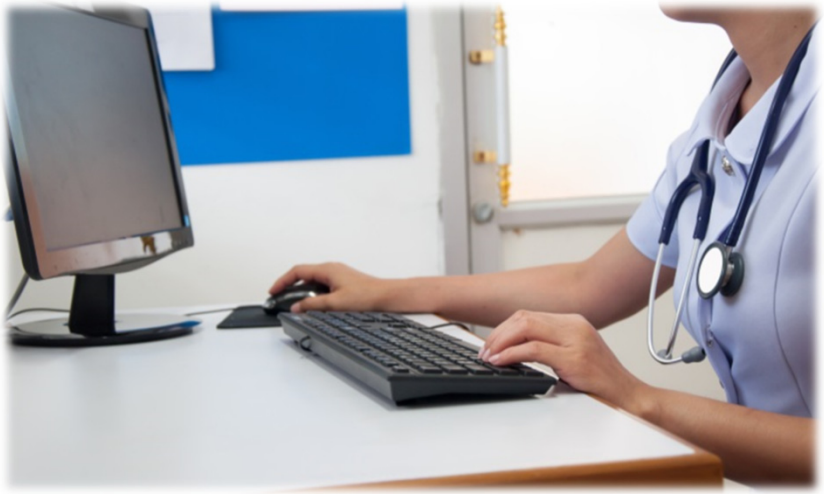
Subrogation

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

Checking Claim Status

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

- There are multiple ways to inquire about a claim listed in the Blue Advantage Provider Administrative Manual.
- For each claim listed, the portal screen will display:
  - Claim number
  - Date(s) of service
  - Provider name
  - Member name
  - Claim status
  - Date of claim status
  - Payment amount



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

Resolving Claims Issues

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

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

When to Contact Provider Relations for Claims Help

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

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

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

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

We have recently 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 previously paid claim line

Providers must submit a corrected claim if all lines of the claim were previously paid and they are wanting to add or remove a claim line or change something on a claim line. Example: date of service, procedure code, etc.

- Examples:
  - adding or removing a previously paid claim line where charges were billed for a service that was not rendered, or provider did not bill for a service that was rendered
  - changing a previously paid claim line where an incorrect date of service or an incorrect procedure code was billed

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

CMS-1500 Corrected Claims

EDI/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

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

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

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

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

UB-04 Corrected Claims

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

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

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

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

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

Provider Pay Disputes

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

1. Disputes must be filed within the timeframe specified in your contract agreement from the date the claim was processed to dispute the payment amount
2. Should be submitted in writing and include the basis for the dispute and documents supporting your position

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

The review is by Blue Advantage and determination is final

Provider Pay Disputes

Once a decision has been made:

1. Blue Advantage will communicate the decision either verbally or in writing if it is determined the correct amount was previously paid
2. If payment is corrected, it will appear on a remittance advice to the requesting provider

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 LA/HMO Louisiana, Inc.
Provider Disputes
130 DeSiard St, Ste 322
Monroe, LA 71201

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:

  "**A1**" "**A2**" "**A3**" etc.

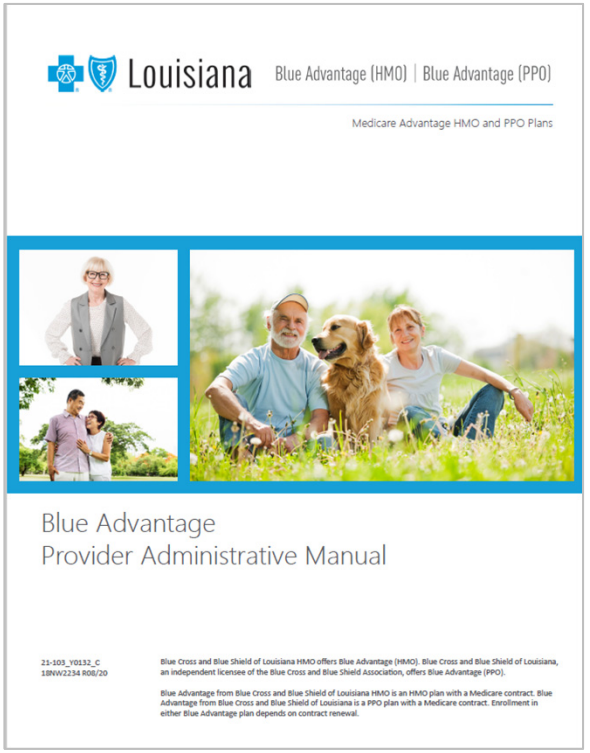
- If an adjustment results in additional payment, it will appear on the provider's remittance
- If an adjustment results in an overpayment, an overpayment letter will be issued to the provider
- If a refund is not received timely, the overpayment will be withheld from the provider's next remittance
- If you discover an overpayment you are obligated, via your contractual agreement and or CMS regulations, to issue a voluntary refund

Resources

Provider Manual

The *Blue Advantage Provider Administrative Manual* includes:

- policies
- procedures
- standards of care
- sample forms
- and more

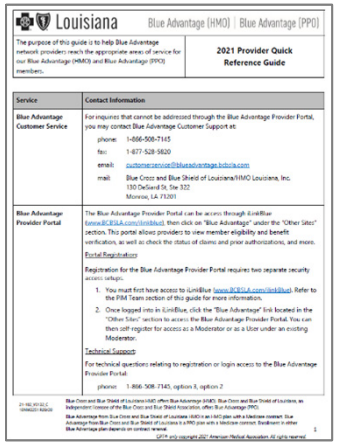


It is located on the Blue Advantage Provider Portal

Provider Guides Available Online

Provider Quick Reference Guide

- Contact information for specific services
- Prior authorization/notification list for services
- Drug prior authorization list


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.

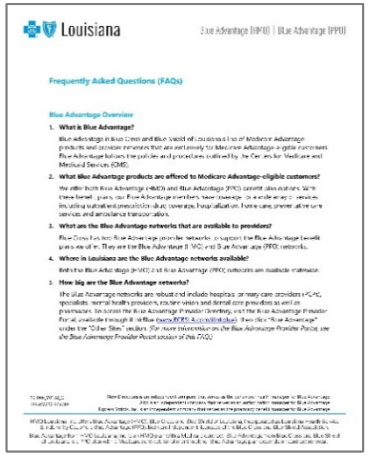
2021 Provider Quick Reference Guide

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: phone: 1-866-508-7345 fax: 1-877-528-9820 email: customerservice@blueadvantage.bcbsla.com mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. 150 DeSiard St, Ste 322 Monroe, LA 71201
Blue Advantage Provider Portal	The Blue Advantage Provider Portal can be access through iLinkBlue (www.BCBSLA.com/ilinkblue), then click on "Blue Advantage" under the "Other Sites" section. This portal allows providers to view member eligibility and benefit verification, as well as check the status of claims and prior authorizations, and more. Portal Registration: Registration for the Blue Advantage Provider Portal requires two separate security access setups: 1. You must first have access to iLinkBlue (www.BCBSLA.com/ilinkblue). Refer to the PIM Team section of this guide for more information. 2. Once logged into iLinkBlue, click the "Blue Advantage" link located in the "Other Sites" section to access the Blue Advantage Provider Portal. You can then self-register for access as a Moderator or as a User under an existing Moderator. Technical Support: For technical questions relating to registration or login access to the Blue Advantage Provider Portal, phone: 1-866-508-7345, option 3, option 2

www.BCBSLA.com/ilinkblue
>Blue Advantage >Resources
(under Manuals and Authorizations)

Frequently Asked Questions (FAQs)

- Blue Advantage Overview
- Member ID Cards
- Authorizations
- And more


Louisiana

Frequently Asked Questions (FAQs)

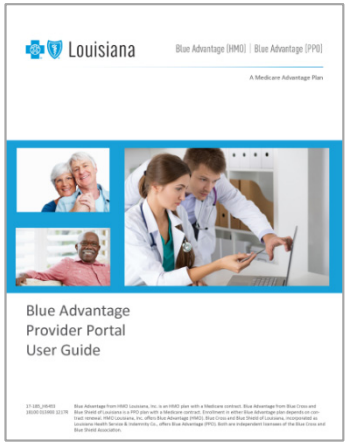
Blue Advantage Overview

1. What is Blue Advantage?
2. What Blue Advantage products are offered to Medicare Advantage-eligible customers?
3. What are the Blue Advantage networks that are available to providers?
4. Where in Louisiana are the Blue Advantage networks available?
5. How big are the Blue Advantage networks?

www.BCBSLA.com/ilinkblue
>Blue Advantage >Resources
(under Reference Materials)

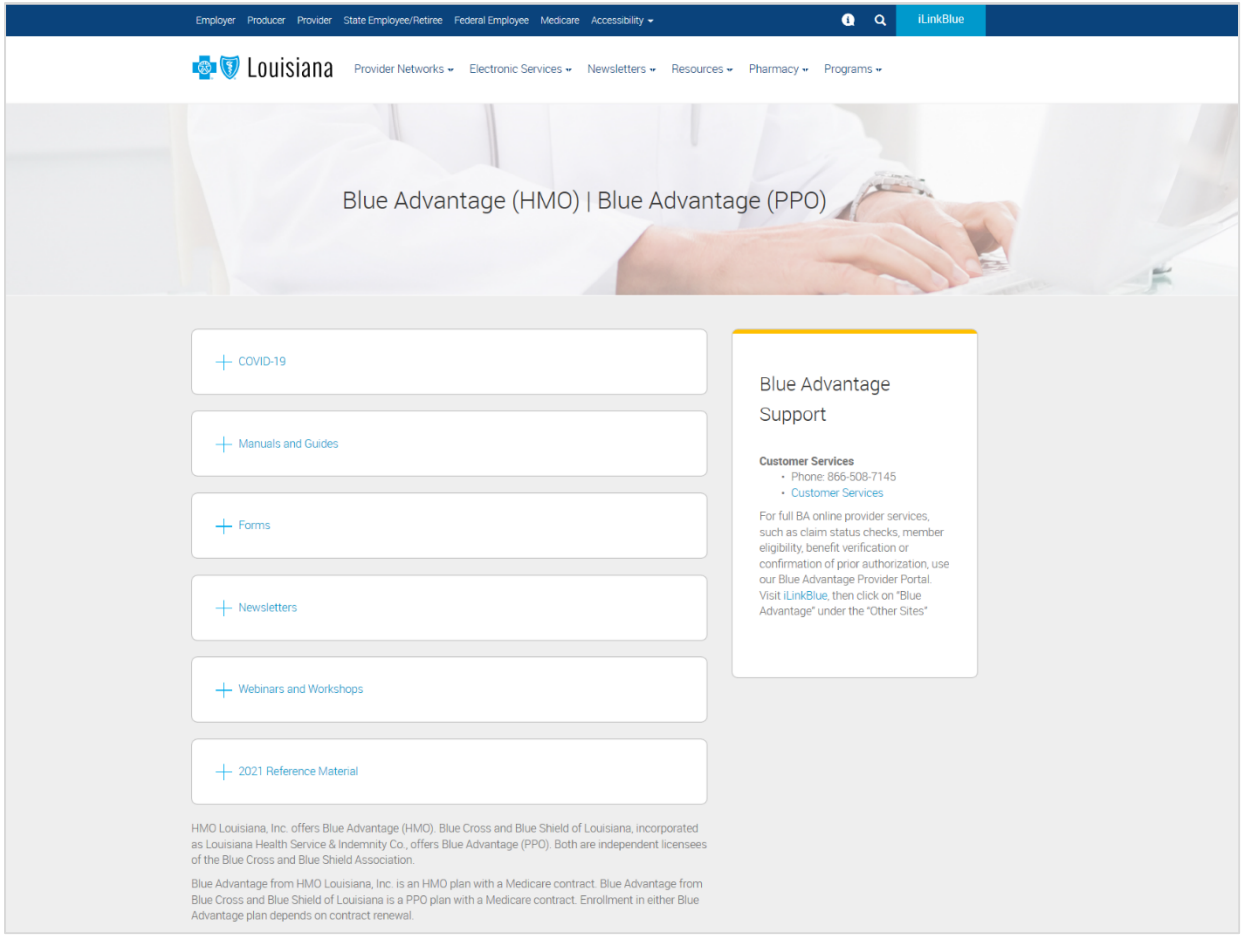
Provider Portal User Guide

- Registering for the provider portal
- Operating portal features
- Accessing reference materials



www.BCBSLA.com/ilinkblue
>Blue Advantage >Provider Portal User Guide (under Reference Materials)

BA Resources Page



Providers can access provider reference guides and forms on the Blue Advantage Resources Page, **www.BCBSLA.com/provider**, then click on "Go to BA Resources" at the bottom of the page

Provider Relations

Provider Education & Outreach

Kim Gassie director

Jami Zachary manager

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard

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

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

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

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

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

Angela Jackson **Paden Mouton** **Jennifer Aucoin**

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Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Red River, Richland, Tensas, Union, Webster, West Carroll

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Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermilion

Sue Condon – **sue.condon@bcbsla.com**
Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge, West Feliciana

Shannon Taylor – **shannon.taylor@bcbsla.com**
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provider.contracting@bcbsla.com | 1-800-716-2299, option 1

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

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Mary Reising manager – mary.reising@bcbsla.com

Anne Monroe provider information supervisor – anne.monroe@bcbsla.com

Rhonda Dyer provider information 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

1-800-716-2299 | option 2 – credentialing | option 3 – provider data management

PCDMstatus@bcbsla.com

Thank You!