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)

New to Blue Advantage Webinar

April 21, 2021

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

Y0132_21-338_PVLA_C

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.

Welcome to the Blue Advantage Network!

Thank you for participating in our Blue Advantage (HMO) and Blue Advantage (PPO) provider networks.

As a participating provider, you play an important role in the delivery of healthcare services to Blue Advantage Plan members.

You have our commitment to work collaboratively with you to provide members access to excellent care and coverage.

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

Welcome to the Blue Advantage Network

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

Vantage Health Plan

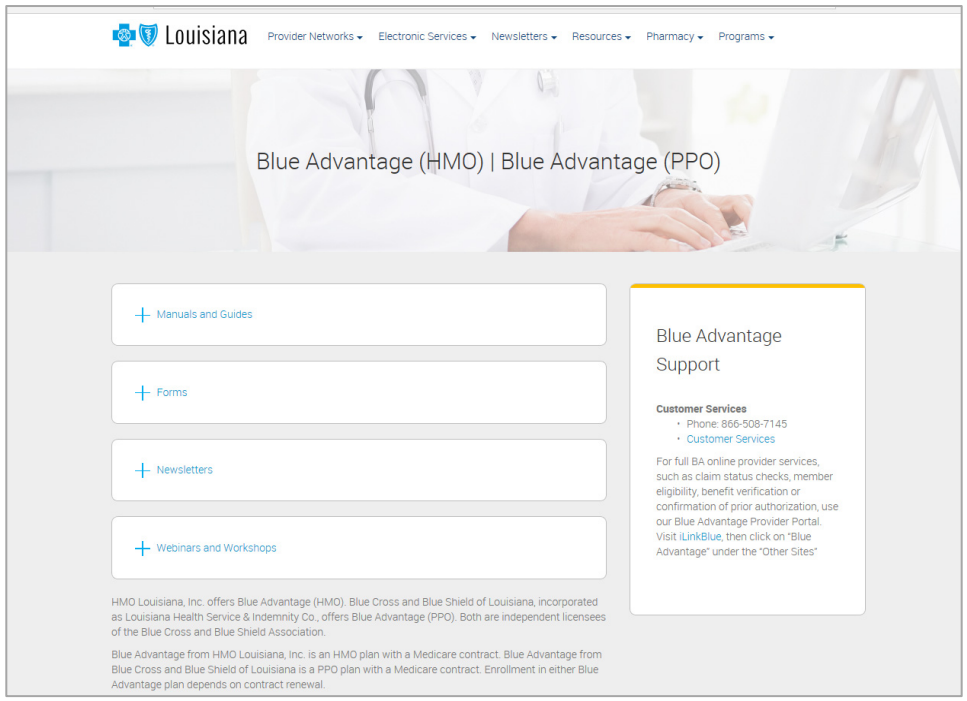
Effective January 1, 2021, Blue Advantage (BA) partnered with Vantage Health Plan to support our network providers and members.

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

Blue Advantage Resources Page



Resources that can be found on this page:

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

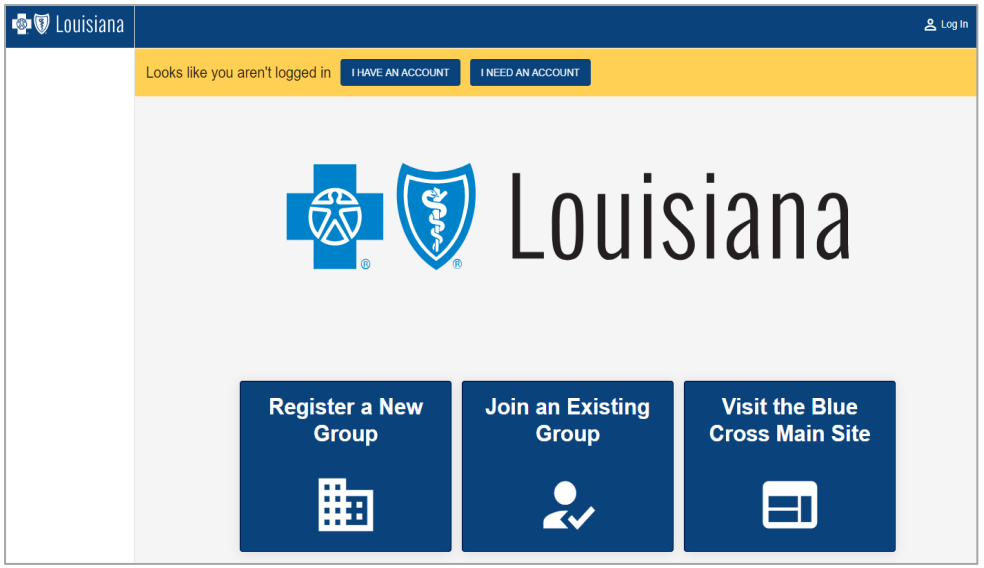
Designed to give providers access to the most current Blue Advantage resources

www.BCBSLA.com/providers >Blue Advantage Resources

Blue Advantage Provider Portal

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

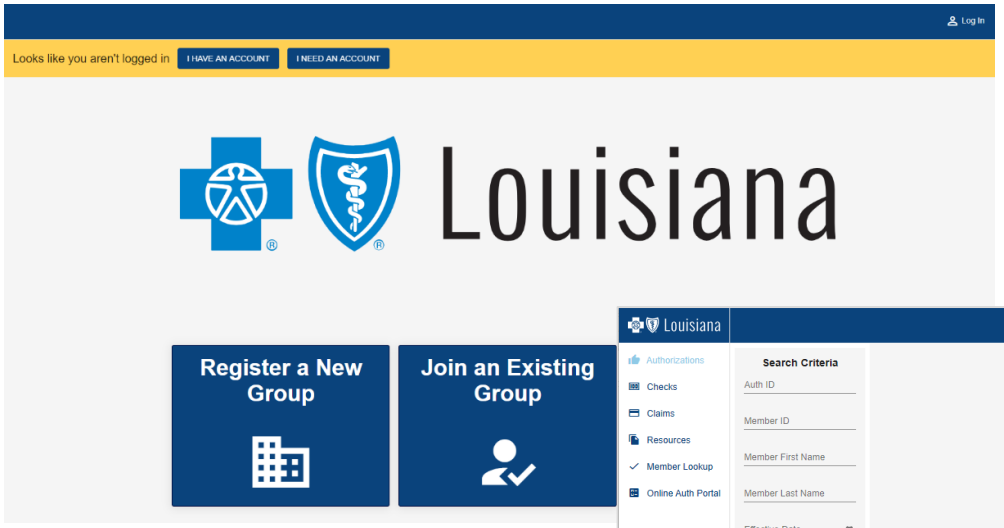
- Claims Inquiry
- Member Eligibility
- Provider Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more



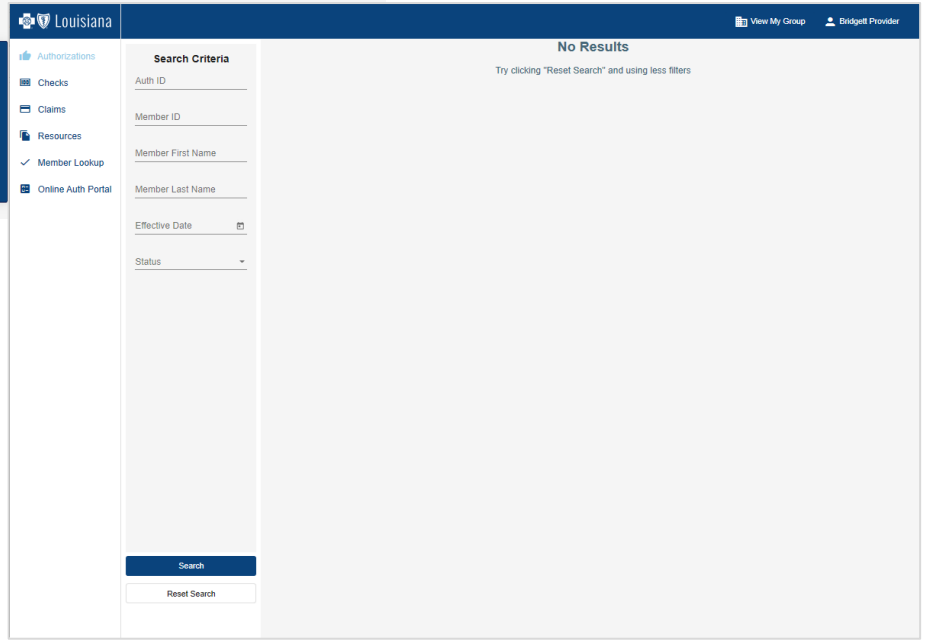
The Blue Advantage Provider Portal is available through iLinkBlue (**www.BCBSLA.com/ilinkblue**) >Blue Advantage (under Other Sites)

Accessing the Blue Advantage Provider Portal

Provider Portal Login



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



Provider Portal Home Page

Helpful Hints

For additional details on how to register for the Blue Advantage Provider Portal, download the 2021 Blue Advantage Portal User Guide. Go to www.BCBSLA.com/ilinkblue then click **"**Blue Advantage" under the "Other Sites" section.

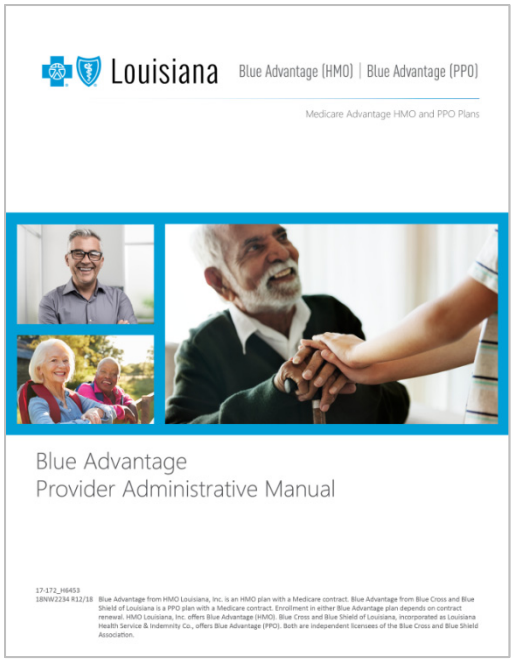
We recommend using Google Chrome to access the 2021 Blue Advantage Provider Portal.

The new portal uses cookies to remember your login information and you **must** enable cookies for the portal, in order to successfully log in and access all its features.

For additional information, please see the "Troubleshooting" section of the *Blue Advantage Provider Portal User Guide* for detailed instructions.

Blue Advantage Provider Administrative Manual

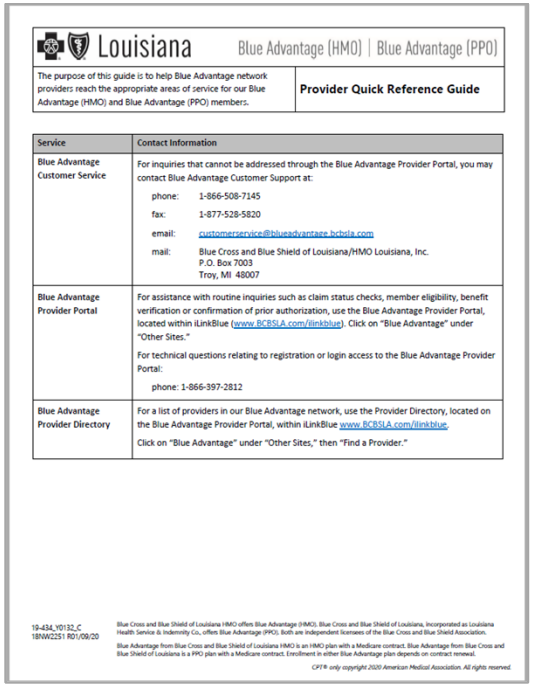
- Policies
- Procedures
- Reference information required of our Blue Advantage network providers



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

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: phone: 1-866-508-7145 fax: 1-877-528-5820 email: customerservice@blueadvantage.bcbsla.com mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. P.O. Box 7003 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." For technical questions relating to registration or login access to the Blue Advantage Provider Portal: 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. Click on "Blue Advantage" under "Other Sites," then "Find a Provider."

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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.

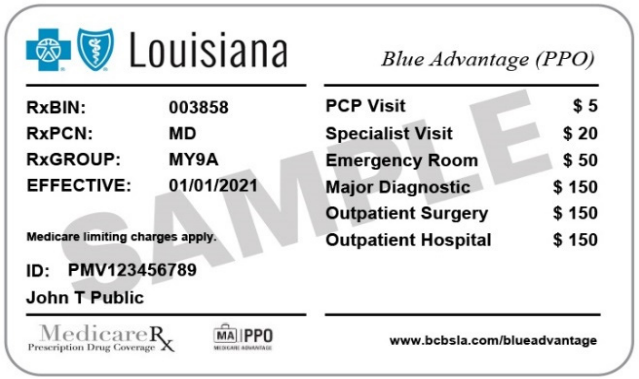
Available on both the Blue Advantage resource page and Provider Portal.

Member ID Cards

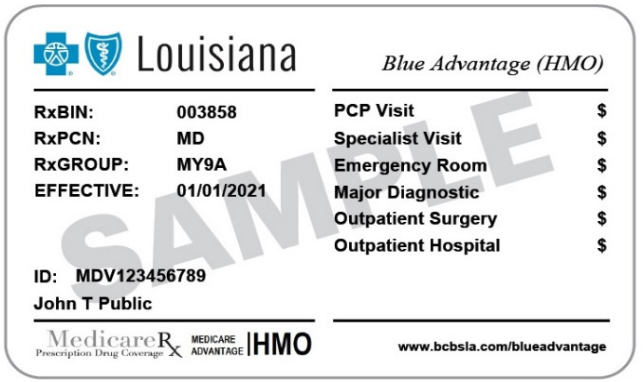
Blue Advantage provides each member with an ID card containing the following:

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

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



PMV prefix



MDV prefix

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

Blue Advantage Customer Service

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

1-866-508-7145

Customer Services prompts have been updated, please listen carefully to the new options when calling in.

1-877-528-5820

customerservice@blueadvantage.bcbsla.com

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

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

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 PCPs, upon request, the prior PCP has 10 business days of request to submit records to new PCP.

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

Members are required to have a PCP, if one is not selected, one will be assigned.

Annual Wellness Coupon Program

- Blue Advantage members will receive a paper coupon in the mail as part of our Annual Wellness Coupon Program.
- The coupons are for the member's annual wellness exam, which should be provided by a primary care provider.
- 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.
- Providers can bill a second wellness visit in the same calendar 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.
- If a member doesn't bring their coupon to their wellness visit, providers can request a personalized copy by calling **1-844-753-1450.**

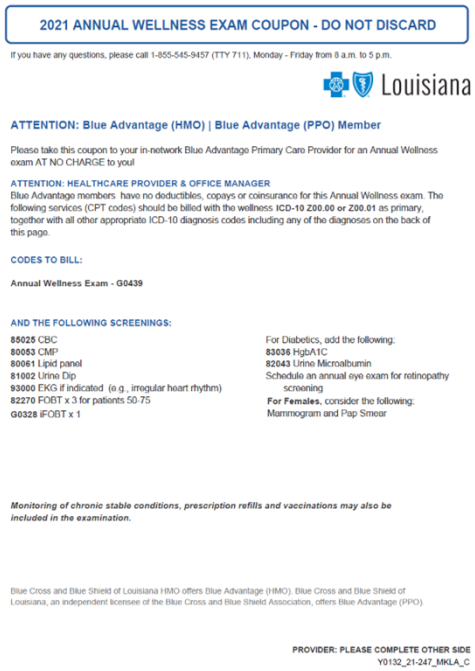
The current coupon program is limited to only Blue Advantage members.

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?



2021 ANNUAL WELLNESS EXAM COUPON - DO NOT DISCARD

If you have any questions, please call 1-855-545-9457 (TTY 711), Monday - Friday from 8 a.m. to 5 p.m.

Louisiana

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

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

ATTENTION: HEALTHCARE PROVIDER & OFFICE MANAGER

Blue Advantage members have no deductibles, copays or 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, an independent licensee of the Blue Cross and Blue Shield Association, offers Blue Advantage (PPO).

PROVIDER: PLEASE COMPLETE OTHER SIDE
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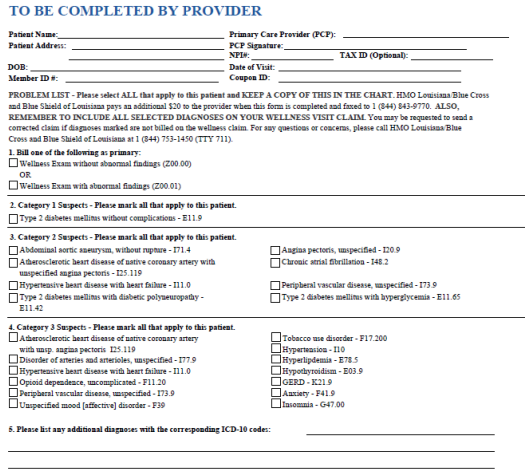
Front



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: _____

Back

Appointment Scheduling & Waiting Time Guidelines for PCPs

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

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

HEDIS and Medical Documentation

HEDIS

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

- A subset of HEDIS measures are collected and reported for the Marketplace (healthcare exchanges) product lines
- Medical record requests are faxed to providers and include a member list that indicates their assigned measures and the minimum necessary information needed
- HEDIS data is collected and reviewed from January to May
- Under the HIPAA Privacy Rule, data collection for HEDIS is permitted, and release of this information requires no special patient consent or authorization

Providers should:

- Provide appropriate care to meet the criteria and timeframes of each measure
- Document care provided in the patient's medical record
- Submit accurate coding for claims
- Provide medical records during the HEDIS process to help us validate the quality of care provided to our members

HEDIS results:

- measure performance
- help identify quality initiatives
- lead us in the development of educational programs for providers and members

HEDIS data is collected through:

- Administrative data (claims only)
- Hybrid data (claims data and medical record review)
- Survey data (member and provider surveys)

We appreciate your cooperation in sending the requested medical record information ASAP (ideally in 5 to 7 business days)

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.

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

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

Medical record request:

- Should be responded to within 10 days of the request

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

Authorizations & Benefit Determinations

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.

Authorization & Benefit Determinations

Hospital Admissions:

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

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

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

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

Standard

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

Expedited

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

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

Member sent written Notice of Right to an Expedited Appeal.

Prior Authorization

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

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

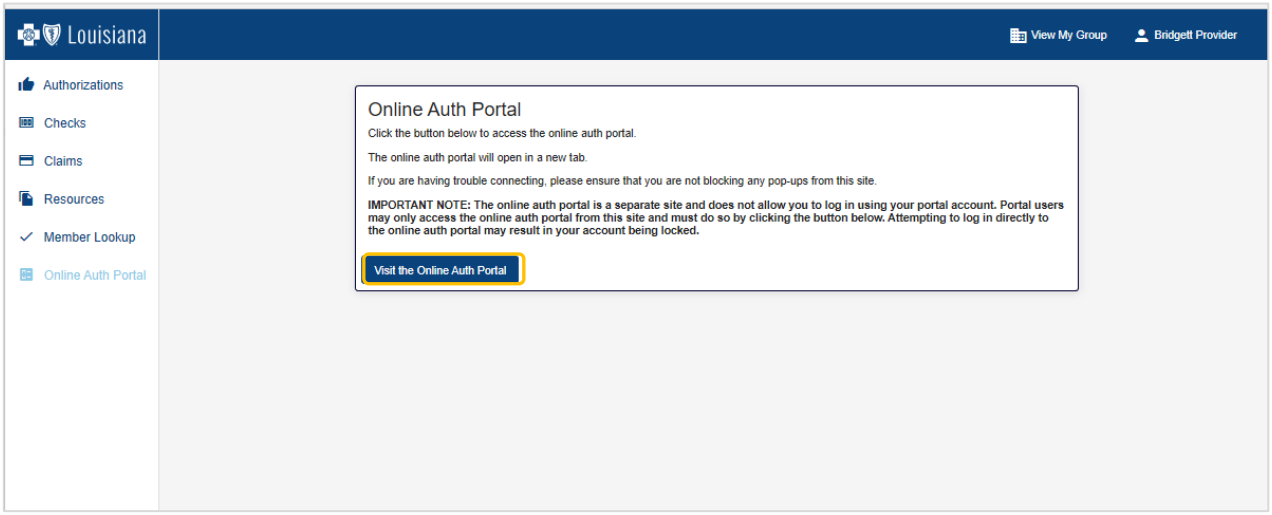
Download authorization forms by going to www.BCBSLA.com/providers, then clicking on Blue Advantage under the Other Sites section. Click "Resources" then "Forms."

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

Prior Authorization

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

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



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).

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.

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 and Therapeutic Opportunities

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/Claims

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

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		✓

2021 Billing Changes

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

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**.

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.

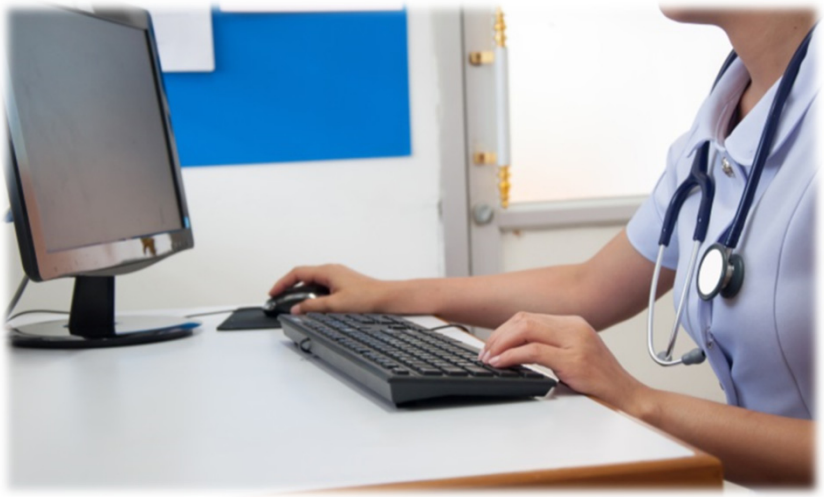
Checking Claim Status

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

- 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.

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

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

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

Provider 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.
3. Participating providers are not allowed to seek additional compensation from members other than copayments, coinsurance and payment for non-covered services.
4. The review is by Blue Advantage and determination is final.

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.

Provider Pay Dispute Address:

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

Member Appeals

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

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

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

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

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

Thank You!

Addendum

Compliance Reminders

As a Blue Advantage provider, you are required to:

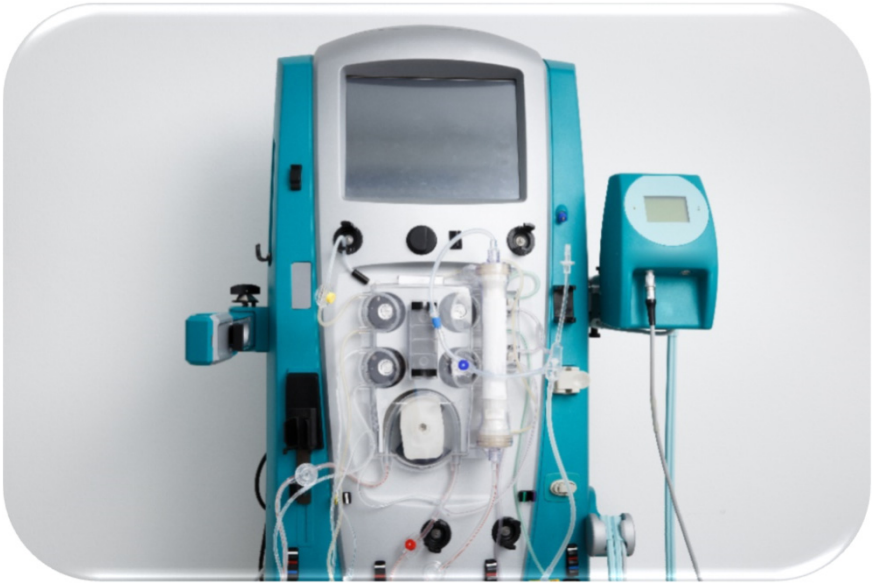
- Follow the provider guidelines in your provider manual when discussing Medicare Advantage.
- Routinely check for exclusions by the OIG/GSA (Office of Inspector General/General Services Administration).
- Report any actual or suspected compliance concerns.
- Notify us of any practice information changes.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

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

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**.

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.

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.

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.

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

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

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

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

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

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.

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.

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.

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

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

Provider Credentialing & Data Management

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

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