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

Blue Cross and Blue Shield of Louisiana

PROFESSIONAL WORKSHOP

FALL 2022

Y0132_22-509_PVLA_C

Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

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

Agenda

- What's New?
- Role of Primary Care Doctor
- Medical Management
- Pharmacy
- Billing and Claims
- Contacts

High Quality Score!

The Centers for Medicare & Medicaid Services (CMS) recently gave both our HMO and PPO plans a 4.5 out of 5 Stars in the CMS Medicare 5 Star Quality Rating system.

- The CMS Medicare Part C (health plan) 5 Star Quality Rating system is designed to help people compare health plans based on quality and performance.
- The ratings are based on member feedback and data from doctors and hospitals that work with the plan, among other factors.
- Plans that receive 4.5 out of 5 Stars in the annual ratings have earned CMS' second-highest rating.

Who are we?

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

Partners with Blue Cross and Blue Shield of Louisiana to provide credentialing and recredentialing, customer service, utilization management, claims expertise & quality improvement support to our Blue Advantage HMO and PPO members.

Offers support for population health visits as well as additional quality programs such as the Blue Advantage Coupon program and HEDIS®/Star Ratings improvement for Blue Advantage members.

What's New?

Credentialing Information

Blue Cross is pleased to announce its partnership with Vantage Health Plan, Inc. to credential and recredential our network providers.

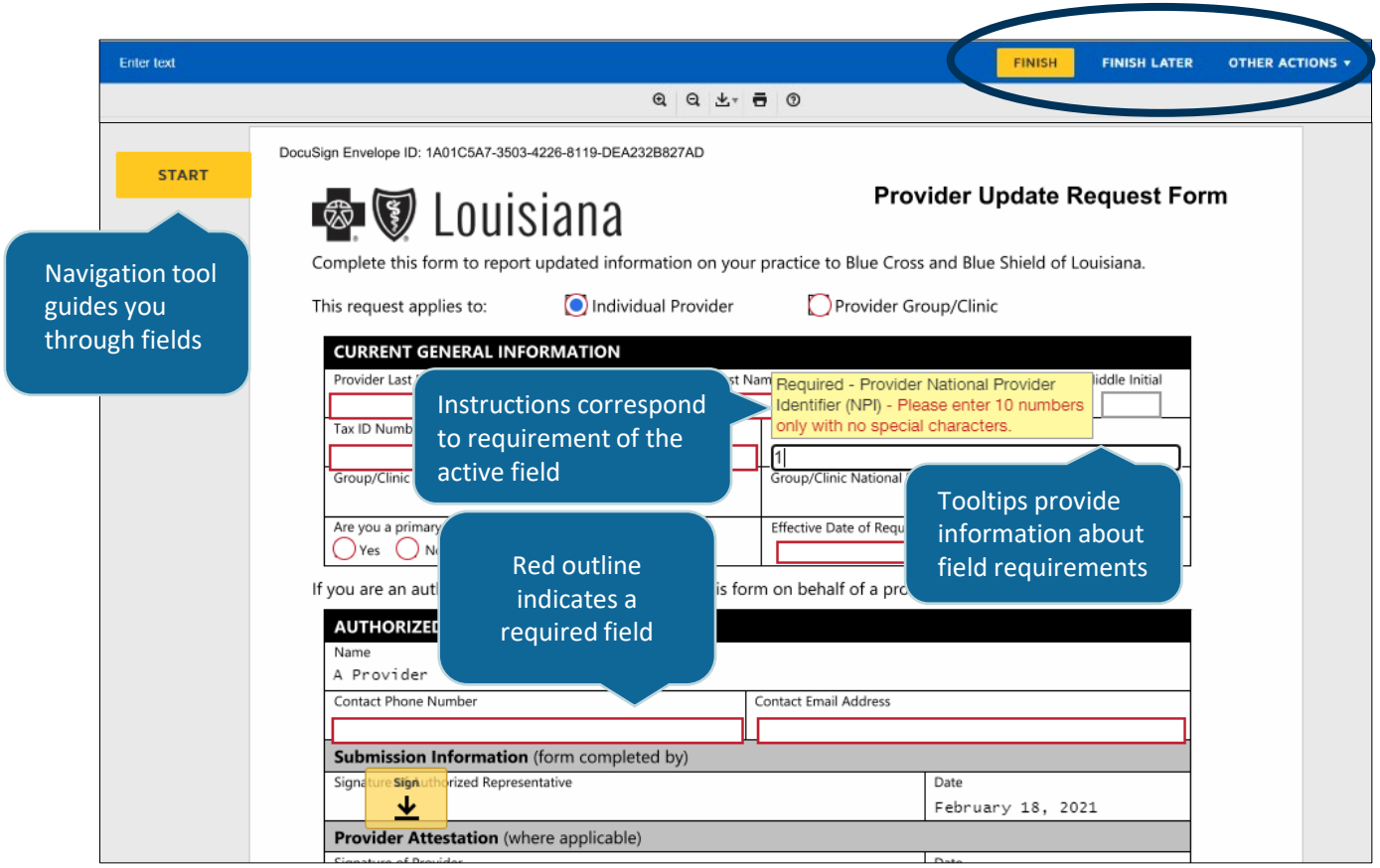
Initial credentialing

- Louisiana Standardized Credentialing Application (LSCA) through DocuSign®
- **PCDMstatus@bcsla.com**, 1-800-716-2299, option 2

Recredentialing

- CAQH Application or LSCA
- **recredentialing@vhpla.com**, (318) 807-4755

Easily Complete Forms with DocuSign



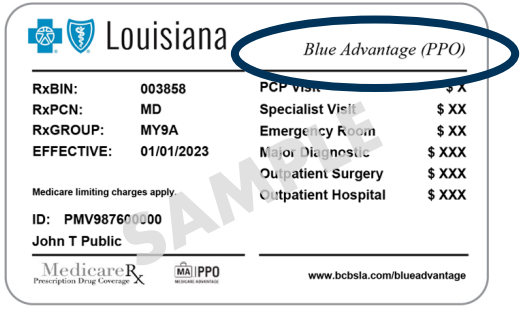
Find our *DocuSign® Guide* at **www.bcbsla.com/providers** >Provider Networks >Join Our Networks >Professional Providers >Join Our Networks.

Member ID Cards

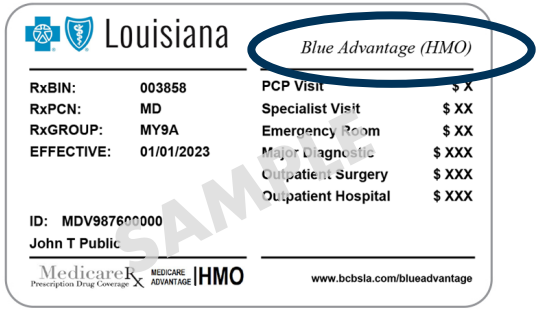
Blue Advantage provides each member with an ID card containing the following:

- 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).



Prefix: PMV



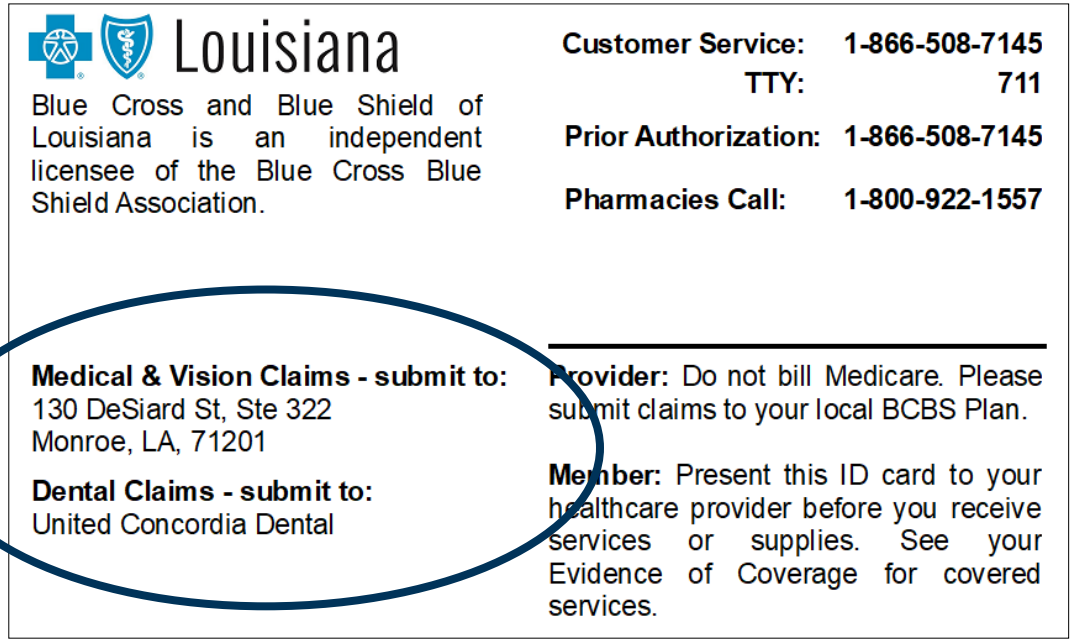
Prefix: MDV

Vision Network

New in 2023

Beginning on January 1, 2023, Blue Cross will no longer use Davis Vision to provide refractive care for our Blue Advantage members.

Members must use one of our contracted Blue Advantage ophthalmologists or optometrists.



Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

Customer Service: 1-866-508-7145
TTY: 711
Prior Authorization: 1-866-508-7145
Pharmacies Call: 1-800-922-1557

Medical & Vision Claims - submit to:
130 DeSiard St, Ste 322
Monroe, LA, 71201

Dental Claims - submit to:
United Concordia Dental

Provider: Do not bill Medicare. Please submit claims to your local BCBS Plan.

Member: Present this ID card to your healthcare provider before you receive services or supplies. See your Evidence of Coverage for covered services.

Find a list of contracted providers in the Blue Advantage Provider Portal available through iLinkBlue (**www.bcbsla.com/ilinkblue**) >Blue Advantage (under "Other Sites").

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

- Later this year, Blue Advantage is transitioning its electronic funds transfer (EFT) and electronic remittance advice (ERA) 835 business from RedCard to Blue Cross and Blue Shield of Louisiana.
- All payments made after this transition will be made through Blue Cross.
- Blue Advantage providers should continue to use the Blue Advantage Provider Portal for claims research and payment information.
- Below are details on how this transition could affect you. It is important that if you are not currently enrolled to receive Blue Cross EFT and ERA, that you do so before this transition to ensure continued receipt of these electronic services.

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

Reminders & Resources

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."

Current Fraud, Waste and Abuse Concerns

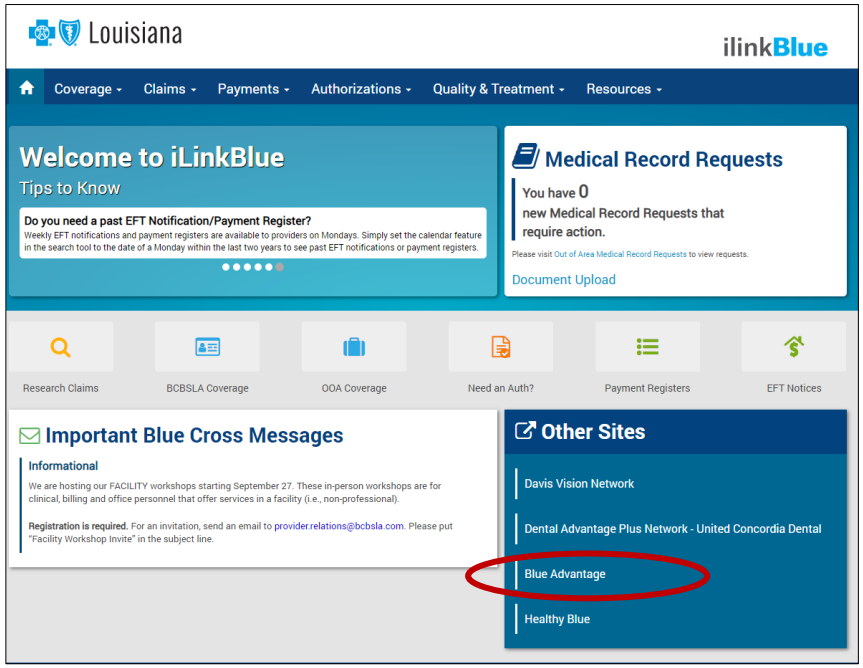
- Elective COVID testing (for travel, return to work, events).
- COVID testing where other tests are routinely added.
- Mid-level practitioner services billed under supervising provider (mid-levels must be credentialed and bill under his/her specific number).
- Referral to out of state/out of network laboratories.
- Telemedicine schemes including DME, genetic testing and expensive topical prescriptions (including practitioner "sign-off" via online portal).
- Falsification of Prior Authorization (typically by a third-party entity acting on behalf of a medical practice).
- Non-medically necessary bi-lateral imaging.
- Inappropriate use of unlisted/undesignated codes.
- "Foot bath" prescribing.

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.



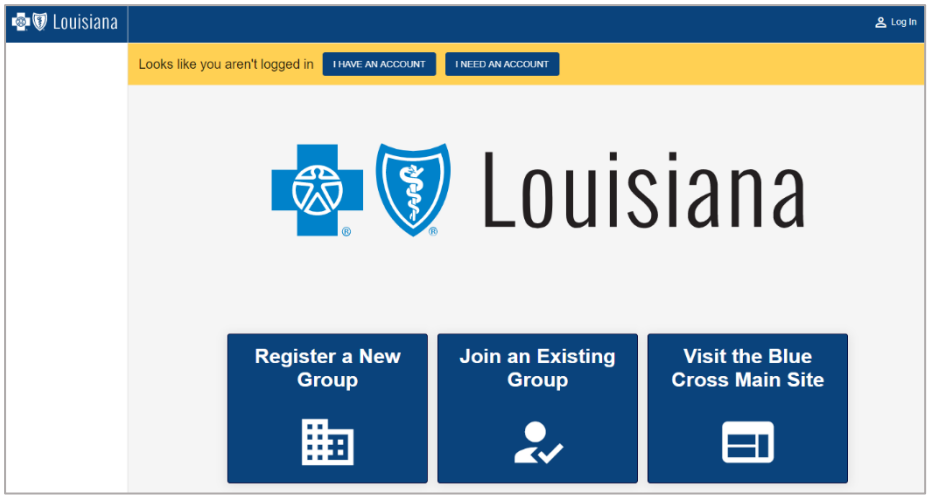
Helpful Hints

- For additional details on how to register for the Blue Advantage Provider Portal, download the *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 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 Portal

Providers need access to the Blue Advantage Provider Portal for the following resources:

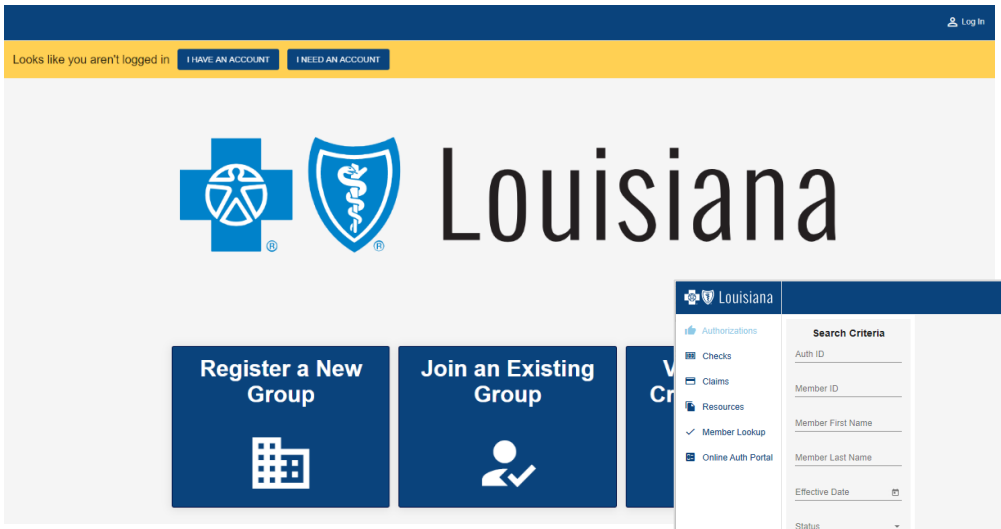
- Claims Inquiry
- Member Eligibility
- Provider/Pharmacy Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more



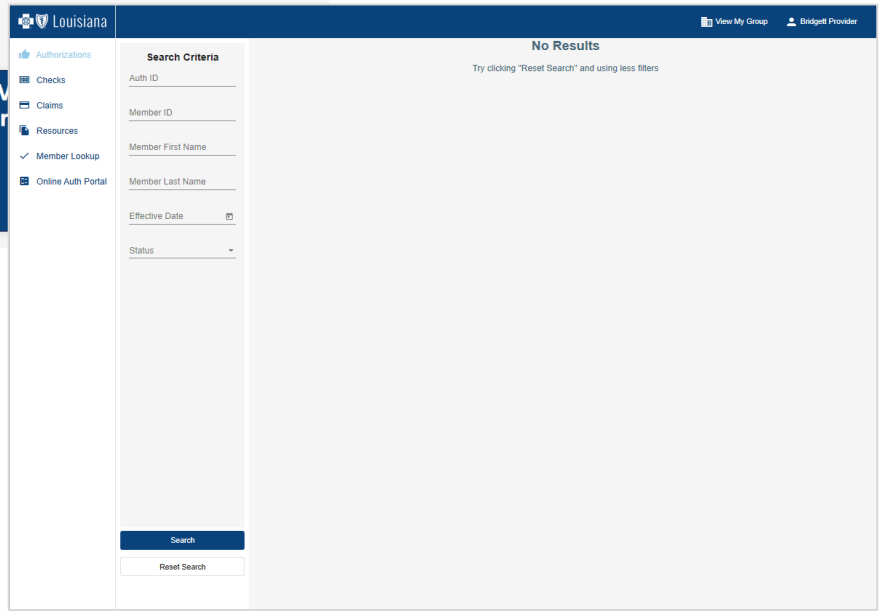
The Blue Advantage Provider Portal is available through iLinkBlue (**www.bcbsla.com/ilinkblue**) >Blue Advantage (under Other Sites).

Accessing the Blue Advantage Provider Portal

Provider Portal Login

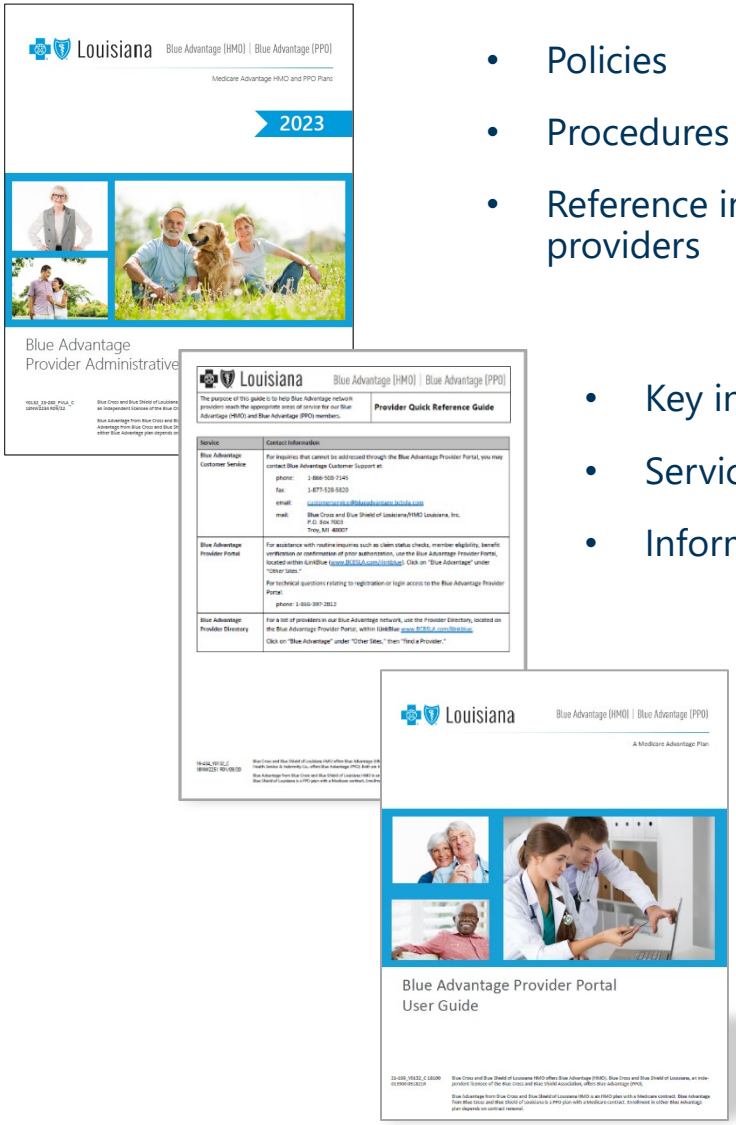


Once registration is complete, providers will be able to log in and access all available portal features.



Provider Portal Home Page

Blue Advantage Manuals and Guides



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

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

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

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

Blue Advantage Customer Service

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

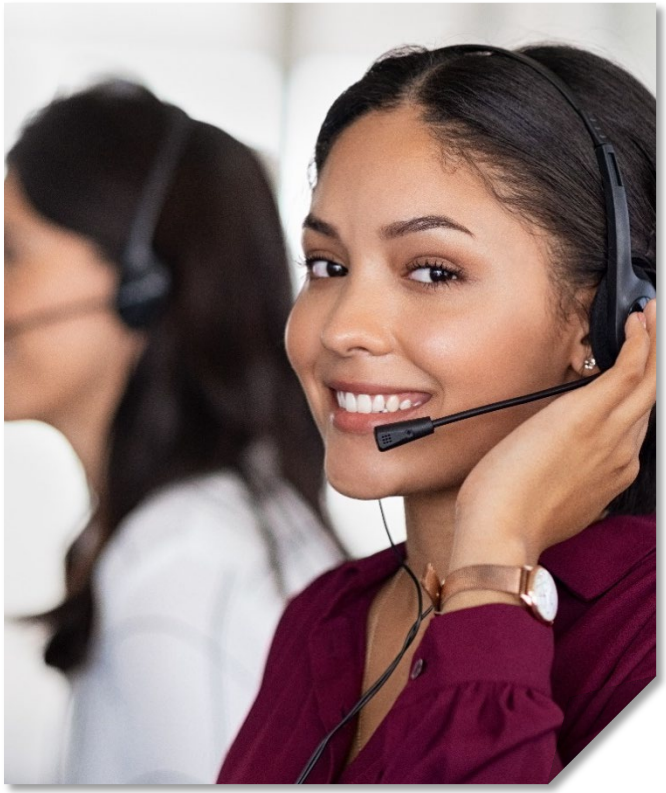
1-866-508-7145

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 Advantage
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 Primary Care Provider

Role of Primary Care Provider (PCP)

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.

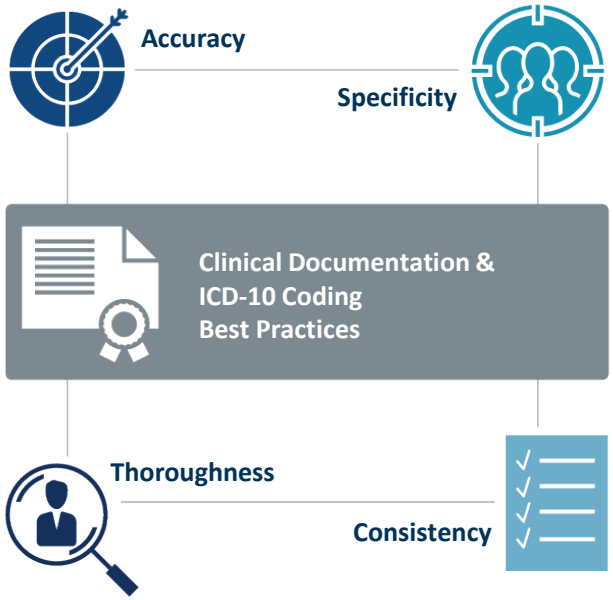
- Responsible for coordinating members' medically necessary services.
- When a member changes PCPs, upon request, the prior PCP has 10 business days of request to submit records to new PCP.

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

Complete and Accurate Clinical Documentation & ICD-10 Coding

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.
- Diagnoses cannot be inferred from physician orders, nursing notes or lab/diagnostic test results; diagnoses need to be in the medical record.
- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., leg amputation and/or transplant status must be reported each year).
- Include condition specificity where required to explain severity of illness, stage or progression (e.g., staging of chronic kidney disease).
- Treatment and reason for level of care needs to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented.



Importance of Annual Wellness Visits

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

Quality

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

Risk Adjustment

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

Coding for Annual Wellness Visits

- G0438: Initial Annual Wellness Visit (AWV)
- G0439: Subsequent AWV
- ICD-10: Z00.00 or Z00.01 medical examination with or without abnormal

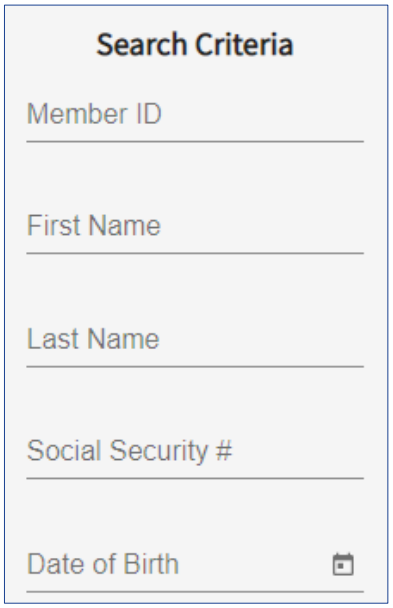
The Annual Wellness Examination costs nothing for the patient.

Annual Wellness Coupon Program

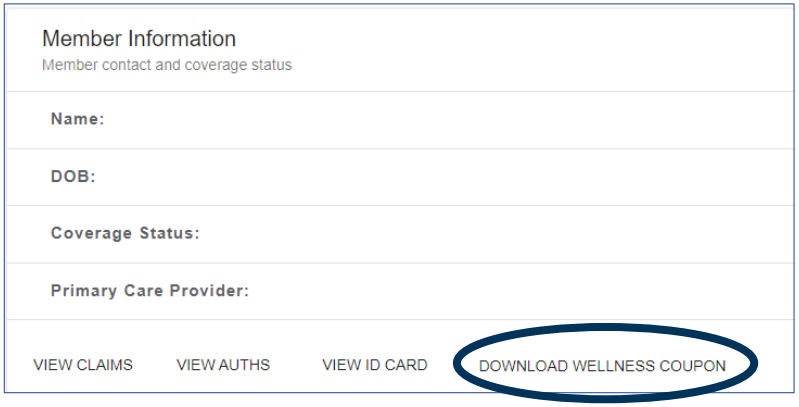
- Blue Advantage members will receive a paper coupon in the mail as part of our Annual Wellness Coupon Program.
- The coupons are for the patient's annual wellness exam, which should be provided by a primary care provider.
- The current coupon program is limited to only Blue Advantage members.

Annual Wellness Coupon Program

Using the Member Lookup tab on the left side of the home screen, you may search for the member using their Member ID, name or date of birth.



After selecting the member's profile, select "Download Wellness Coupon" and a PDF copy of the coupon will be generated. Please note that the member must be assigned to a provider associated with your group or this option will not be available.



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

Goals of the Annual Wellness Coupon Program

- To help facilitate wellness visits by the patient's primary care provider.
- Document commonly overlooked conditions/diagnoses that may be applicable to the patient.
- Identify conditions based on claims history.
- Ensure all diagnoses are submitted yearly.
- Complete preventative services.

Annual Wellness Coupon

2022 ANNUAL WELLNESS EXAM COUPON - DO NOT DISCARD

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

Louisiana

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

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

ATTENTION: HEALTHCARE PROVIDER & OFFICE MANAGER

Blue Advantage members have no deductibles, copays or coinsurance for the 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 other 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-
G0328 iFOBT x 1

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

For Females, consider the following:
Mammogram and Pap Smear

Patient specific services due:
Flu Shot, Wellness Visit

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

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

PROVIDER: PLEASE COMPLETE OTHER SIDE
Y0132_22-346_MKLA_C

SAMPLE

TO BE COMPLETED BY PROVIDER IN 2022

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

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

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

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

2. Category 1 Suspects - Please mark all that apply to this patient.
- ☐ Atherosclerosis of aorta - I70.0
- ☐ Stem cells transplant status - Z94.84
- ☐ Chronic kidney disease, stage 3 (moderate) - N18.3
- ☐ 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
- ☐ Angina pectoris, unspecified - I20.9
- ☐ Hypertensive heart disease with heart failure - I11.0
- ☐ Peripheral vascular disease, unspecified - I73.9
- ☐ Type 2 diabetes mellitus with diabetic polyneuropathy - E11.42
- ☐ Unspecified mood [affective] disorder - F39
- ☐ Alcohol dependence, uncomplicated - F10.20
- ☐ Chronic atrial fibrillation - I48.2
- ☐ Morbid (severe) obesity due to excess calories - E66.01
- ☐ Rheumatic heart failure - I09.81
- ☐ 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 - I7
- ☐ Hypertensive heart disease with heart failure - I11.0
- ☐ Opioid dependence, uncomplicated - F11.20
- ☐ Peripheral vascular disease, unspecified - I73.9
- ☐ Unspecified mood [affective] disorder - F
- ☐ 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: _____

SAMPLE

Pay for Performance Medicare Advantage Star Rating Incentive

- We are optimizing the reimbursement for PCPs through a Pay for Performance Medicare Advantage Star Rating Incentive (**P4P MA SI**) module related to outcomes surrounding population health measures.
- **Effective October 1, 2022**, all PCPs participating in our BA network(s) are eligible to receive performance incentive payments for the 2022 calendar year and subsequent calendar years based on closing gaps in care for population health measures.
- This P4P MA SI will be administered by Vantage Health Plan. We are structuring the P4P MA SI like the Blue Advantage Primary Care Provider Pay for Performance (QB BA PCP P4P) module that is part of the Quality Blue (QB) program. For BA PCPs in the QB program, self-contracted or contracted with another QB provider, your QB BA PCP P4P agreement remains the same.

Appointment Scheduling & Waiting Time Guidelines for PCPs

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.

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).

Authorizations & 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.

Authorizations

Hospital Admissions:

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

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

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

Authorizations

Inpatient Admission:

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

Observation:

- Plan requires notification within one business day of observation (OBS) admission.
- Notification is required within one business day of **discharge**.

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

Medical Necessity Criteria:

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

Prior Authorizations

Standard

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

Expedited

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

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

ABNs Not Used for Blue Advantage

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

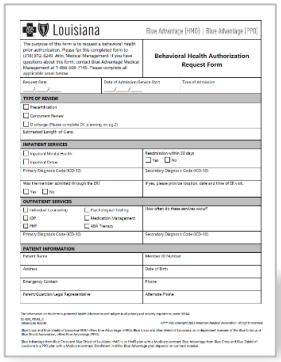
To hold members financially liable for non-covered services not clearly excluded in the member's Evidence of Coverage (EOC), contracted providers must do the following:

- 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.

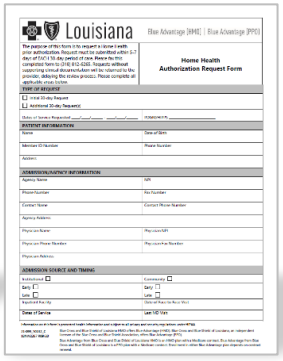
More information can be found in the Other Medicare Advantage Services section of the *Blue Advantage Provider Administrative Manual*.

Prior Authorizations

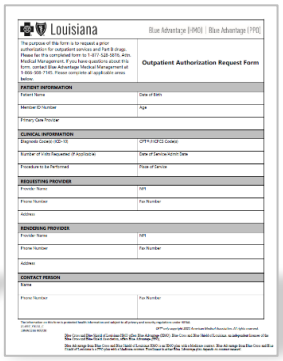
Providers may submit prior authorization requests by using one of the following authorization forms:



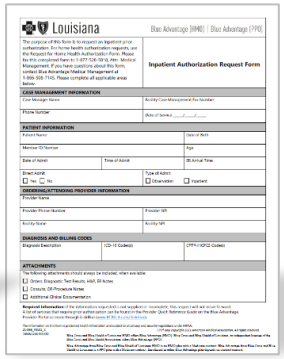
Behavioral Health Authorization Request Form



Home Health Authorization Request Form



Outpatient Authorization Request Form



Inpatient Authorization Request Form

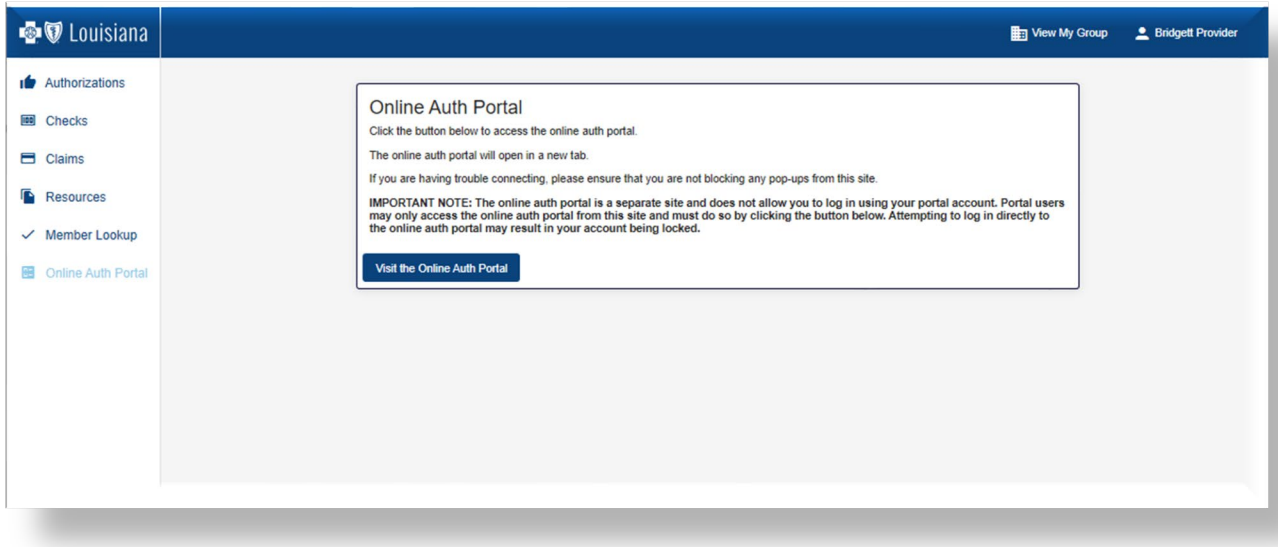
Download authorization forms by going to **www.bcbsla.com/providers**, then clicking on "Blue Advantage" under the Other Sites section. Click "Resources" then "Forms."

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

Prior Authorizations

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

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



Transition of Care

Care teams conduct transition of care services with members who have discharged home from an inpatient stay.

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:

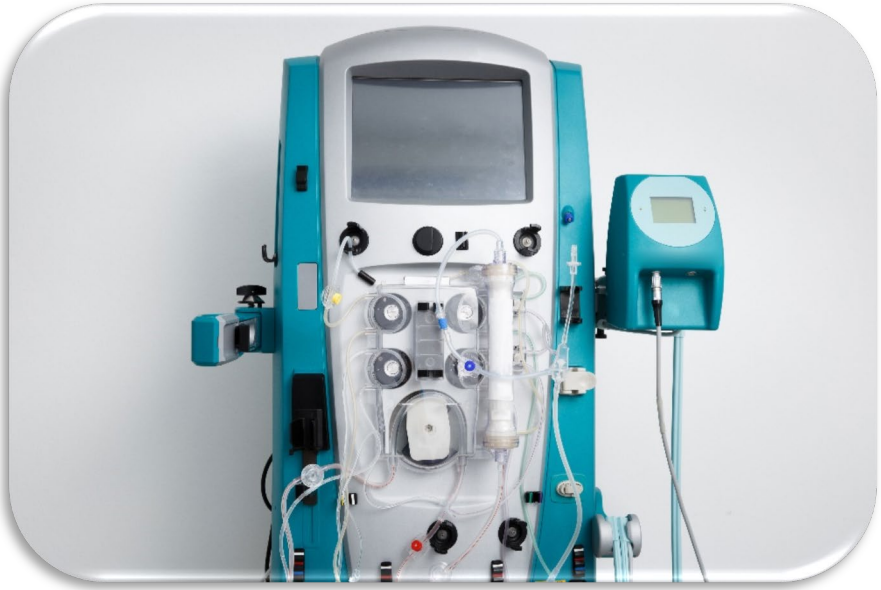
- Education and support of members and family/caregivers, including self-management
- Coordination of care
- Medication adherence
- Fall prevention and safety
- Access to community resources
- Advance care planning
- Telephonic outreach

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").

Other Services

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

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

The Basics: Outpatient Drug Coverage

Part D drugs

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

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

Part B drugs

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

  (ex. albuterol from a nebulizer)

Members have a 20% Part B coinsurance.

This amount applies to the **Max Out-Of-Pocket (MOOP)**.

The Basics: Outpatient Drug Coverage

What we do not cover:

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

Part D Exclusions: Examples

Vitamins and supplements

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

Drugs for symptomatic relief of cough and colds

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

Nonprescription/OTC drugs

- Acetaminophen
- Gas-X® (simethicone)

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

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

Drugs used for cosmetic purposes, hair growth, hair removal

- Retin-A® (tretinoin)
- Vaniqa®

Drugs to treat sexual dysfunction

- Levitra®
- Viagra®
- Addyi®

Inflation Reduction Act (IRA) Drug Coverage Changes Coming in 2023

NEW

Costs for Covered Insulin Products

- Members won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on and regardless if their deductible has been met.

Costs for Covered Part D Vaccines

- Most Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines will be covered at $0, regardless if the member's deductible has been met. Examples:
  - Shingrix (Shingles)
  - Adacel and Boostrix (Tdap)

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 in-network but are not in the Preferred Network.

Louisiana chain pharmacies include:

Walgreens, Sam's Club, Walmart, Costco

Many independent pharmacies also participate

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

- Write for 90-day supply of maintenance medications.
- 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.

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 directly to Express Scripts Mail Order Pharmacy.
   - 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.
   - 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: **expressscripts.com/get90**

To Be Safe:

- New prescriptions and refills should allow 10-14 days for processing and shipping.
- When first switching from retail to mail-order, we recommend members have a 30-day supply of medication on hand to allow processing time.

Diabetic Testing Supplies

How members may get FREE meters and strips:

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

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

- Documents
- 2023 Diabetes Testing Supplies Coverage at Network Pharmacies

Outreach Initiatives

Therapeutic Opportunities

Provider Outreach

- Star Report Cards containing gaps in care opportunities will be distributed by the Blue Advantage provider team.

Member Outreach

- Pharmacists will call members who are late to fill targeted medications.

Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

Targets members who meet the following criteria:

- 3+ chronic conditions
- 8+ select maintenance medications
- Spent $1,233 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

Reimbursement for COVID-19 Treatments

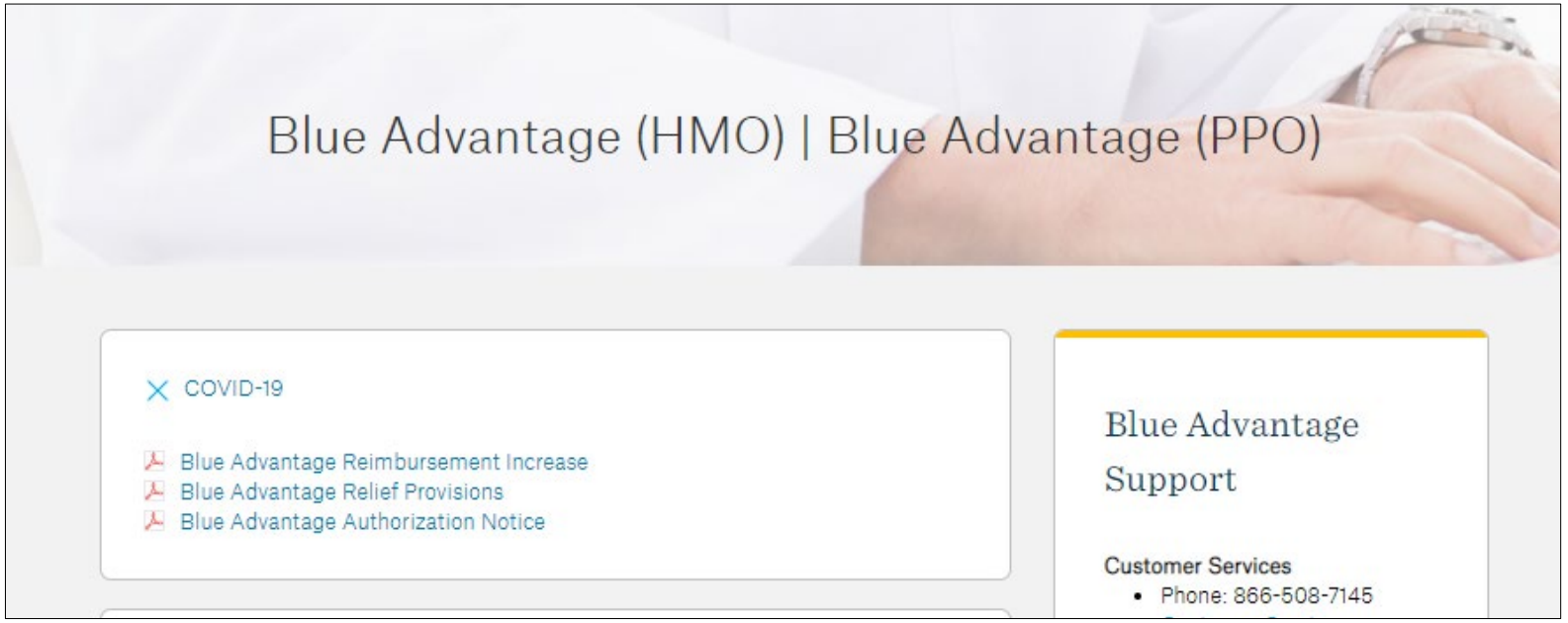
- CMS will reimburse for COVID-19 vaccines and monoclonal antibody treatment claims with 2020 and 2021 dates of service.
- For dates of service on or after January 1, 2022, the obligation to pay these claims is the responsibility of Blue Advantage. Use the product-specific coding provided by CMS and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

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

COVID-19 Provider Resources Page

Visit **www.bcbsla.com/providers** >Blue Advantage Resources >COVID-19:

- Authorizations
- Telehealth
- Billing & Coding Guidelines
- Credentialing & Provider Data Management



Billing Reminders

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

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

Billing Requirements

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

- Faxed claims are not accepted.

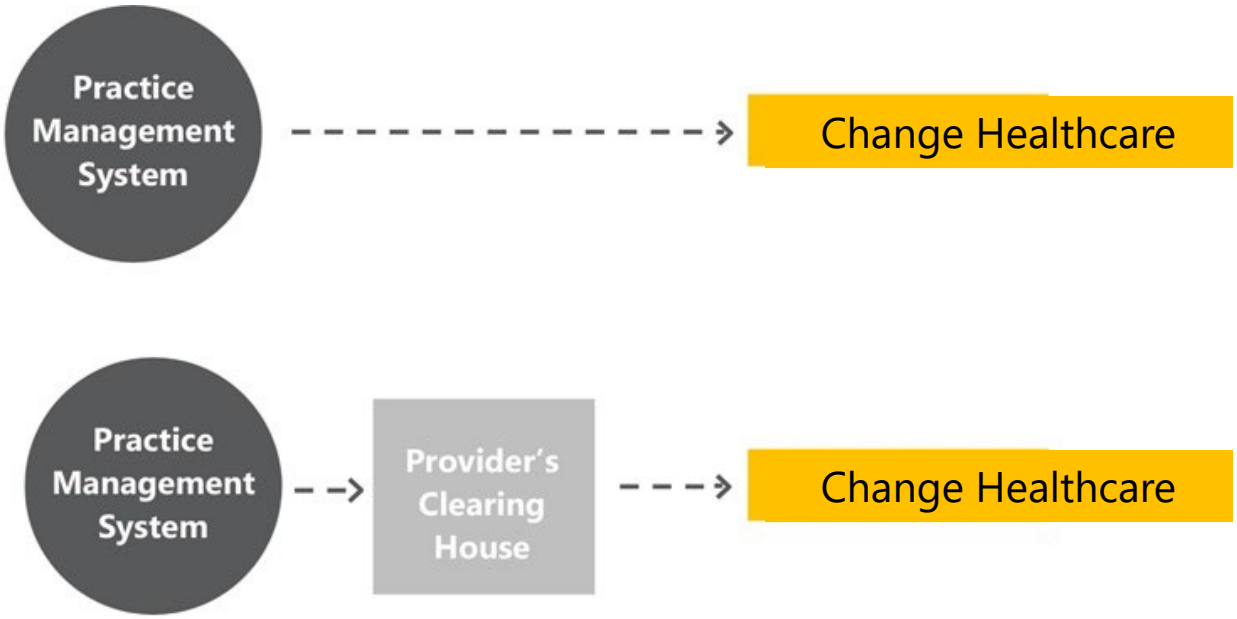
Timely Filing

- Providers should check the language in their Blue Advantage agreement.

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

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 Claims Submission

- Providers submitting directly to Change Healthcare must make the system changes necessary to send their Blue Advantage claims with the Payer ID **72107**.
- Providers who do not currently send to Change Healthcare, please notify your clearinghouse to do so with 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 Blue Advantage.
- Blue Advantage pharmacy claims should be filed to Express Scripts.

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

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.

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

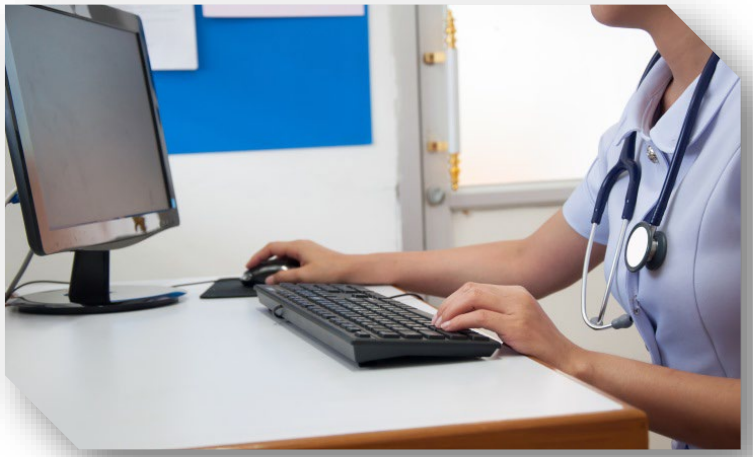
  - A UB-04/CMS-1500 with the original date billed **AND** documentation supporting the claim was submitted within the timeframe specified in your contract agreement from the date of service, **AND** follow-up was done at a minimum of every 60 days.

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.

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.

Claims Resubmission

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

- No payment was issued on the claim line in question.
- The incorrect or missing information on the original claim resulted in the claim denial. This would be corrected/added and resubmitted (i.e., invalid procedure code modifier combination).

The claim can be resubmitted on paper or electronically, not faxed.

The claim will be treated as an initial claim for processing purposes with no provider explanation necessary.

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

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.

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 and date for each call.

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 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 carriers 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 Pay Disputes

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

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

Once a decision has been made:

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

Provider Pay Dispute Address:

Blue Advantage
Attn: Provider Disputes
130 DeSiard St, Ste 322
Monroe, LA 71201

Call Centers

Authorizations (including Medical Management)

1-866-508-7145, choose option 3, then option 3

Behavioral Health

1-866-508-7145, choose option 3, then option 3

Blue Advantage Customer Service

1-866-508-7145
customerservice@blueadvantage.bcbsla.com

Blue Advantage Provider Portal

1-866-508-7145, choose option 3, then option 2

Provider Credentialing & Data Management

1-866-716-2299, choose option 2
PCDMstatus@bcbsla.com

Pharmacy

1-800-935-6103/TTY:711

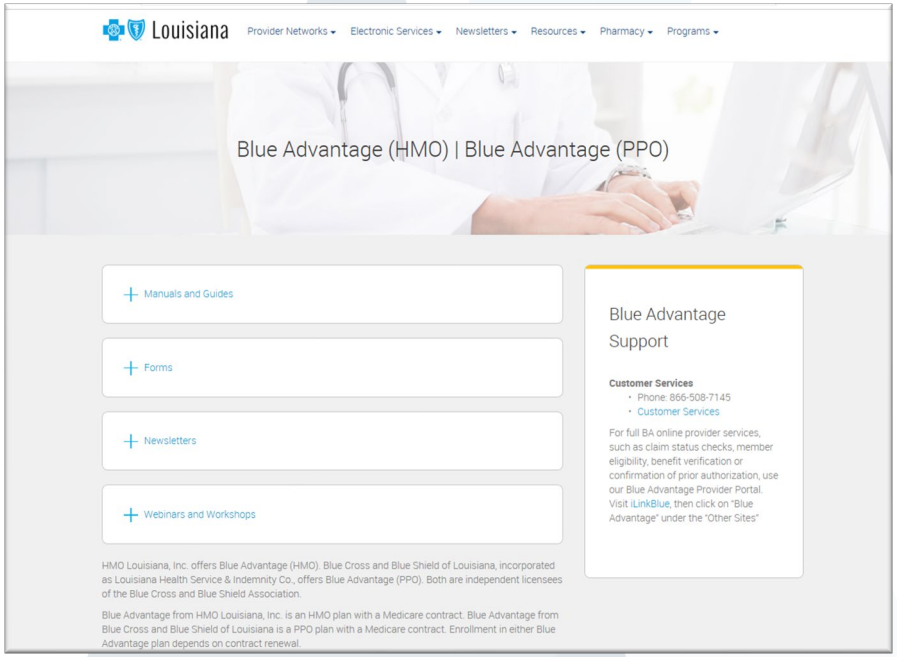
Thank You!

Addendum

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.

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 Retention and Requests

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

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

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

Medical record request:

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

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

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

Provider Relations

Kim Gassie Director

Jami Zachary Manager

Anna Granen Senior Provider Relations Representative

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

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

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

Kathy Doty, Value Program Representative

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

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

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

Audrey Couvillion, Value Program Representative

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Paden Mouton, Supervisor

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Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Grant, Jefferson Davis, Rapides, Vernon parishes

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

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

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

Provider Credentialing & Data Management

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

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

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

Questions about initial credentialing: **PCDMstatus@bcbsla.com** 1-800-716-2299, option 2
Questions about recredentialing: **recredentialing@vhpla.com** (318) 807-4755