New to Blue Advantage

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.
- Please limit your questions to information presented in today's webinar.

How to submit questions:

- Open the Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

Louisiana

Blue adVantage (HMO) | Blue adVantage (PPO)

New to Blue Advantage

Presented by: Anna Granen
Senior Provider Relations Representative
Blue Cross and Blue Shield of Louisiana

March 2024

Y0132_24762PVLA_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.

High Quality Score!

Our HMO plan recently earned 4.5 out of 5 Stars, and our PPO plan recently earned a 4.0 out of 5 Stars for the 2024 Star Ratings from the Centers for Medicare & Medicaid Services (CMS).

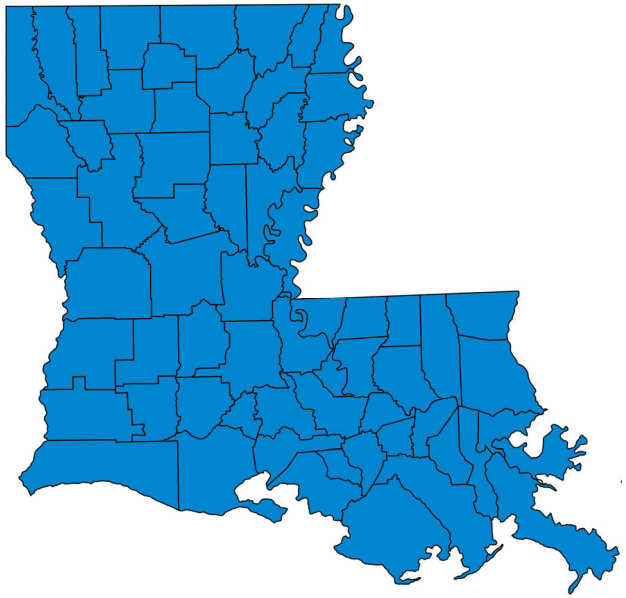
- The CMS Star Rating system helps Medicare consumers compare quality of Medicare health and drug plans being offered so they are empowered to make the best healthcare decisions for them.
- The ratings are based on member feedback and data from doctors and hospitals that work with the plan, among other factors.
- Plans that receive a 4.5 out of 5 Stars in the annual ratings have earned CMS' second-highest rating.

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.

Welcome to the Blue Advantage Network

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

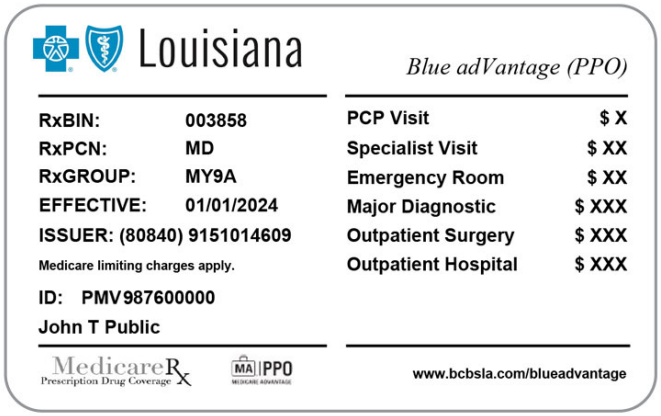


Member ID Cards

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 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. Blue Advantage Customer Service is available from 8 a.m. to 5 p.m., Monday – Friday.

1-877-528-5820

customerservice@blueadvantagela.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.

Primary Care Provider (PCP) Roles

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

Blue Advantage 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.

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 calendar year**, 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.

Blue Advantage Quality Program/Shared Value Program

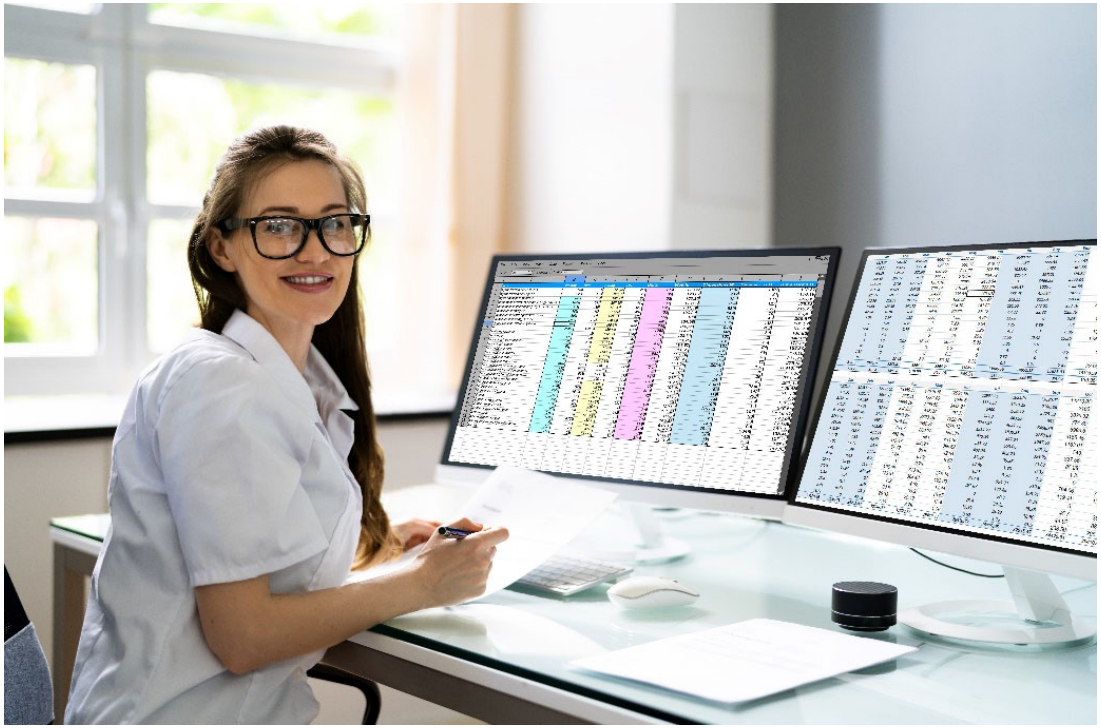
- Pay for Performance Medicare Advantage Star Rating Incentive (P4P MA SI) is available to all PCPs participating in BA Networks.

- BA 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.
  - PCPs review and complete coupon at the visit.
  - PCPs will be compensated $100 for completion of the coupon above the claim's reimbursement.
- Information is then used to help build STAR rating incentive.
  - 4 Star: $50 PMPY
  - 5 Star: $100 PMPY

  Payments are Risk Adjusted

Coding

Importance of Complete and Accurate Clinical Documentation and ICD-10 Coding

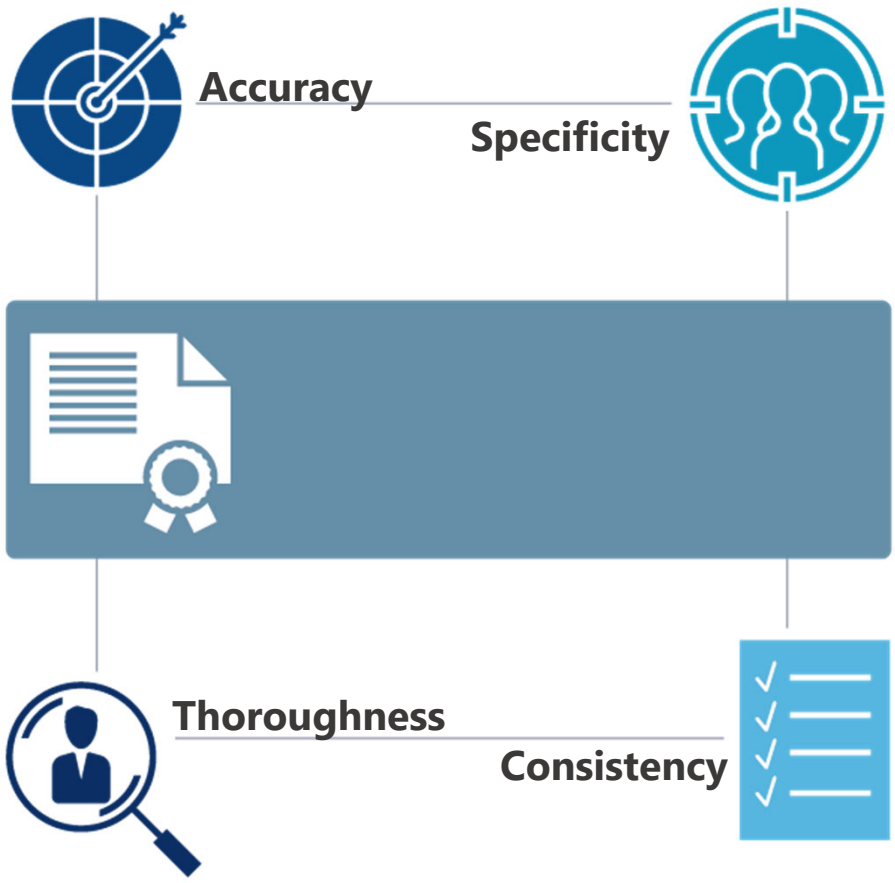


- Physicians that treat sicker populations have higher average cost and utilization per patient. Risk-adjusted reporting can accurately reflect these sicker patients.
- The Centers for Medicare and Medicaid Services (CMS) sets risk scores for a calendar year based on diagnoses from the previous calendar year.
- All existing diagnoses must be submitted every calendar year for risk scores to be accurate.
- Member attribution is done by wellness exams.

Complete and Accurate Clinical Documentation and ICD-10 Coding

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.
- 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.



Advantage of Assigning CPT II Codes

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.

- Lessens the administrative burden of chart review for quality programs such as:
  - Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures
  - Blue Advantage HHC gaps
  - RADV gap
- 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.

Authorizations

Prior Authorizations

Standard

- Determination and member notification provided within 14 days of receipt (non-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.

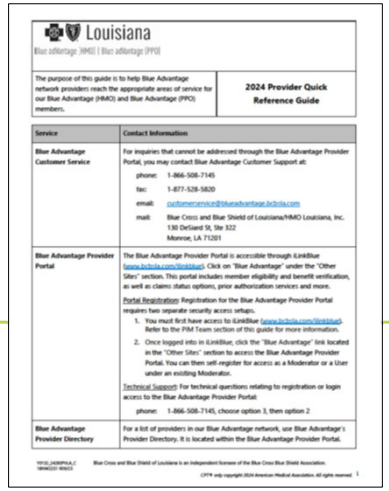
Contracted providers can submit an appeal only when it involves a pre-service request and the member sent written Notice of Right to an Expedited Appeal.

Hospital 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)*.


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.

2024 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. 130 DeSiard St, Ste 322 Monroe, LA 71201
Blue Advantage Provider Portal	The Blue Advantage Provider Portal is accessible through iLinkBlue (www.bcbsla.com/iLinkBlue). Click on "Blue Advantage" under the "Other Sites" section. This portal includes member eligibility and benefit verification, as well as claims status options, prior authorization services and more. Portal Registration: Registration for the Blue Advantage Provider Portal requires two separate security access setups. 1. You must first have access to iLinkBlue (www.bcbsla.com/iLinkBlue). Refer to the PIM Team section of this guide for more information. 2. Once logged into iLinkBlue, click the "Blue Advantage" link located in the "Other Sites" section to access the Blue Advantage Provider Portal. You can then self-register for access as a Moderator or a User under an existing Moderator. Technical Support: For technical questions relating to registration or login access to the Blue Advantage Provider Portal: phone: 1-866-508-7145, choose option 3, then option 2
Blue Advantage Provider Directory	For a list of providers in our Blue Advantage network, use Blue Advantage's Provider Directory. It is located within the Blue Advantage Provider Portal.

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

Hospital 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**.

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

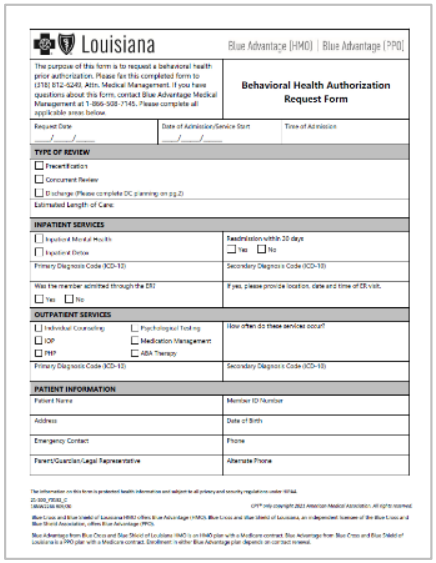
The plan reviews and makes determinations for IP/OBS, SNFs, Acute Rehabs, LTACs, HHCs, LOSs, LOCs and discharge planning.

Medical Necessity Criteria:

- Standardized criteria (e.g., InterQual®, DSM-5, ASAM, etc.)
- Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD)

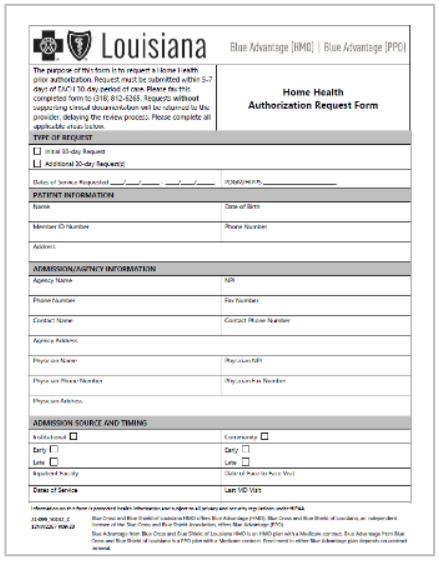
Prior Authorizations Forms

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


Louisiana Blue Advantage [HMO] | Blue Advantage [PPO]

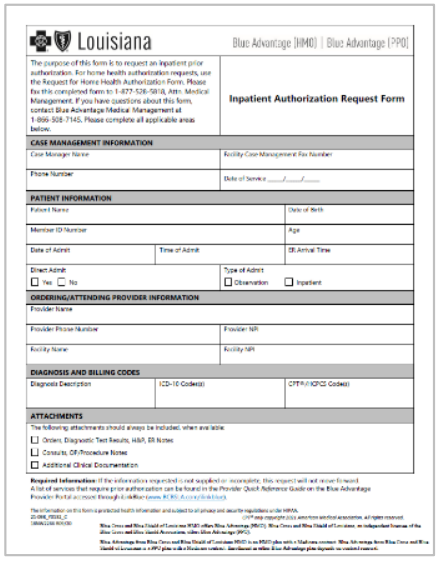
Behavioral Health Authorization Request Form

Behavioral Health Authorization Request Form


Louisiana Blue Advantage [HMO] | Blue Advantage [PPO]

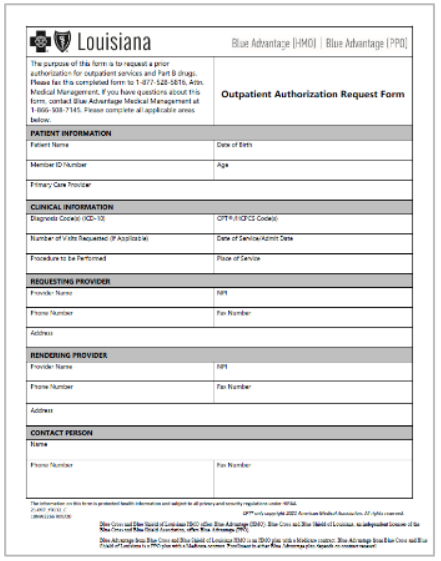
Home Health Authorization Request Form

Home Health Authorization Request Form


Louisiana Blue Advantage [HMO] | Blue Advantage [PPO]

Inpatient Authorization Request Form

Inpatient Authorization Request Form


Louisiana Blue Advantage [HMO] | Blue Advantage [PPO]

Outpatient Authorization Request Form

Outpatient Authorization Request Form

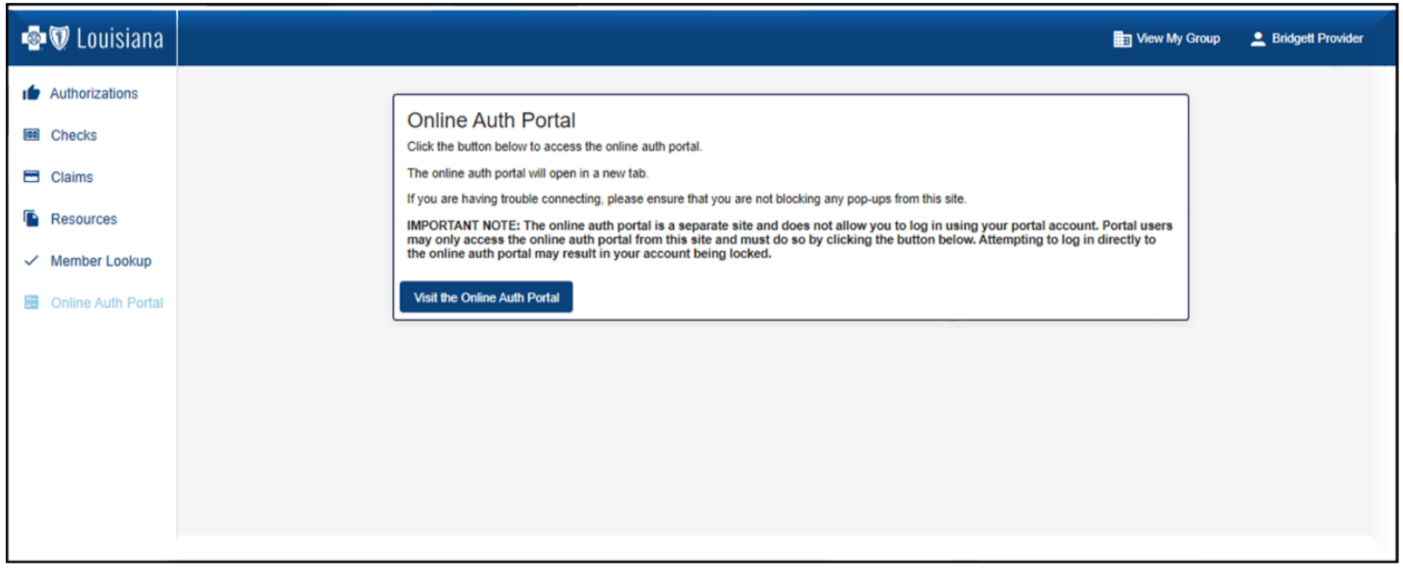
Download authorization forms by going to **www.bcbsla.com/ilinkblue**, then clicking on "Blue Advantage" under the "Other Sites" section. Click "Resources" then "Forms."

The 2024 *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 on "Blue Advantage" under the "Other Sites" section. Click "Resources" then "Reference Materials."

Online Prior Authorizations Portal

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



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)**.
- Member cost share depends on the drug's assigned tier.*

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 (e.g., albuterol from a nebulizer).
- Members may have a 20% Part B coinsurance.
- This amount applies to the **Max Out-Of-Pocket (MOOP)**.

**D-SNP Plan does not include drug tiering.*

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 (e.g., 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)
- Wegovy ® (semaglutide)

Drugs used for cosmetic purposes, hair growth, hair removal

- Retin-A® (tretinoin)
- Vaniqa®

Drugs to treat sexual dysfunction

- Levitra®
- Viagra®
- Addyi®

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 copayments 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

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 three-month supply of maintenance medications.
  - Improve engagement with patient and physician outreach.
- **Connect members to pharmacies that support Clinical Star measures**

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.

In order to improve medication adherence, we ask that maintenance medications are written for a 3-month supply to ensure that patients continue to take as directed. Express Scripts Pharmacy® also has autofill options to help avoid forgetting refills.

Express Scripts Mail-order Pharmacy

Two Steps to set up home delivery:

1) Prescribe a three-month 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: 1-800-282-2881 (24 hours a day, 7 days a week)
      TTY users: 1-800-759-1089
    - Go online: **www.express-scripts.com**

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 information on the following products online at **www.bcbsla.com/blueadvantage**:

- Abbott
- LifeScan
- Arkray

Outreach Initiatives

Therapeutic Opportunities

Provider Outreach

- Star Report Cards containing gaps in care opportunities are distributed by the Blue Advantage provider team.
- Value Program Pharmacists are assigned organizations and assist them with improving their pharmacy quality measures and identify ways to reduce pharmacy costs, when clinically appropriate.
    - Meet with organizations at an agreed upon cadence to discuss pharmacy opportunities and review reports.
    - Provide pharmacy reports at an agreed upon cadence to appropriate personnel for each organization (i.e., weekly, monthly, quarterly).
    - Provide educational pieces on pharmacy quality measures.

Member Outreach

- Pharmacists reach out to members eligible for Medication Therapy Management (MTM), members falling into pharmacy star measures, such as Medication Adherence, and members meeting specific criteria with certain chronic disease states (i.e., COPD and diabetes).

Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

Targets members who meet the following criteria:

- 3+ chronic conditions
- 8+ select maintenance medications
- Spent $1,332 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.

Claims and Billing

Blue Advantage Flex Card

- Personal prepaid debit card with allowances that can only be used for approved products for Blue Advantage members.
- Card allowances are not transferable.
- Card allowances do not roll over.
- If purchases exceed the allowance amount of the Flex Card, the member is responsible for paying the difference.

- Card allowances will vary by plan and include:
  - Annual allowance for prescription hearing aids
  - Annual allowance for eyewear like eyeglasses and contact lenses
  - Quarterly allowance for over-the-counter supplies available for purchase at major retailers or online
  - D-SNP has a monthly allowance for over the counter health-related products and healthy foods

To set up, replace or ask questions about your Flex Card, please call us at 1-833-952-2772, Monday – Friday, 7 a.m. to 7 p.m.

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

- 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.

Claims Submission

Mail all paper claims to:

Blue Advantage
130 DeSiard St, Ste 322
Monroe, LA 71201

Blue Advantage Medical Record Reviews

- Blue Advantage is currently partnered with **Cognisight** to assist us in conducting medical record reviews.
- As a provider in our Blue Advantage network, you are not to charge a fee for providing medical records to Blue Advantage or vendors acting on our behalf.
- Additionally, the patient's Blue Advantage member contract allows for the release of information to Blue Advantage or its designee.
- In accordance with all applicable state and federal laws and Health Insurance Portability and Accountability Act (HIPAA), any information shared with our vendors will be kept in the strictest of confidence.

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"

- 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.

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.

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: Payment 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 original 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.

Other Services

Refractions

- Refractions are not covered unless performed by a contracted Blue Advantage ophthalmologist or optometrist.
- 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 Blue Advantage provider directory or call 1-866-508-7145.

The provider directory can be accessed through iLinkBlue (**www.bcbsla.com/ilinkblue**) >Blue Advantage under "Other Sites." Once logged into the Blue Advantage Provider Portal, click on Provider Directory, then select "Visit the Provider Search."

Other Services

- **Express Scripts**

  administers pharmacy benefit management

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

- **Liberty Dental**

  administers preventative and comprehensive dental services

  phone: 1-866-609-0424

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

Outpatient Lab Tests

Blue Advantage network providers can:

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

Blue Advantage Preferred Labs:

- Clinical Pathology Laboratories (CPL)

  www.cpllabs.com

- Laboratory Corporation of America (LabCorp)

  www.labcorp.com

- Quest Diagnostics

  www.questdiagnostics.com

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 "Forms & Resources" section, click on "Compliance Program," under "Helpful Links" then "CMS Medicare Compliance and Fraud, Waste and Abuse Training."

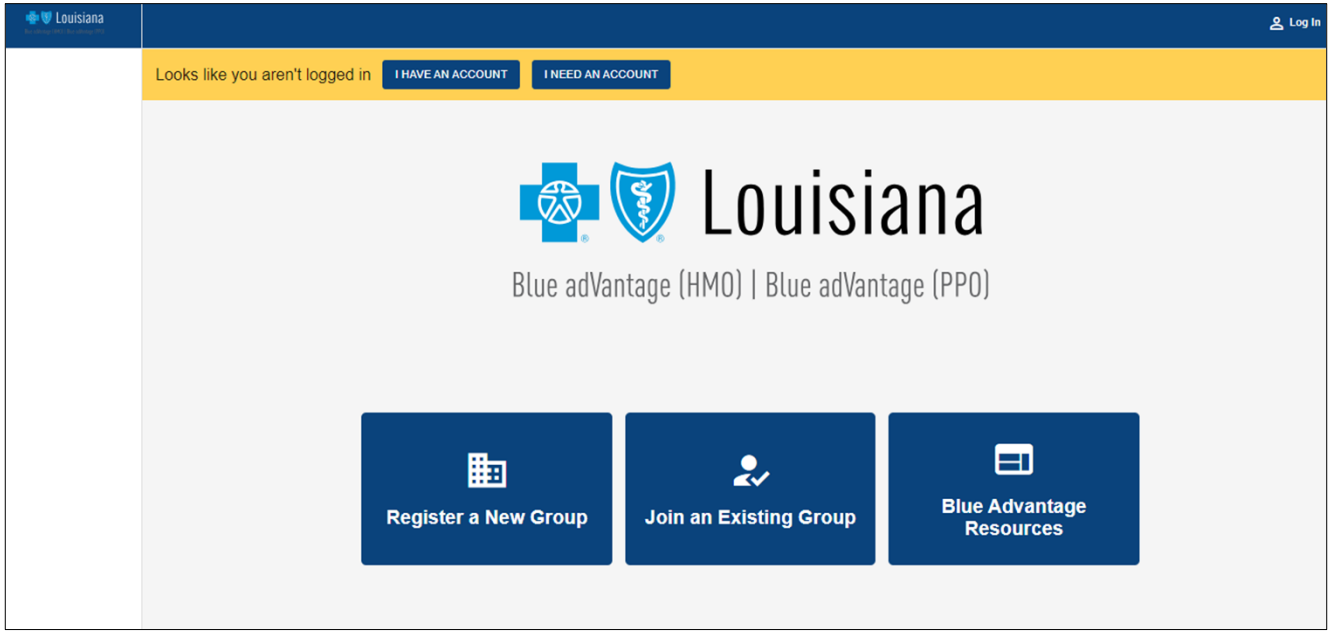
Required Dual Advantage (HMO D-SNP) Training

Dual Eligible Special Needs Plans (D-SNPs) are for individuals who are entitled to both Medicare and Medicaid.

The Centers for Medicare and Medicaid Services (CMS) is requiring D-SNP provider training in 2024. More information will be sent to providers once details are available.

Blue Advantage Provider Portal

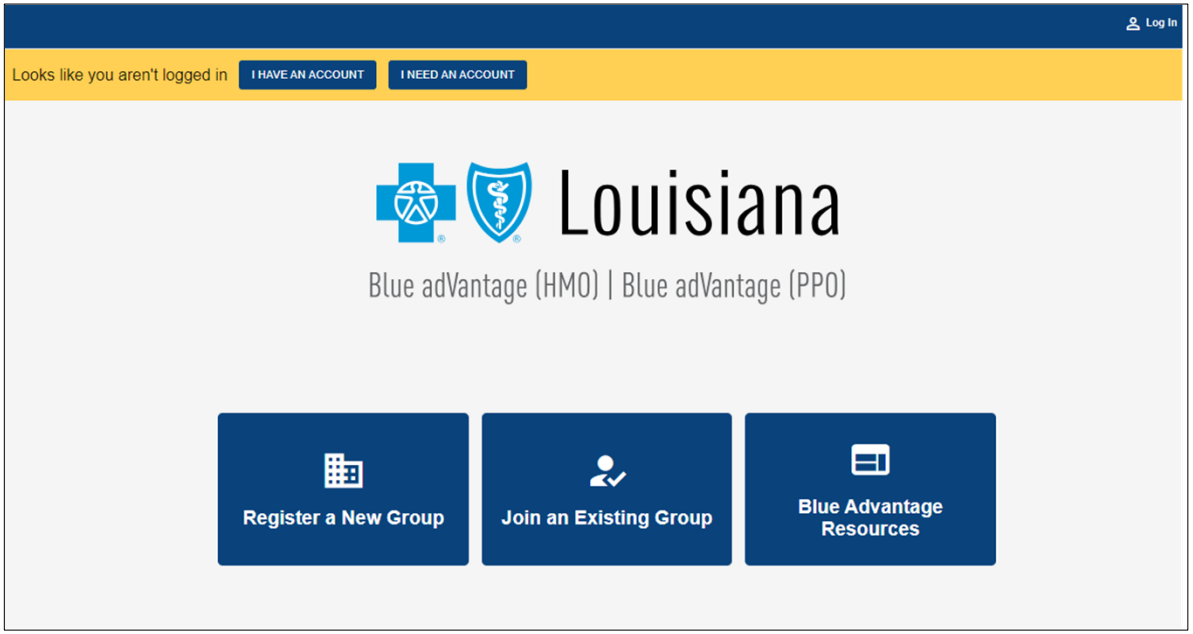
- Claims Inquiry
- Member Eligibility
- Provider Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more



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

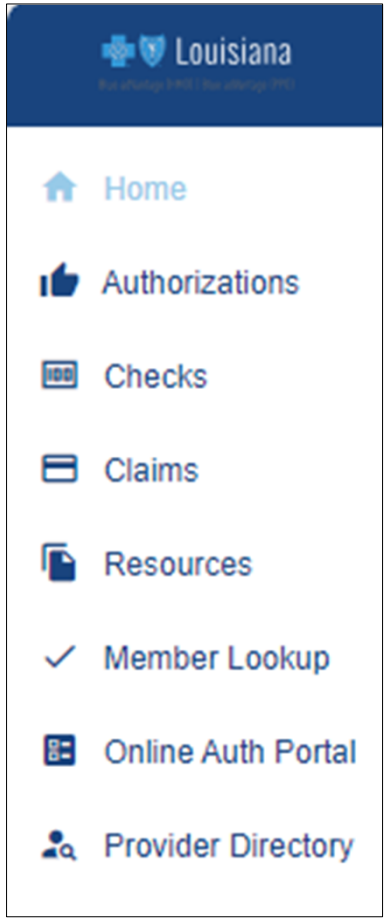
Accessing the Blue Advantage Provider Portal

Provider Portal Login



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

Provider Portal Features



To access the Blue Advantage Provider Portal, visit **www.bcbsla.com/ilinkblue**, then click on "Blue Advantage" under the "Other Sites" section and select the option to log in.

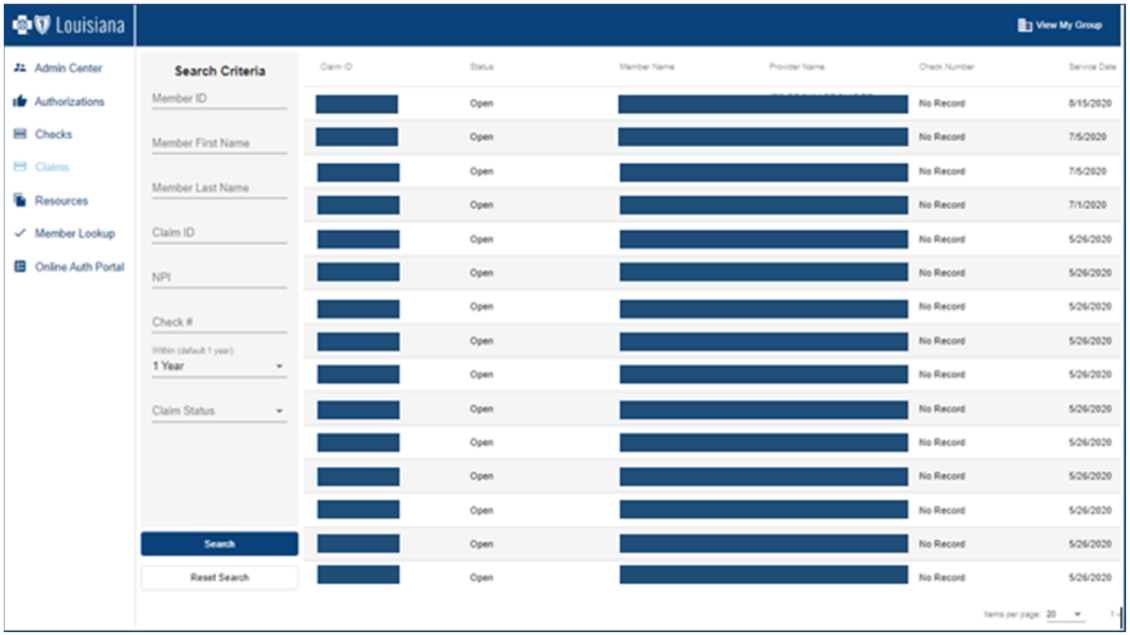
Checking Claim Status

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*.

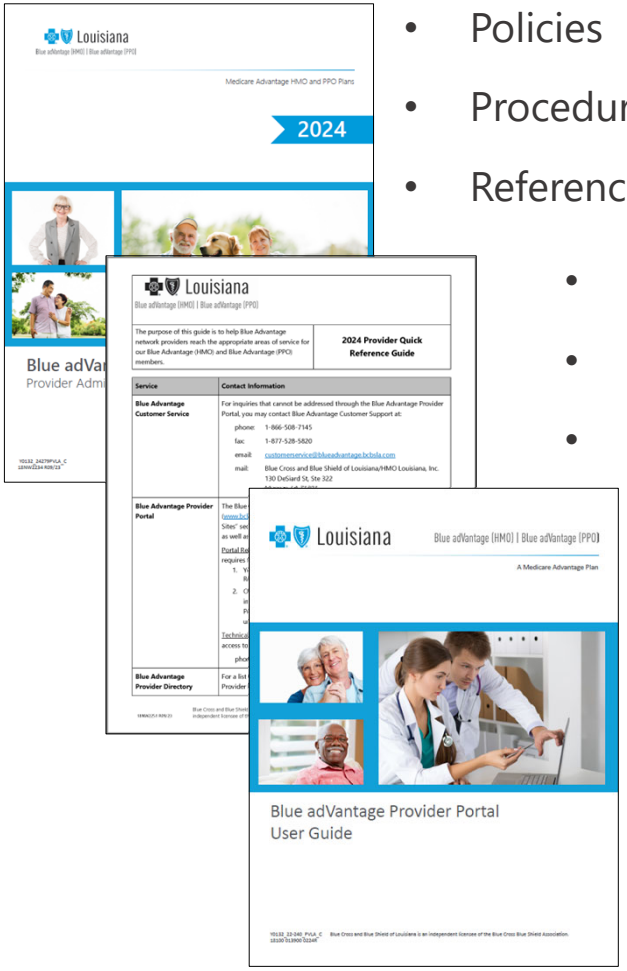
For each claim listed, the portal screen will display:

- 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.

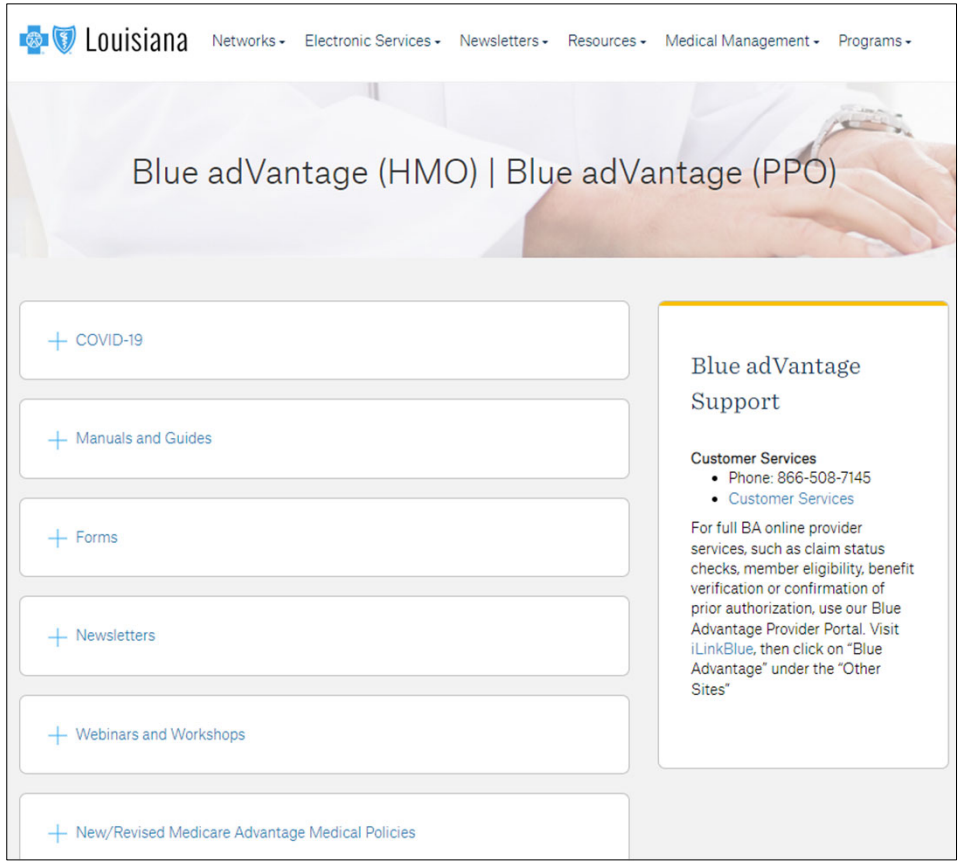
Blue Advantage Manuals and Guides



- 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 resource page and Provider Portal**.** To access the Blue Advantage Provider Portal, visit **www.bcbsla.com/ilinkblue**, then click on “Blue Advantage” under the “Other Sites” section and select the option to log in.

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.

Questions?

Addendum

Blue Cross to Process EFTs and ERAs for Blue Advantage Claims

In 2023 Blue Cross and Blue Shield of Louisiana began the processing of electronic funds transfer (EFT) and electronic remittance advice (ERA) 835. Therefore, all Blue Advantage claims payments will be made through Blue Cross and Blue Shield of Louisiana.

For questions about EFT and ERA, please contact our EDI Department at EDIservices@bcbsla.com or by phone at 1-800-716-2299, option 3.

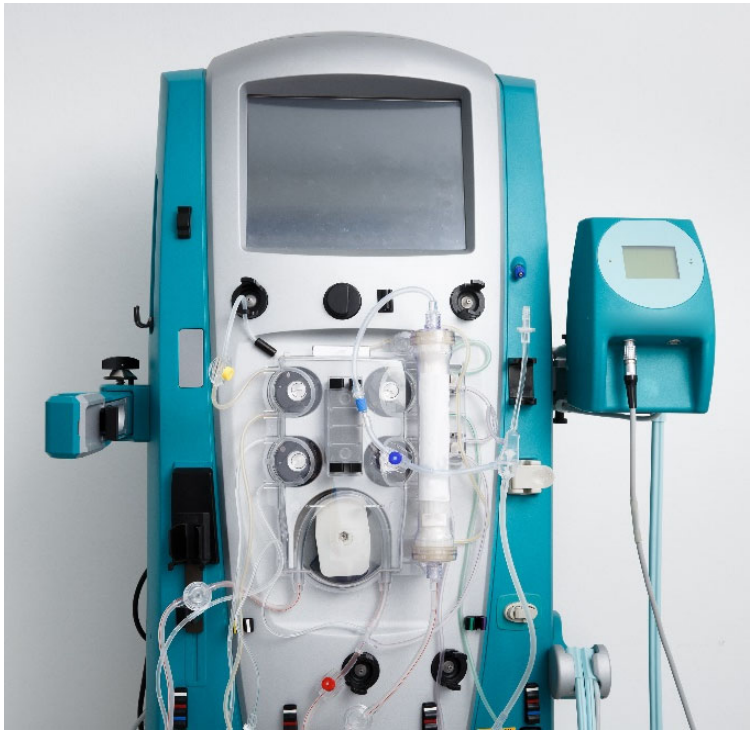
Blue Cross Processing Electronic Transactions for Blue Advantage

HIPAA 837 and 27x electronic transactions for Blue Advantage are managed by Blue Cross.

New Hostname	Use the Blue Cross SFTP application (MessageWay) server hostname mft.lhec.net for batch submissions.
New Batch File Naming Requirements	Submit all batch files with the first three positions of the file name as "BAM" for Blue Advantage. Not including these three-letters at the beginning of the file name will result in the claims routed incorrectly and rejected.
Payor ID	72107
Real Time rules for 2100A Loop	Real Time requests must be submitted to the following URL: www.bcbsla.com/realtimesubmission/realtimesubmission.aspx. Trading partners must submit the 27x real-time transactions using the following rules for the 2100A loop in the 270/276 request: • NM101 = PR • NM103 = BAM • NM108 = PI • NM109 = 72107
ISA06-Interchange Sender ID/Trading Partner ID	ISA06 is the Trading Partner number assigned by Blue Cross. ISA06 field is a fixed length requiring 15 positions and must be left justified. ISA06 must be identical to GS02.
ISA08-Interchange Receiver ID/BCBSLA	ISA08 must be BCBSLA001. The field is fixed length requiring 15 positions and must be left justified.

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 **https://mycrownweb.org**.

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.

Medical Record Retention and Requests

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

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

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

<u>Medical record request</u>:

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

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

Note: Providers are contractually responsible for sending medical records without charge.

Helpful Hints for Accessing the Blue Advantage Provider Portal

- 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.

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").

Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

- Targets members who meet the following criteria:
  - 3+ chronic conditions.
  - 8+ maintenance medications.
  - Spent $1,233 in the previous three months on Part D covered medications.
- Members will be invited to schedule a Comprehensive Medication Review (CMR) with an MTM-certified pharmacist and 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.

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.

Billing Reminders

- Blue Advantage ambulatory surgical center (ASC) claims must be submitted on a CMS-1500. 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 must 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.

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.

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.

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