



Blue Advantage Network Workshop

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

2019



Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

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Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal. HMO Louisiana, Inc. offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

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

Provider Relations



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

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

Agenda

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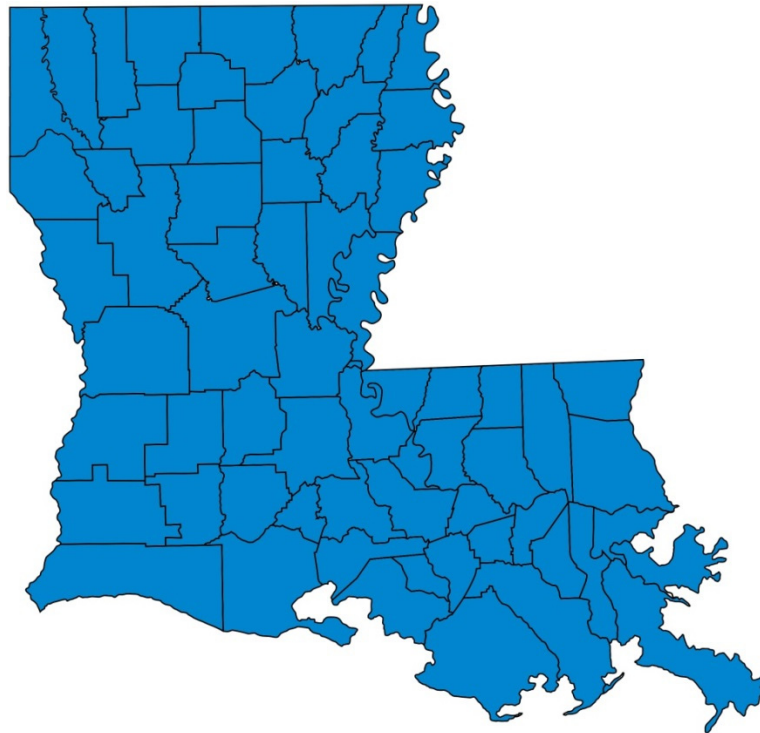
Welcome to our Blue Advantage Networks



Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

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



Lumeris Partnership

Why partner with Lumeris?

- Experts in Medicare Advantage plan management

Lumeris assists with:

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



Information on this slide provided by Lumeris.

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 "Helpful Links" section, click on "Compliance Program," then "CMS Medicare Compliance and Fraud, Waste and Abuse Training." See Slide 18 for how to access the portal.



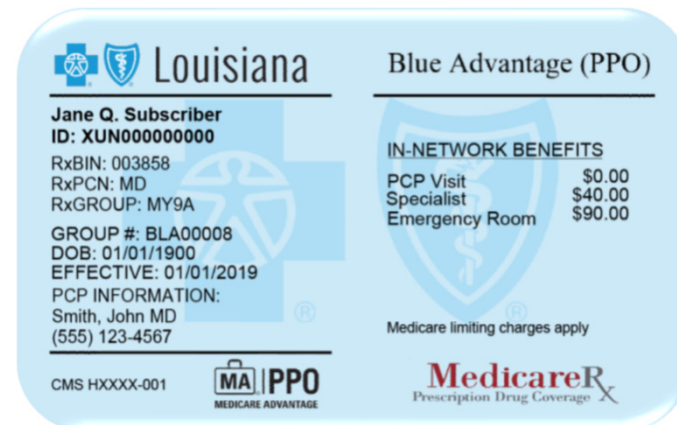
Member ID Cards

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

- Demographic information about covered member
- PCP name and phone number
- Copayment or coinsurance responsibilities
- Important phone numbers



XUM prefix

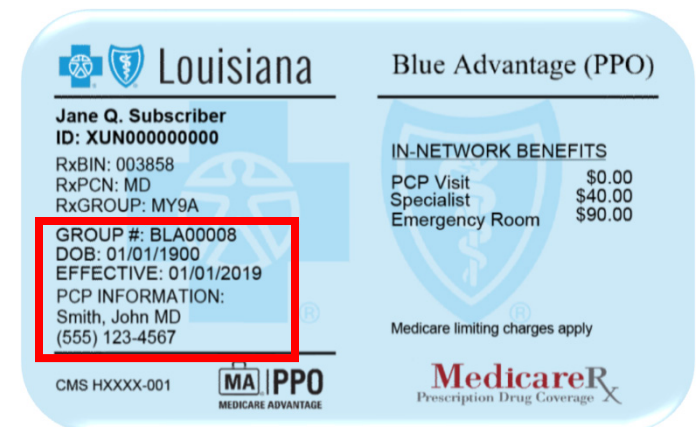
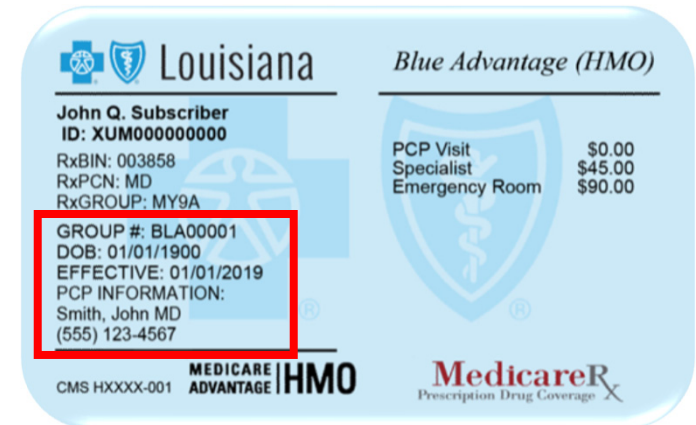


XUN prefix

Member ID Cards

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

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



Blue Advantage Customer Service

Blue Advantage Customer Service representatives are available to assist Blue Advantage members

Members may contact customer service for questions concerning:

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



1-866-508-7145

Providers may also contact Blue Advantage Customer Service on the patient's behalf and request a representative call the member to assist with their questions

Role of the Primary Care Provider (PCP)

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

- Oversee, coordinate, discuss and direct the member's care with the member's care team, specialists and hospital staff
- Develop and grow the provider-member relationship while being proactive and cost effective
- Responsible for coordinating members' medically necessary services



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

ADSP: Online Tool for the PCP



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

The ADSP is accessible through the Blue Advantage Provider Portal:

www.BCBSLA.com/ilinkblue

Click “Blue Advantage” under the other sites section. Once on the Blue Advantage Provider Portal, click “Lumeris ADSP” under the Additional Features section.

Access to the ADSP requires an additional level of security

ADSP: Features of the Tool

- View Blue Advantage patient panel
- Review patient-level details from claims data:
 - Admit/Discharge history
 - Labs
 - Prescriptions
 - Imaging
 - And more
- Identify Actionable Gaps in Care data:
 - A1c values not current
 - Blood Pressure (BP) reading not current
 - No PCP visit in current year
 - And more
- Access content library:
 - Contains educational resources from Lumeris
 - Documents deliver information needed to achieve best cost and clinical outcomes

To set up ADSP training, email Provider Relations at provider.relations@bcbsla.com and include "ADSP training" in the subject line or call 1-800-716-2299, option 4

Appointment Scheduling & Wait Times

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

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

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

Health Risk Assessments (HRAs)

New member HRAs

- Paper-based questionnaire sent to each new member upon confirmation of the member's effective date
- These HRAs are analyzed in order to identify members who have complex or serious medical conditions

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

PCPs are notified of high-risk HRA members with a copy of the member's care plan or actual completed HRA



Our Secure Online Services

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
- Behavioral Health Authorizations
- AIM **ProviderPortal**_{SM}
- and more (as we develop new services)

At least one administrative representative is required to self-manage user access to our secure online services, but we recommend each organization assign more than one



Administrative Representative (AR)

- Registered with Blue Cross to designate user access to our secure online tools
- Only grants access to employees who legitimately need access to fulfill their job responsibilities
- If you do not have an AR, please complete the Administrative Representative Registration Packet, which can be found on our Provider page under the Provider Networks section, www.BCBSLA.com/providers



Blue Advantage Provider Portal

The Blue Advantage Provider Portal includes access to:

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



Providers in our Blue Advantage network must access the *Blue Advantage Provider Portal* through iLinkBlue (www.BCBSLA.com/ilinkblue)

> Blue Advantage (under Other Sites)

Accessing the Blue Advantage Provider Portal

www.BCBSLA.com/ilinkblue

The screenshot displays the iLinkBlue provider portal. At the top is a dark blue navigation bar with a home icon and menu items: Coverage, Claims, Payments, Authorizations, Quality & Treatment, and Resources. Below this is a main content area with a light blue header. On the left, a 'Welcome to iLinkBlue' section includes 'Tips to Know' and a 'Are Your Codes Valid for Your Claim?' tool description. On the right, a 'Medical Record Requests' section shows 'You have 0 new Medical Record Requests that require action.' and a link to 'Out of Area Medical Record Requests'. Below these are six icons for Research Claims, BCBSLA Coverage, OOA Coverage, Need an Auth?, Payment Registers, and EFT Notices. Further down, an 'Important Blue Cross Messages' section features a 'Newsletter' link to a 1st Quarter 2019 Provider Network News. On the bottom right, an 'Other Sites' section lists Davis Vision Network, Dental Advantage Plus Network - United Concordia Dental, and Blue Advantage, which is highlighted with a red rectangle.

Welcome to iLinkBlue
Tips to Know

Are Your Codes Valid for Your Claim?
You can use the Medical Code Editing tool to verify if the CPT/HCPCS codes are valid for the date of service. This tool is located under the Claims menu.

Medical Record Requests
You have 0 new Medical Record Requests that require action.
Please visit [Out of Area Medical Record Requests](#) to view requests.

Research Claims BCBSLA Coverage OOA Coverage Need an Auth? Payment Registers EFT Notices

Important Blue Cross Messages
Newsletter
[Click here](#) to view a copy of the 1st Quarter 2019 Provider Network News.

Other Sites
Davis Vision Network
Dental Advantage Plus Network - United Concordia Dental
Blue Advantage

Blue Advantage Provider Portal Registration

[Forgot Login ID](#) [Forgot Password](#) [Registration](#)

[Provider Home](#) [Provider & Pharmacy Search](#) [Reminders & Notices](#) [Contact Information](#)

Attention
CMS requires Medicare Advantage plans to maintain an up to date provider directory. Please use the Provider Demographic Change Form below if you have any demographic changes that need to be reported.

2019 Guides & Resources

- [Benefits](#)
- [Pharmacy Benefit Resources](#)
- [Provider Directory](#)
- [Evidence of Coverage](#)
- [Provider Administrative Manual](#)
- [Provider Quick Reference Guide](#)
- [Medical Necessity Criteria](#)

+ 2018 Guides & Resources

Additional Features (Login required)

- [Member Eligibility](#)
- [Member ID Card](#)
- [My Dashboard](#)
- [Claims Inquiry](#)
- [Authorization Inquiry](#)
- [Lumeris ADSP](#)

Forms

- [Part B Drug Prior Auth Criteria & Forms](#)
- [General Prior Auth Form](#)
- [Home Health Prior Auth Form](#)
- [Part D Prescription Drug Coverage Determination Request Forms](#)
- [Voluntary Refund Explanation Form](#)
- [Waiver of Liability](#)
- [Provider Demographic Change Form](#)
- [2019 Super Visit Form](#)

Help Documents

- [Provider Portal Quick User Guide](#)
- [Blue Advantage \(HMO\)/Blue Advantage \(PPO\) FAQ](#)
- [AIM Oncology Program FAQ](#)
- [DME and O&P Prior Auth List](#)

Claims

- [Electronic Payment & Remit](#)
- [Electronic Claims](#)
- [Billing Guidelines](#)

Newsletters & Events

- [Newsletters](#)
- [Workshops](#)
- [Webinars](#)

Helpful Links

- [Compliance Program](#)
- [BMI Calculator](#)
- [Secure File Transfer](#)

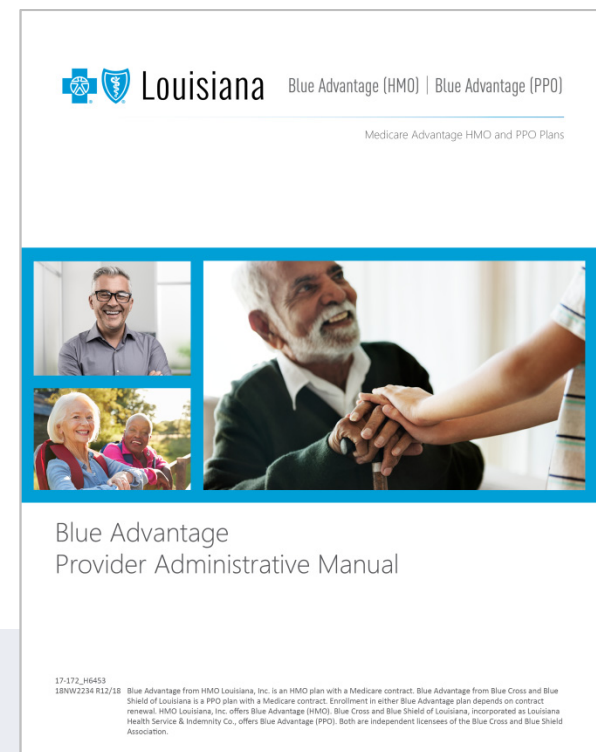
While many of the resources on the portal are accessible without logging in, some do require security access. To gain login access, click **"Registration"** in top right corner. Refer to the *Provider Portal User Guide* under the **"Help Documents"** section for more information.

Provider Manual

The *Blue Advantage Provider Administrative Manual* includes:

- policies
- procedures
- reference information required of our Blue Advantage network providers

It is located on the Blue Advantage Provider



Online Provider Guides

Provider Quick Reference Guide

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

www.BCBSLA.com/ilinkblue > Blue Advantage
> Provider Quick Reference Guide (under 2019 Guides & Resources)

Durable Medical Equipment (DME) and Orthotic & Prosthetic (O&P) List

- Contact information for DME and O&P services
- DME prior authorization list
- Orthotics and Prosthetics prior authorization list

www.BCBSLA.com/ilinkblue > Blue Advantage > DME and O&P
Prior Auth List (under Help Documents)

| Louisiana Blue Advantage (HMO) Blue Advantage (PPO) | |
|---|--|
| <p>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.</p> <p>Provider Quick Reference Guide</p> | |
| SERVICE | CONTACT INFORMATION |
| Blue Advantage Provider Portal | <p>For assistance with routine inquiries such as claim status checks, member eligibility, benefit verification or confirmation of prior authorization, use the Blue Advantage Provider Portal, located within www.BCBSLA.com/ilinkblue, by clicking on "Blue Advantage" under Other Sites.</p> <p>For technical questions relating to registration or login access to the Blue Advantage Provider Portal:</p> <p>phone: 1-866-508-7145</p> |
| Blue Advantage Customer Service | <p>For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Service at:</p> <p>phone: 1-866-508-7145</p> <p>fax: 1-877-528-5800</p> <p>email: customerservice@blueadvantage.la.com</p> <p>mail: HMO Louisiana, Inc. P.O. Box 33006 St. Louis, MO 63132</p> <p>online: www.BCBSLA.com/BlueAdvantage</p> |
| Authorizations (Including Case and Medical Management) | <p>2019 Durable Medical Equipment and Orthotic & Prosthetic List</p> <p>Blue Advantage requires prior authorization prior to coverage of certain durable medical equipment (DME), orthotics and prosthetics (O&P) items. Certain DME and O&P items are not covered by Medicare and therefore not covered by Blue Advantage. It is the responsibility of the provider to secure a prior authorization before delivery of items requiring a prior authorization.</p> <ul style="list-style-type: none"> Requests may be faxed to 1-877-528-5816 For questions call 1-866-508-7145, option 4, option 4 <p>Table 1 - DME Prior Authorization List This is a complete list of DME codes that require a prior authorization (PA) based on Medicare coverage guidelines.</p> <p>Table 2 - Orthotics & Prosthetics Prior Authorization List This is a complete list of CPT codes that require a prior authorization based on Medicare coverage guidelines.</p> <p>Please Note:</p> <ul style="list-style-type: none"> DME must be supplied by an in-network provider with a plan contract that includes the provision of DME items to health plan members. CSP can be provided by any in-network provider. Please consult the member's individual contract regarding Plan coverage for add-ons or upgrades. When add-ons or upgrades are beyond what is necessary to meet the member's basic functional medical needs, they are generally not considered medically necessary. Requested "up grades" for equipment, supplies, orthotics and prosthetics require that an OOD (out of network) determination be secured and the member be notified in writing of the decision before the item/service can be provided and the member held financially responsible. The request can be pursued by the provider or the member. The request should be made to the Medical Management department. Duplicate equipment - Please consult the member's individual contract regarding Plan coverage for duplicate equipment. This would generally not be covered and may include, but not be limited to, equipment that is intended as a "back-up," such as a second C-Pap machine. DME Non-Covered Items - Providers must request a pre-service initial organization determination (prior authorization) before supplying items and holding the member responsible for payment. CSP Non-Covered Items - Providers must request a pre-service initial organization determination (prior authorization) before supplying items and holding the member responsible for payment. |

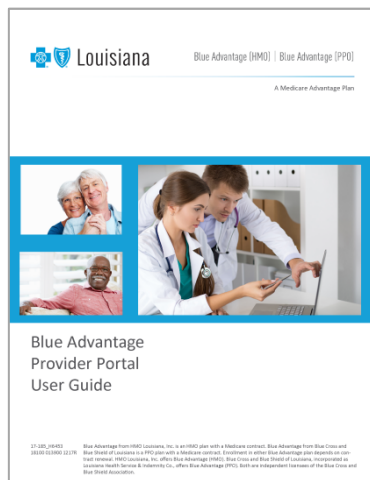
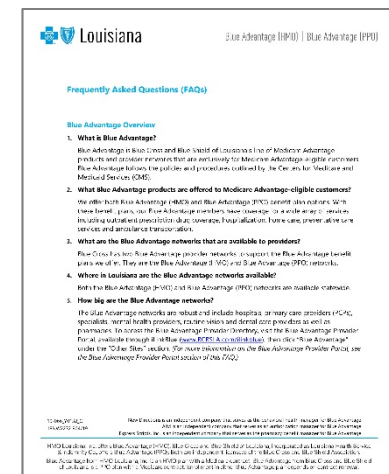
Online Provider Guides

Frequently Asked Questions (FAQs)

Answers provider questions regarding:

- Blue Advantage Overview
- Selecting a PCP
- Member ID cards
- And more

www.BCBSLA.com/ilinkblue > Blue Advantage > Blue Advantage (HMO)/Blue Advantage (PPO) FAQ (under Help Documents)



Provider Portal User Guide

- register to use the Blue Advantage Provider Portal
- use the Member Eligibility feature
- use the Member ID Card feature
- use the Claims Inquiry feature
- use the Authorization Inquiry feature

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

Medical Documentation

Medical Records Documentation & Audits/Reviews

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

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
- Varis, Health Data Vision Inc. (HDVI) and Inovolan are approved vendors for these requests

When a member changes to a new PCP, upon request, the prior PCP has 10 business days of request to submit records to new PCP



Medical Records Signature Requirements

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

Electronic Signatures



Acceptable:

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



Unacceptable:

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

Medical Management

Role of Medical Management



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

- Prior authorization, concurrent review, discharge planning and assistance with referrals
- Notify PCP offices of acute admissions and discharges for PCP follow-up
- Complex Case Management program

Authorization and Benefit Determinations

Inpatient Admission:

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

Observation:

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

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

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

Medical Necessity Criteria:

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

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



Prior Authorization

Standard

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

Expedited

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

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

Member sent written Notice of Right to an Expedited Appeal

Prior Authorization

Requests submitted via fax, letter or phone

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

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

Provision of robust clinical information upon initial submission is key

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

Prior Authorization

Hospital Admissions:

- Providers can report inpatient admissions to the Blue Advantage Medical Management team by:

Phone: 1-866-508-7145

Fax: 1-877-528-5818
(available 24 hours a day)

- Phones are forwarded to a secure voicemail system during non-business hours
- Confirmed by Blue Advantage Medical Management staff with a reference number

(A reference number does not guarantee payment)

- 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

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

Prior Authorizations

Musculoskeletal (MSK)

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

Blue Advantage Medical Management administers authorizations for inpatient MSK services

fax: 1-877-528-5816

phone: 1-866-508-7145

AIM Specialty Health administers authorizations for outpatient MSK services

online: AIM *ProviderPortal_{SM}* through iLinkBlue

phone: 1-866-455-8416

Please include all supporting clinical information with authorization request

Prior Authorizations

AIM Specialty Health administers authorizations for the following services:

Radiation Oncology

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

High-tech Radiology

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

Cardiology

Prior authorizations for select office and outpatient non-emergency procedures

online: AIM **ProviderPortal_{SM}** through iLinkBlue

phone: 1-866-455-8416

**Once on iLinkBlue
(www.BCBSLA.com/ilinkblue),
click on the “Authorizations”
menu option**

Please include all supporting clinical information with authorization request

Prior Authorizations

New Directions administers behavioral health facility authorizations for the following services:

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

online: New Directions WebPass Portal through iLinkBlue

phone: 1-877-250-9167

Once on iLinkBlue
(www.BCBSLA.com/ilinkblue),
click on the “Authorizations”
menu option

Please include all supporting clinical information with authorization request

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

Notice of Discharge from an Inpatient Facility

The Important Message (IM) from Medicare:

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

The Notice of Medicare Non-Coverage (NOMNC):

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

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

Transition of Care

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

Overall Program Goals Using the Coleman Care Transitions Intervention Model[©]



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



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 projectcrownweb.org

Other Services

Outpatient Lab Tests

Blue Advantage network providers can:

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



Blue Advantage Preferred Labs:

- Clinical Pathology Laboratories (CPL)
www.cpllabs.com
- Laboratory Corporation of America LabCorp
www.labcorp.com
- Quest Diagnostics
www.questdiagnostics.com

Refractions



- Refractions are not covered unless performed by a Blue Advantage Davis Vision provider
- As a CMS requirement, contracted providers are not permitted to render non-covered services and hold the member responsible
- For network vision providers, please search the Davis Vision website at www.davisvision.com or call 1-800-247-2814

Other Services

- **United Concordia**
administers routine dental services
phone: 1-866-445-5825
- **Express Scripts**
administers pharmacy benefit management
phone: 1-800-935-6103/TTY:711



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

Pharmacy

Part B vs. Part D Overview

B/D

Some drugs may be covered under Part B or Part D depending on what it treats or where/how it is given

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

B

Part B Covered Drugs

- Primarily drugs covered "Incident To" a physician's service
 - Some drugs are covered at a pharmacy under specific circumstances
 - Member cost-share is the Part B coinsurance
-

D

Part D Covered Drugs

- Most prescription medications
- Except those covered under Part B or excluded per CMS regulations (see next slide)
- Member cost-share depends on the drug's assigned tier

Overview of Drug Coverage Rules

B

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

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

D

Part D

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

Part D Exclusions

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

Preferred Value Pharmacy Network

Benefits of Preferred Network

Cost-savings for member

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

Enhanced programs to improve adherence

- Improve engagement with patient and physician outreach

Connect members to pharmacies that support Clinical Star measures

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



Preferred Value Pharmacy Network

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



Louisiana chain pharmacies include:

Walgreens

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



Many independent pharmacies also participate

Benefits of Home Delivery



No-cost Shipping

- Standard shipping right to the member's door at no extra cost

Refill Reminders

- Refill reminders make it less likely to miss a dose

Avoid Interactions

- Safety reviews to find possible interactions with other drugs

Pharmacists Available

- Access to a pharmacist 24/7 from the privacy of member's home

Express Scripts Mail-order Pharmacy

2 Steps to set up home delivery:

1) Prescribe a 90-day supply

- Prescription can be sent electronically from the EMR or called in to Express Scripts Pharmacy

2) Member can contact Express Scripts directly to have prescription transferred

Starting home delivery is easy:

Call:

1-800-841-3351



Monday through Friday, 9 a.m. to 7 p.m. Eastern Time (except office holidays)

TTY users: **1-800-716-3231**

Go Online: express-scripts.com/get90



TO BE SAFE:

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

Diabetic Testing Supplies

Two ways members may get a FREE meter:

1) Go to a Blue Advantage network pharmacy

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

2) Call to get a meter delivered at home

- Call Abbott or LifeScan and give the code provided to have a covered meter delivered at home
- Strips are available at network pharmacies

Members can find complete information online:

- 1) www.BCBSLA.com/myblueadvantage
- 2) Documents
- 3) 2019 Diabetes Testing Supplies Coverage at Network Pharmacies

New

Pharmacist Outreach Initiatives

Medication Adherence

Provider Outreach

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

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

Member Outreach

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

New

Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

- Targets members who meet the following criteria:
 - 3+ chronic conditions
 - 7+ maintenance medications
 - Spent \$1,011 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 Requirements

Billing Requirements

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

- Faxed claims are **not** accepted
- All nurse practitioners, physician assistants and other physician extenders must be identified on the claim **with their own NPI**

Timely Filing

- Participating providers have 12 months **from the date of service** to file an initial claim
- Participating providers have 12 months **from the date the claim was processed** (remit date) to resubmit or correct the claim

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

Timely Filing Disputes

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

Electronically

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

Paper

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

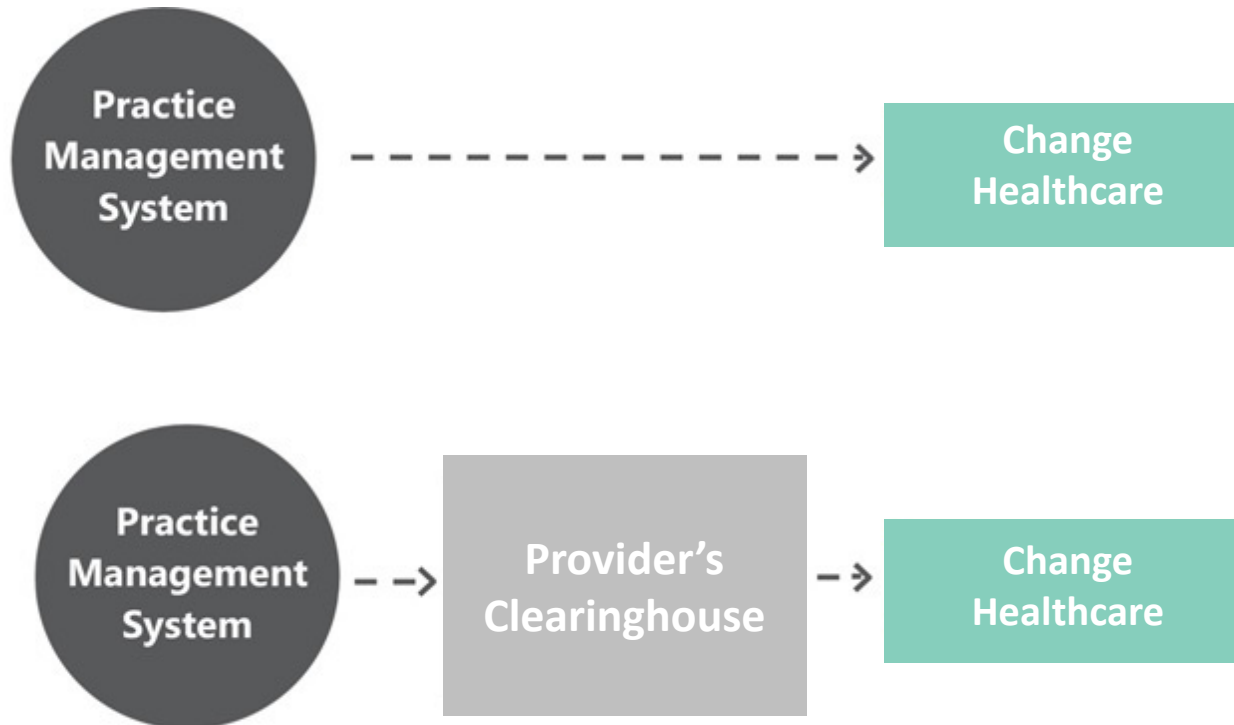
OR

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

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

Electronic Claim Submission

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



Electronic Claim Submission



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

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

Paper Claims

Mail all paper claims to new address:

Blue Cross and Blue Shield of LA/HMO Louisiana, Inc.

P.O. Box 7003

Troy, MI 48007



Reimbursement Guidelines for Facilities



Multiple Surgeries

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

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

** minus copayments and deductibles, as applicable*

Reimbursement Guidelines for Physicians

Multiple Surgeries

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

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

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

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

** minus copayments and deductibles, as applicable*

Endoscopies

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



Reimbursement Guidelines for Physicians

Assistant Surgeon Payments



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

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

Multiple surgery restrictions apply

Reimbursement Guidelines

Subset Procedure

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

Examples:

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

Subrogation

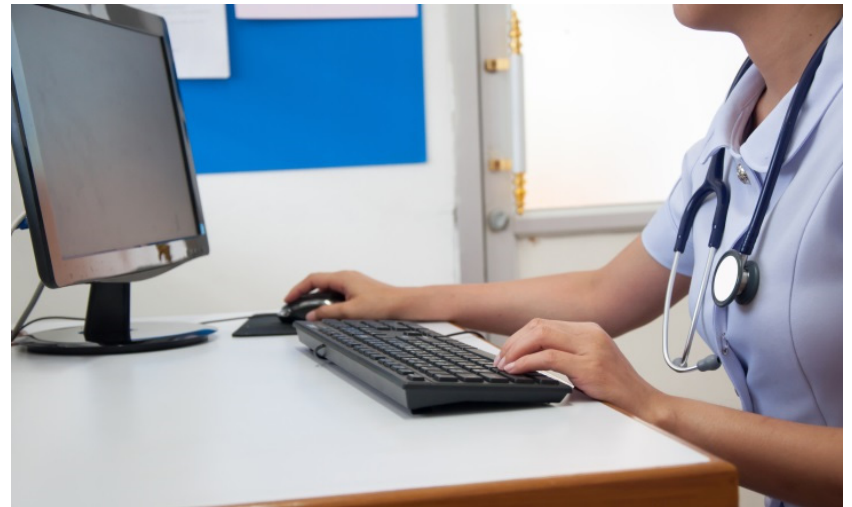
- Blue Advantage subrogates with other liability carrier to recoup CMS funds
- Conditional payments are made, which allows recoupment when a settlement is reached
- Blue Advantage allowable charges apply
- Claims that contain potential third party liability (TPL) will be paid by Blue Advantage on a conditional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



Checking Claim Status

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

- Providers can inquire about a claim by date range or by a specific claim ID.
- For each claim listed, the portal screen will display:
 - Claim number
 - Dates of service
 - Provider name
 - Member name
 - Claim status
 - Date of claim status
 - Payment amount



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

Resolving Claims Issues

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

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




When to Contact Provider Relations for Claims Help

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


Claims Resubmission

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

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

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

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

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

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

Corrected Claims

A **previously paid claim** in which the provider needs to add, remove or change a previously paid claim line

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

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

All requests must be submitted and clearly identified as a **corrected claim**

CMS-1500 Corrected Claims

EDI/1500/Professional claims can be submitted electronically as “Corrected Claims”

- In Loop 2300 ~ CLM05-03 must contain a “7,” REF01 must contain an “F8” and REF02 must contain the original reference claim number
- Indicate a reason for the correction in the note field

1500 paper claim forms can be submitted as “corrected claims”

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

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

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

UB-04 Corrected Claims

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

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

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


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

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

Provider Pay Disputes

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

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



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

The review is by Blue Advantage and determination is final

Provider Pay Disputes

Once a decision has been made:

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



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

**Blue Cross and Blue Shield
of LA/HMO Louisiana, Inc.**

Provider Disputes

P.O. Box 7003

Troy, MI 48007

Appeals

When a member disagrees with a denial of services:

1. An appeal must be filed in writing within 60 days from the date of the prior authorization (EOB-issued or provider remit, whichever is applicable)
2. Appeals can be filed by a member or a **non-participating provider**



Adjustments, Additional Payments, Overpayments & Voluntary Refunds

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

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

"01" "02" "03" etc.

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

Continuing Medical Education

- We are offering free continuing medical education (CME) credits for all providers directly through the Washington University CME portal
- More than 30 courses are available on a variety of topics
- Please be sure to take advantage of these free CME credits before this opportunity ends on **December 31, 2019**



Accessing the Washington University CME Portal:

1. Go to <https://cmeonline.wustl.edu/bcbsl/>
2. Click "New Account"
3. Enter registration information (* indicates required information)
4. Click "Sign Up"

Provider Relations

provider education & onsite training

Kim Gassie

Director

Jami Zachary

Supervisor

Marie Davis

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

Anna Granen

Jefferson, Orleans, Plaquemines, St. Bernard

Mary Guy

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

Kelly Smith

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

Melonie Martin

East Baton Rouge

Patricia O'Gwynn

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

Lisa Roth

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

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

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Darnell Kling

Jennifer Aucoin

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network.development@bcbsla.com | 1-800-716-2299, option 1

Doreen Prejean

Mary Landry

Karen Armstrong

Provider Credentialing and Data Management (PCDM)

network setup, credentialing, provider data and demographic changes

Justin Bright Director

Wendy Barber Provider Data Manager

Anne Monroe Provider Data Supervisor

Rhonda Dyer Credentialing Supervisor

Use **network.administration@bcbsla.com** for submitting network agreements, applications and forms

Recredentialing applications should be emailed to **recredentialing.application@bcbsla.com**

These email addresses should not be used to submit general inquiries

If you would like to check the status on your credentialing application or provider data change, please call the PCDM department

To create more efficiency and reduce processing time, information emailed and faxed to PCDM should be sent as separate submissions

Example:

1. Contract
2. Application and supporting documentation (licenses, education, etc.)
3. EFT & iLinkBlue agreements

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

Thank You!
