For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly

- This helps prevent background noise (e.g. unmuted phones or phones put on hold) during the webinar
- This also means we are unable to hear you during the webinar
- Please submit your questions directly through the webinar platform only

How to submit questions:

- Open the chat feature at the top of your screen to type your question related to today's training webinar
- In the "Send to" field, select "Webinar Host"
- Once your question is typed in, hit the "Send" button to send it to the presenter
- We will address submitted questions at the end of the webinar

New to Blue Advantage (HMO) and Blue Advantage (PPO) Webinar

March 13, 2019

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

Welcome to the Blue Advantage Network!

- Thank you for participating in our Blue Advantage (HMO) and Blue Advantage (PPO) provider networks
- You play an important role
- You are one of the select providers chosen to be in our Blue Advantage network
  - High-quality medical care and efficient services

Welcome to the Blue Advantage Network

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
- Pioneers in population health management solutions

Lumeris assists with:

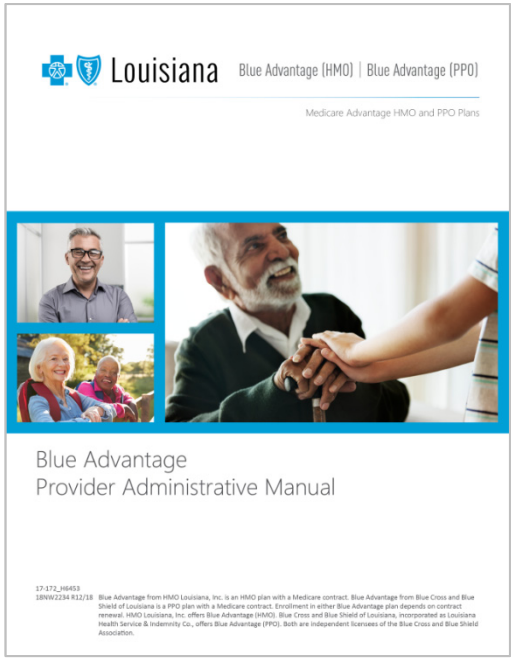
- Improvement in quality of care measures
- Better coordination, transition of care and self-management
- Customer Service, claims and medical management

Information on this slide provided by Lumeris.

Provider Manual

Blue Advantage Provider Administrative Manual

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



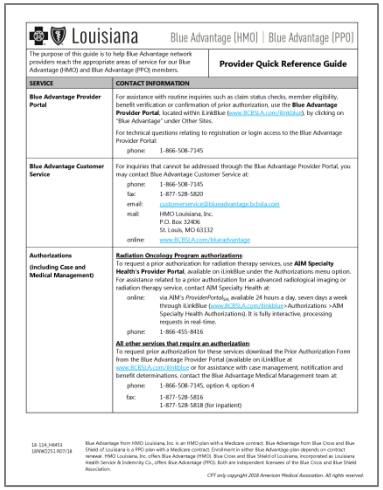
Located on the Blue Advantage Provider Portal page accessed through iLinkBlue
www.BCBSLA.com/ilinkblue >Blue Advantage >Provider Administrative Manual (under 2019 Guides & Resources)

Online Provider Guides

Provider Quick Reference Guide

- key information about the Blue Advantage Network
- services requiring authorization
- information on our Blue Advantage electronic tools

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


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

The purpose of this guide is to help Blue Advantage network providers reach the appropriate areas of service for our Blue Advantage (HMO) and Blue Advantage (PPO) members.

Provider Quick Reference Guide

SERVICE	CONTACT INFORMATION
Blue Advantage Provider Portal	For assistance with routine inquiries such as claim status checks, member eligibility, benefit verification or confirmation of prior authorization, use the **Blue Advantage Provider Portal**, located within iLinkBlue (www.BCBSLA.com/ilinkblue), by clicking on "Blue Advantage" under Other Sites. For technical questions relating to registration or login access to the Blue Advantage Provider Portal: phone: 1-866-508-7145
Blue Advantage Customer Service	For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Service at: phone: 1-866-508-7145 fax: 1-877-528-5820 e-mail: customerservice@blueadvantage.bcbsla.com mail: HMO Louisiana, Inc. P.O. Box 32406 St. Louis, MO 63132 online: www.BCBSLA.com/blueadvantage
Authorizations (including Case and Medical Management)	**Radiation Oncology Program authorizations:** To request a prior authorization for radiation therapy services, use **AIM Specialty Health's Provider Portal**, available on iLinkBlue under the Authorizations menu option. For assistance related to a prior authorization for an advanced radiological imaging or radiation therapy service, contact AIM Specialty Health at: online: via AIM's ProviderPortal℠, available 24 hours a day, seven days a week through iLinkBlue (www.BCBSLA.com/ilinkblue)>Authorizations >AIM Specialty Health Authorizations). It is fully interactive, processing requests in real-time. phone: 1-866-455-8416 **All other services that require an authorization:** To request prior authorization for these services download the Prior Authorization Form from the Blue Advantage Provider Portal (available on LinkBlue at www.BCBSLA.com/ilinkblue or for assistance with case management, notification and benefit determinations, contact the Blue Advantage Medical Management team at: phone: 1-866-508-7145, option 4, option 4 fax: 1-877-528-5816 1-877-528-5818 (for inpatient)

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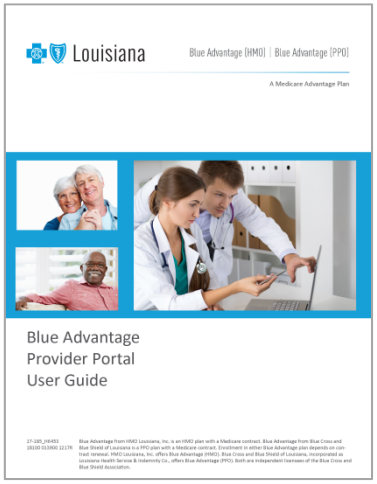
Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal. HMO Louisiana, Inc. offers Blue Advantage (HMO). Blue 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.



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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 Quick User Guide (under Help Documents)

Compliance Reminders

As a Blue Advantage provider you are required to:

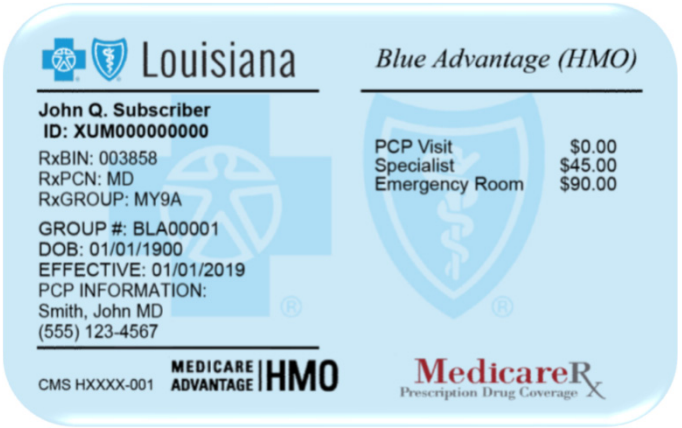
- Follow the provider guidelines in your provider manual when discussing Medicare Advantage
- Routinely check for exclusions by the OIG/GSA (General Services Administration)
- Report any actual or suspected compliance concerns
- Notify us of any practice information changes
- Verify that provider training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

The provider training modules listed above are available at **www.BCBSLA.com/ilinkblue** >Blue Advantage >Helpful Links >Compliance Program >CME Medicare Compliance and Fraud, Waste and Abuse Training

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



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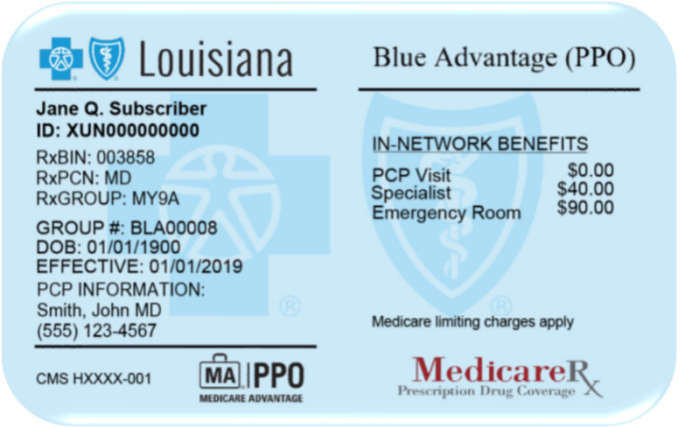
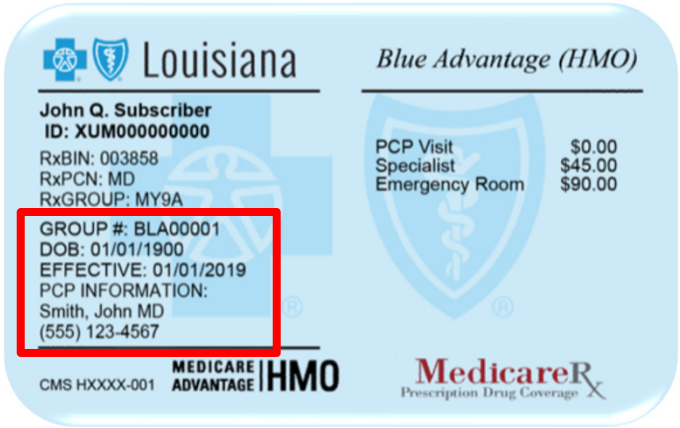
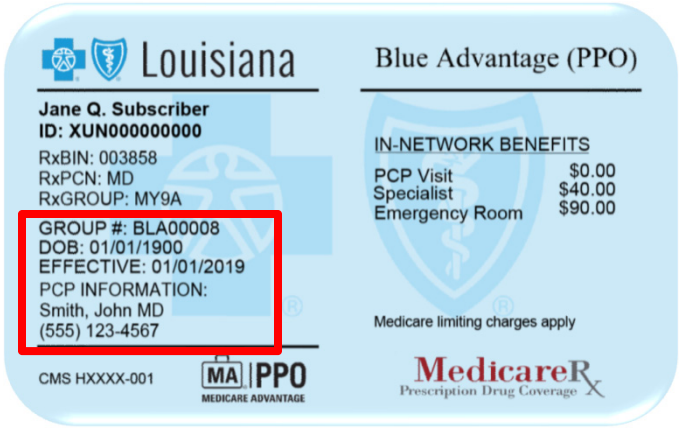


XUN prefix

Member ID Cards

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





Blue Advantage Customer Service

Blue Advantage Customer Service representatives are available to assist members once they have enrolled

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

1-866-508-7145

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

Role of the Primary Care Provider

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

- Oversees, coordinates, discusses and directs the member's care in a coordinated approach 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 member 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 doctor

Tools for the Primary Care Provider

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 Portal:

www.BCBSLA.com/ilinkblue

>Other sites
>Blue Advantage
>Additional Features
>Lumeris ADSP

Access to the ADSP requires an additional level of security

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

Health Risk Assessments (HRA)

New member HRA

- Paper-based questionnaire sent to each new member upon confirmation of the member's effective date
- Analyzed 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

Comprehensive Visits

There are two options for incentive payments:

1. **Pay $100: Send Medical Record or grant EMR access**
2. **Pay $150: Send EMR extracts and grant EMR access**

- Bill Comprehensive Visit with E&M CPT Code appropriate for level of the visit
  - **One payment for a Comprehensive Visit per member, per year**
- PCPs are eligible for payment for a Comprehensive Visit **or** Enhanced Encounter for the same member in the same year
  - **Retrospective audits to determine all criteria are met**
- PCPs participating in the Shared Savings or Quality Rewards program are eligible for payment for the Comprehensive Visits
- PCPs not participating in the Shared Savings or Quality Rewards program are eligible for payment for Enhanced Encounters

Filing Claims for Comprehensive Care Visits

Claims should include the following:

- Bill the appropriate E&M CPT codes that reflect the complexity and level of decision-making for the comprehensive visit

- The claim form can accommodate up to 12 ICD-10 codes

- CPT II codes should also be used on the claim form, when applicable. By using CPT II codes, you reduce the need for medical record reviews. Remember that these codes are not reimbursable by CMS.

Enhanced Encounter Tool

- This web-based tool allows the completion of a comprehensive visit that reviews all of the member's conditions to ensure that we are accurately and fairly predicting health cost expenditures

- Find the tool in the Accountable Delivery System Platform (ADSP) accessed through the Blue Advantage Provider Portal

Use of CPT Category II Codes

What is a CPT Category II Code?

The American Medical Association creates and maintains CPT Category II codes to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures that have an evidence base as contributing to quality patient care.

Why use CPT II Codes?

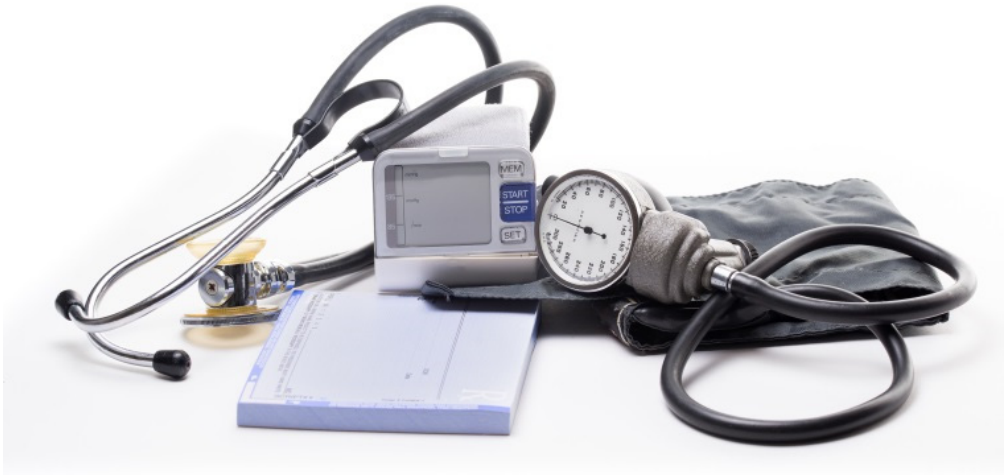
CPT II codes describe clinical components that may be typically included in evaluation and management services, or other clinical services and do not have a relative value associated with them. These codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

Is there additional reimbursement when I use CPT II codes?

CPT II codes are not reimbursable and should reflect a $0 charge.

The Advantage of Assigning CPT II Codes

- Lessens the administrative burden of chart review for many Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures
- Enables organizations to monitor internal performance for key measures throughout the year, rather than once per year as measured by health plans and pay for performance
- Identifies opportunities for improvement so interventions can be implemented to improve performance during the service year



The Blue Advantage Provider Portal

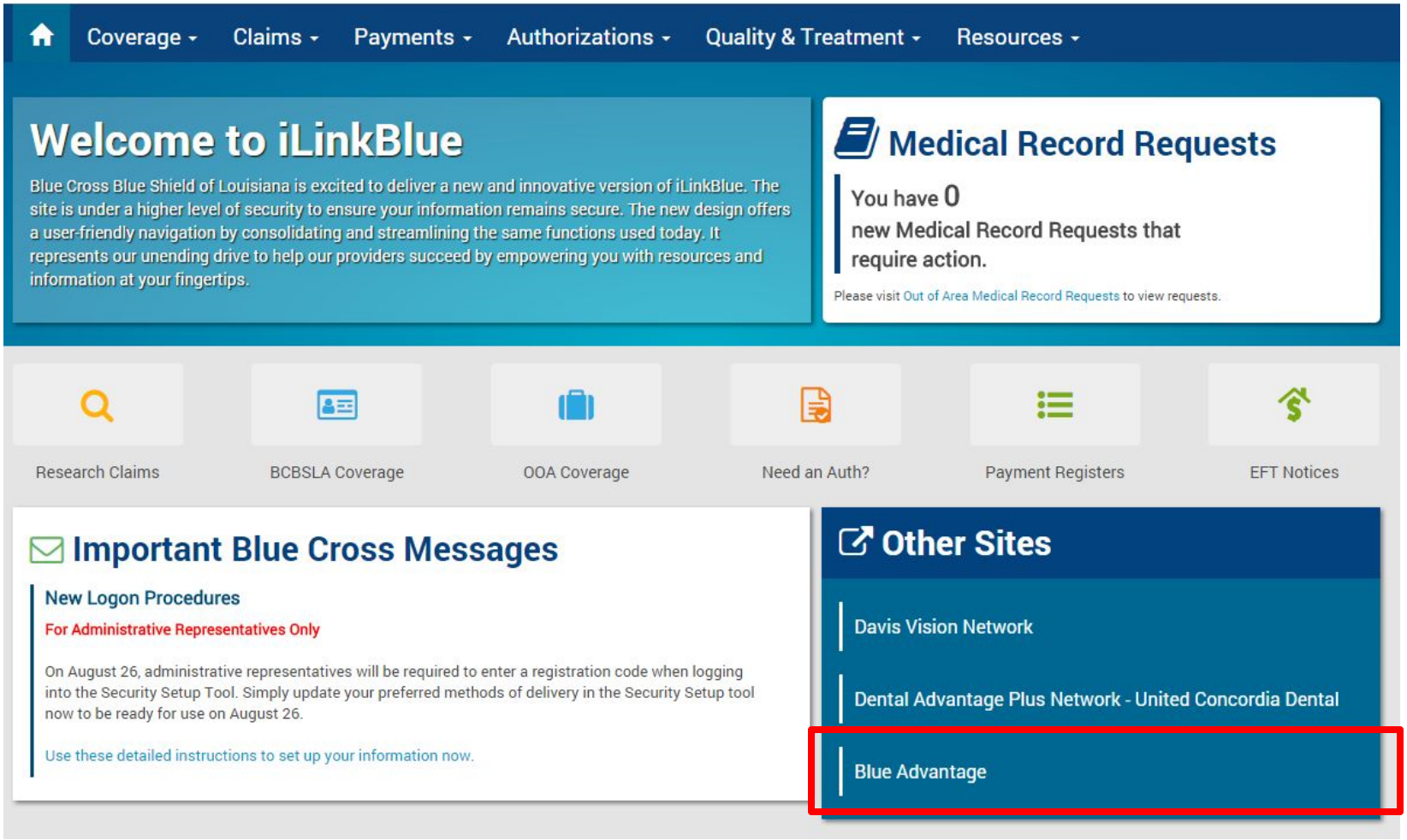
Blue Advantage network providers will have access via the Provider Portal to the Blue Advantage:

- **Provider Administrative Manual**
- **Quick Reference Guide**
- **Provider Directory**
- **Drug Formulary Search**
- **Member Eligibility Inquiry**
- **Claims Inquiry**
- **Provider Forms**

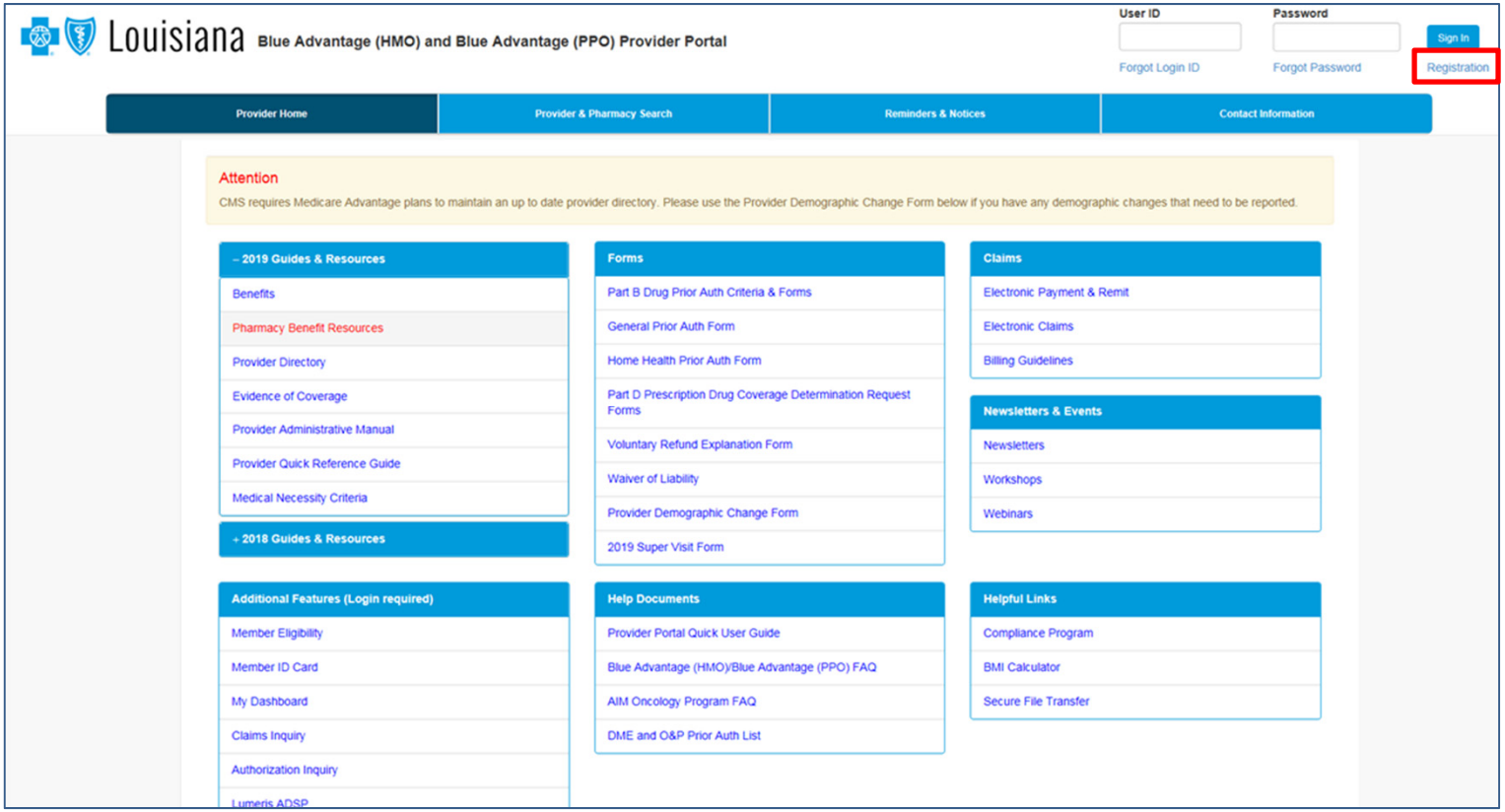
Providers in our Blue Advantage network must access the **Blue Advantage Provider Portal** located within iLinkBlue (**www.BCBSLA.com/ilinkblue**) > Blue Advantage (under Other Sites)

Accessing the Blue Advantage Provider Portal

www.BCBSLA.com/ilinkblue



Blue Advantage Provider Portal Registration



Click "Registration" in top right corner. Refer to the *Provider Portal User Guide* under the "Help Documents" section for more information.

Medical Record Documentation, Audits & Reviews

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

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

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

<u>Medical record request</u>:

- Should be responded to within 10 days of the request

If a member changes their PCP and requests transfer of their medical records, they must be forwarded to the member or new provider within 10 business days of request

Authorization & Benefit Determinations

Inpatient Admission:

Plan requires notification within **One business day** of inpatient admission

Observation:

Plan requires notification within **One business day** of observation admission.

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

Medical Necessity Criteria:

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

- Nurses review for IP/OBS, SNF, Acute Rehab, LTAC, HHC, LOS, LOC and discharge planning
- Plan reviews for IP vs. OBS and site of care

Authorization & Benefit Determinations

Hospital Admissions:

- Providers can report inpatient admissions to the 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)*

<u>The notification process serves to</u>:

- 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

Services requiring authorization are included in the *Provider Quick Reference Guide* found on the Blue Advantage Provider Portal available through iLinkBlue (**www.BCBSLA.com/ilinkblue**)

Prior Authorization

Requests submitted to Plan via fax, letter or phone

- Requests can originate from the ordering physician, the member, his/her provider or representative
- Medical necessity criteria applied

CMS requires multiple provider outreach attempts to obtain necessary clinical info upon which to make organization determinations

Provision of robust clinical info upon initial submission is key

See Provider Quick Reference Guide for a list of services requiring a prior authorization, available on the Blue Advantage Provider Portal

Prior Authorization

Standard

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

When services are partially or fully denied, members are sent a **Notice of Right to an Expedited Grievance** form.

Behavioral Health Authorizations

New Directions:

Administers authorizations for the following services for Blue Advantage members:

Facility Authorizations

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) and Partial Hospital Program (PHP)

online: New Directions WebPass Portal through iLinkBlue

phone: 1-877-250-9167

Once on iLinkBlue, click on the "Authorizations" menu option

www.BCBSLA.com/ilinkblue

Other Authorizations

AIM Specialty Health:

Administers authorizations for the following services for Blue Advantage members:

Radiation Oncology Program

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

Note: Authorizations required for inpatient procedures are still handled by Lumeris

New in 2019:

There are two new prior authorization programs—managed by AIM—that were implemented:

Effective March 1, 2019
(outpatient services only)

Muscuoskeletal (MSK) Services

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

Cardiology Services

Prior authorizations for select office and outpatient non-emergency procedures

online: AIM ***Provider****Portal*$_{SM}$ through iLinkBlue | **phone:** 1-866-455-8416

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

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 a patient follow-up visit 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, have the member sign and mail to the Social Security Administration office

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

Outpatient Lab Tests

Blue Advantage network providers can:

- Perform lab work in the office if they are CLIA certified for test(s) being performed
- Draw specimen and send to one of our preferred labs

<u>Blue Advantage Preferred Labs</u>:

Clinical Pathology Laboratories (CPL)

LabCorp

Quest Diagnostics

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**

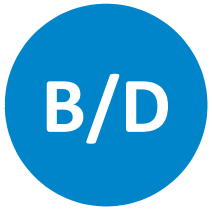
  administers routine dental services

- **Express Scripts**

  administers pharmacy benefit management

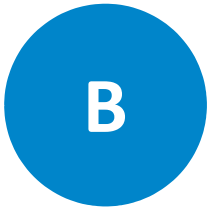
See the "Plan Information Contact List" section of the *Blue Advantage Provider Administrative Manual* for more information about these services

Part B vs. Part D Overview



Some drugs may be covered under Part B or Part D depending on what they treat or where/how they are 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



Part B Covered Drugs

- Primarily drugs covered "Incident To" a physician's service
  - Drug is usually not considered self-administered and must be furnished by the physician's office
- Some drugs are covered at a pharmacy under specific circumstances
- Member cost-share is their Part B coinsurance

Part D Covered Drugs

- Most prescription medications dispensed by a pharmacy
- Outpatient administered drugs that are dispensed by a pharmacy to be given in a provider office (aka "brown bagging" and "white bagging")
- Except those covered under part B or excluded per CMS regulations
- Member cost-share depends on the drug's assigned tier

Overview of Drug Coverage Rules

Exceptions and Exclusions to Part D Drug Coverage

B

Drugs filled or administered at a pharmacy but covered under Part B instead of Part D (not exhaustive)

- Drugs that require a medical device to administer (ex. albuterol from a nebulizer)
- Select oral chemotherapy drugs if contain same active ingredient as not self-administered chemotherapy drug
- Immunosuppressive drugs following a Medicare-covered transplant (ex. prednisone – will require prior authorization to determine Part B vs D)
- Select vaccines such as influenza or pneumococcal
- Hemophilia clotting factors

D

Part D Exclusions

- Drugs used for cosmetic purposes, weight loss or weight gain (unless used for AIDS wasting, 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

- 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 home

Express Scripts Mail-order Pharmacy

Two Steps to Set Up Home Delivery:

1) **Prescribe a 90-day supply**
   - Prescription can be sent electronically from the EMR or called in to Express Scripts Pharmacy

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

Starting home delivery is easy:

Call: **1-800-841-3351**
Monday through Friday, 9 a.m. to 7 p.m. Eastern Time (except office holidays)
TTY users: **1-800-716-3231**

Go Online: express-scripts.com/get90

TO BE SAFE:
When setting up 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

- Can receive free OneTouch® (LifeScan) and Freestyle® (Abbott) meters
- $0 co-insurance for covered diabetic test strips
- Available at a network pharmacy or can be delivered to the member's home

Find complete information online:
1) www.bcbsla.com/myblueadvantage
2) Documents
3) 2019 Diabetes Testing Supplies Coverage at Network Pharmacies

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

ABNs Not Used for Blue Advantage

CMS does not allow use of Advanced Beneficiary Notices (ABNs) in 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 providers know or have 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** IDN has been issued, the provider may collect from the member for the specific services outlined in the IDN after services are rendered

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

- 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

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

Paper Claims

Direct all paper claims to:

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

P.O. Box 7003

Troy, MI 48007

Subrogation

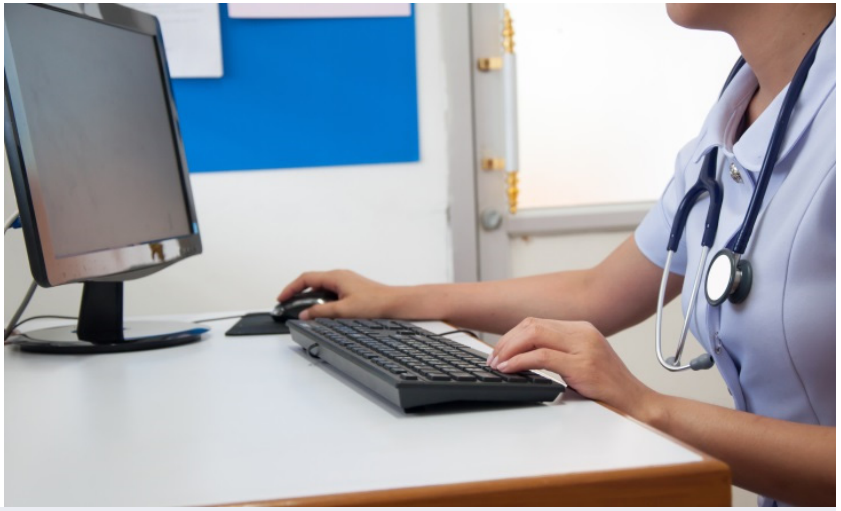
- Blue Advantage subrogates with other liability carrier to recoup CMS funds
- Conditional payments are made, which allows recoupment when a settlement is reached
- Blue Advantage allowable charges apply

Checking Claim Status

All participating providers should use the online Claim Inquiry on the Blue Advantage Provider Portal at **www.BCBSLA.com/ilinkblue** under "Other Sites" for standard claims status checks

- Once a claim has been submitted, it can be found online by going to the Blue Advantage Provider Portal. 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



Please note: 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 Blue Advantage 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 your claims issue is still unresolved after the second request, you may email an overview of the issue along with documentation of your two requests to Provider Relations at:

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

Note: We 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 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.
  - Example: adding or removing a previously paid claim line where charges were billed for a service that was not rendered, or the provider did not bill for a service that was rendered
  - Example: 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 correction will be rejected if the Original Reference Claim Number is not correct either in format or for the member and date of service

UB-04 Corrected Claims

- EDI/UB-04/Facility corrected claims can be submitted electronically as "Corrected Claims"
  - The TOB must indicate a frequency 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 correction will be rejected if the Original Reference Claim Number is not correct either in format or for the member and date of service

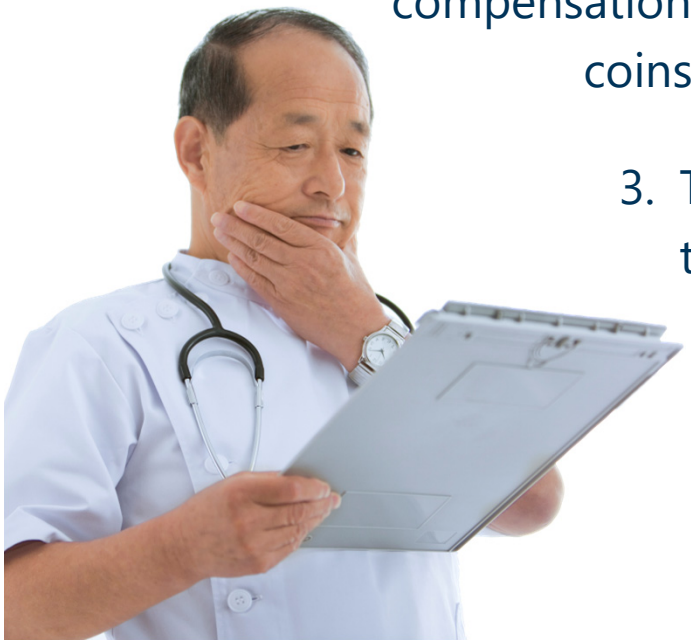
Provider Pay Disputes

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

1. The claim must be filed within the timeframe specified in your contract agreement from the date the claim was processed to dispute the payment amount

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

3. The claim should be submitted in writing and include the basis for the dispute and documents supporting your position



The review is by Blue Advantage and determination is final

Provider Pay Disputes

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

4. The claim should be sent with all supporting documentation

5. Blue Advantage will communicate the decision either verbally or in writing if it is determined the correct amount was previously paid

6. 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 Louisiana / HMO Louisiana, Inc.
Provider Disputes
P.O. Box 7003
Troy, MI 48007

Appeals

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

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

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

3. Claim payment appeals can be filed by a member, their authorized representative, or a non-participating provider, and must be submitted in writing

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 Customer Service

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

Provider Relations

Your Blue Cross and Blue Shield of Louisiana Provider Relations Team

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

Provider Relations

provider education & onsite training

Kim Gassie
Director

Jami Zachary
Supervisor

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard

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

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

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

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

Melonie Martin
East Baton Rouge

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

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

Angela Jackson **Darnell Kling** **Jennifer Aucoin**

Network Development

provider contracting

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Manager

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

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

Provider Credentialing & Data Management

provider data & credentialing

Justin Bright - Director

Wendy Barber - Provider Data Manager

The **network.administration@bcbsla.com** email address should be used by providers as an electronic option for submitting contracts, applications and forms

If you would like to check the status on your credentialing application or provider file change or update, please contact the Provider Credentialing and Data Management Department

To create more efficiency and reduction in processing time, information emailed and faxed to Provider Credentialing and Data Management should be sent as separate documents

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 file
Fax: 225-297-2750 • network.administration@bcbsla.com

EDI Contact Information

iLinkBlue

www.BCBSLA.com/ilinkblue
1-800-216-2583
EDIServices@bcbsla.com

Electronic Funds Transfer

Network Administration
1-800-716-2299, option 3 or (225) 297-2758
network.administration@bcbsla.com

Questions