FALL 2023

Blue Cross and Blue Shield of Louisiana

PROVIDER WORKSHOP

Louisiana Blue adVantage (HMO) | Blue adVantage (PPO)

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HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

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Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

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

Agenda

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

High Quality Score!

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

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

Who are we?

- Blue Advantage provides HMO and PPO networks to our Blue Advantage members.
- Offers support for population health visits as well as additional quality programs such as the Blue Advantage Coupon program and HEDIS®/Star ratings improvement for Blue Advantage members.

Welcome to the Blue Advantage Network

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

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

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

Welcome to the Blue Advantage Network

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

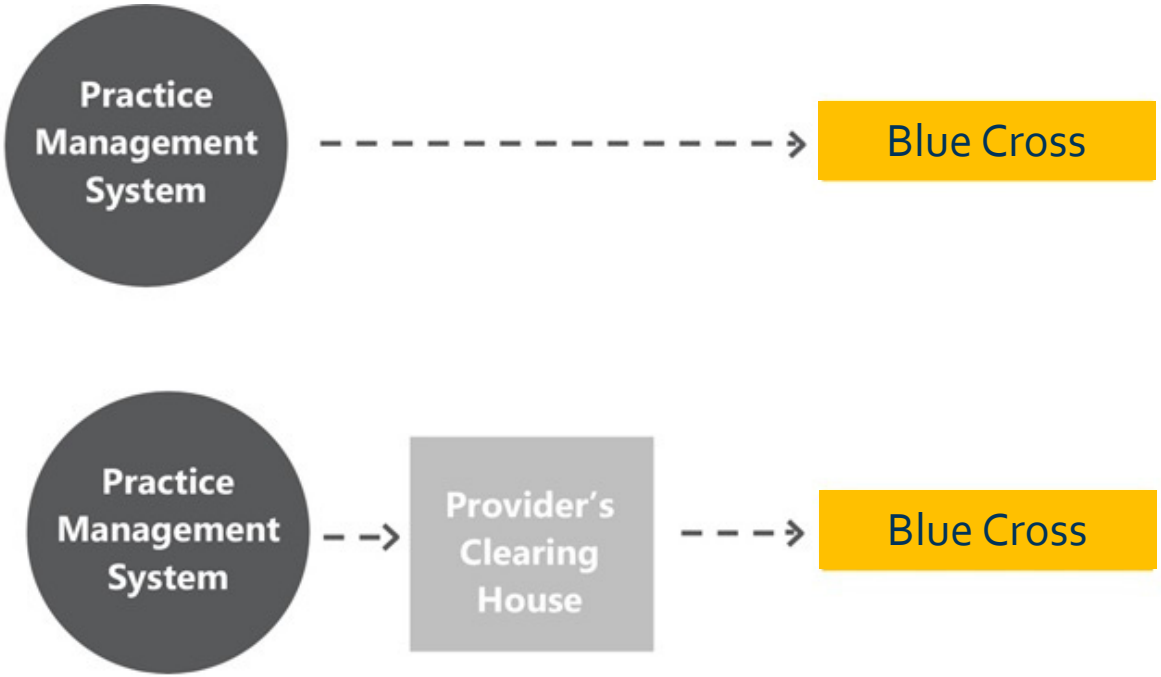
Louisiana

Blue adVantage (HMO) | Blue adVantage (PPO)

What's New?

Electronic Claim Submission

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



Blue Cross to Process Electronic Transactions for Blue Advantage

Communications were sent to providers on June 16, 2023, advising that HIPAA 837 and 27x electronic transactions for Blue Advantage are now managed by Blue Cross. Any electronic transactions submitted to Change Healthcare on or after **July 15, 2023,** will not be processed. Below are the details on how these changes can affect you.

New Hostname	Use the Blue Cross SFTP application (MessageWay) server hostname mft.lhec.net for batch submissions.
New Batch File Naming Requirements	Submit all batch files with the first three positions of the file name as "BAM" for Blue Advantage. Not including these three-letters at the beginning of the file name will result in the claims routed incorrectly and rejected.
Payor ID	72107
Real Time rules for 2100A Loop	Real Time requests must be submitted to the following URL: www.bcbsla.com/realtimesubmission/realtimesubmission.aspx. Trading partners must submit the 27x real-time transactions using the following rules for the 2100A loop in the 270/276 request: • NM101 = PR • NM103 = BAM • NM108 = PI • NM109 = 72107
ISA06-Interchange Sender ID/Trading Partner ID	ISA06 is the Trading Partner number assigned by Blue Cross. ISA06 field is a fixed length requiring 15 positions and must be left justified. ISA06 must be identical to GS02.
ISA08-Interchange Receiver ID/BCBSLA	ISA08 must be BCBSLA001. The field is fixed length requiring 15 positions and must be left justified.
No Runout Period	Electronic transactions submitted to Change Healthcare on and after July 15, 2023, will not be processed.

Blue Cross to Process EFTs and ERAs for Blue Advantage Claims

Effective **May 2023**, the processing of electronic funds transfer (EFT) and electronic remittance advice (ERA) 835 transactions transferred from RedCard to Blue Cross and Blue Shield of Louisiana. Therefore, all Blue Advantage claims payments are made through Blue Cross and Blue Shield of Louisiana.

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

Blue Advantage Flex Card

- Personal prepaid debit card with allowances that can only be used for approved products for Blue Advantage members.
- Card allowances are not transferable.
- Card allowances do not roll over.
- If purchases exceed the allowance amount of the Flex Card, the member is responsible for paying the difference.
- Card allowances will vary by plan and include:
  - Annual allowance for prescription hearing aids
  - Annual allowance for eyewear like eyeglasses and contact lenses
  - Quarterly allowance for over-the-counter supplies available for purchase at major retailers or online*

*D-SNP has a monthly allowance for OTC health-related products and healthy foods.

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

Required D-SNP Training in 2024

More information will be sent to providers once details are available.

Liberty Dental

- Effective January 1, 2024, Blue Advantage preventive and routine dental services will be filed to Liberty Dental.
- Providers must be contracted directly with Liberty Dental to be in-network for members.

Phone:

1-866-609-0424

Mail:

Liberty Dental

P.O. Box 401086

Las Vegas, NV 89140

Reminders & Resources

Member ID Cards

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

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

Prefix: PMV

Prefix: MDV

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

Blue Advantage Customer Service

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

1-866-508-7145

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

1-877-528-5820

customerservice@blueadvantagela.com

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

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

Credentialing Information

Blue Cross requires all providers to be credentialed prior to participating in our networks.

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

Recredentialing is done every three years. Failure to return your recredentialing information will result in network termination.

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

Vision Network

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


Louisiana

Blue adVantage (HMO)

RxBIN:	003858
RxPCN:	MD
RxGROUP:	MY9A
EFFECTIVE:	01/01/2024
ISSUER: (80840)	9151014609

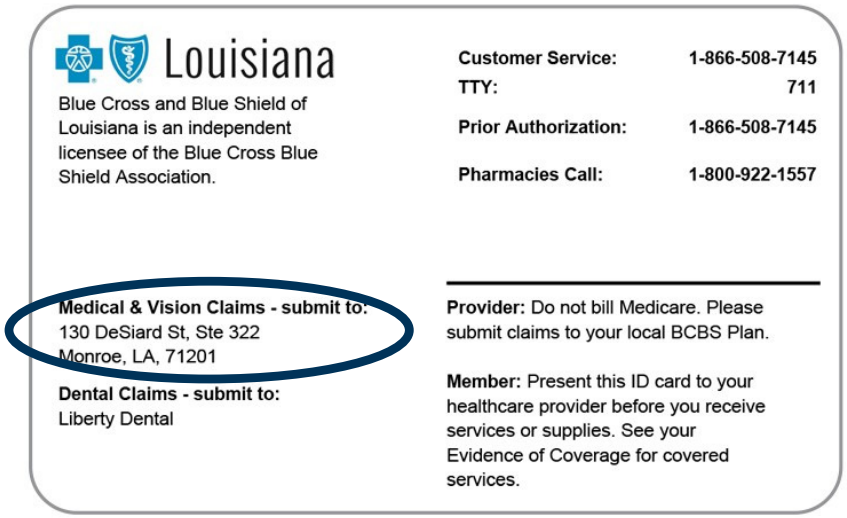
ID: MDV987600000

John T Public

PCP Visit	$ X
Specialist Visit	$ XX
Emergency Room	$ XX
Major Diagnostic	$ XXX
Outpatient Surgery	$ XXX
Outpatient Hospital	$ XXX

MedicareRx Prescription Drug Coverage MEDICARE ADVANTAGE HMO

www.bcbsla.com/blueadvantage


Louisiana

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

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

Dental Claims - submit to:
Liberty Dental

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

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

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

Compliance Reminders

As a Blue Advantage provider, you are required to:

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

CMS offers more information on compliance that you can access through the Blue Advantage Provider Portal. Under the "Resources" section, click on "Compliance."

To notify us of any practice changes, use our Provider Update Request Form found online at **www.bcbsla.com/providers** under "Resources," then "Forms."

Appointment Scheduling & Waiting Time Guidelines for PCPs

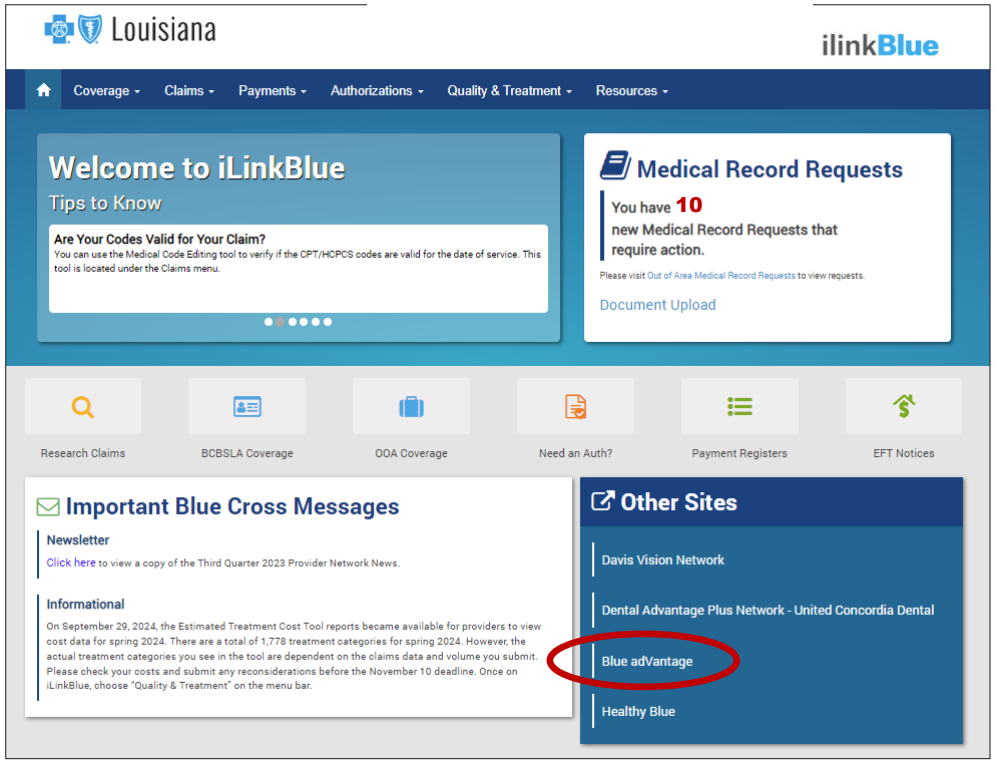
PCP - New Patient	Within 30 days of the patient's effective date on the PCP's panel – to be initiated by the PCP's office.
Routine Care without symptoms	Within 30 days.
Non-routine Care with symptoms	Within five business days or one week.
Urgent Care	Within 24 hours.
Emergency	Must be available immediately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

Accessing Our Secure Online Services

We offer many online services that require secure access. These services include applications such as:

- iLinkBlue
- Blue Advantage Provider Portal

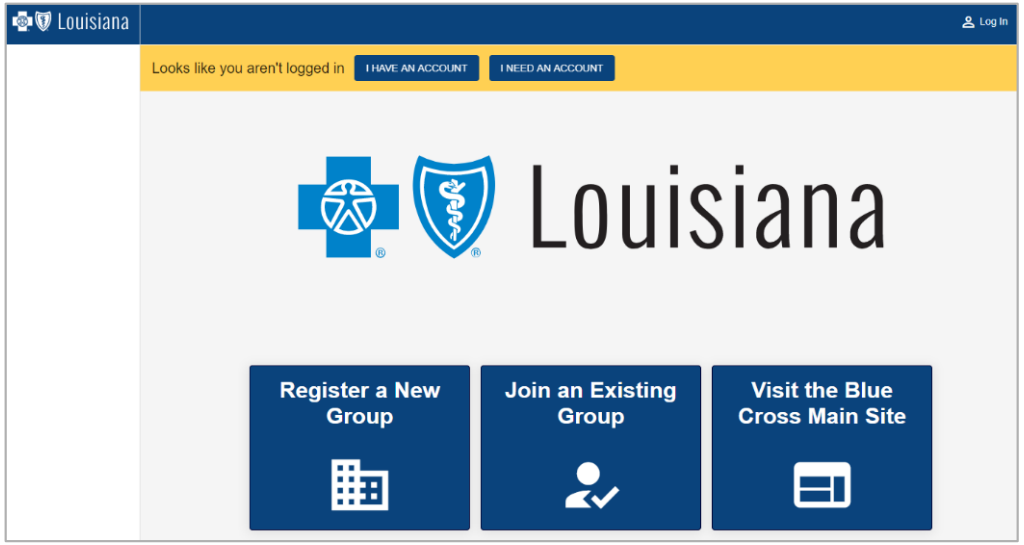
Access to these applications are granted by your organization's Group Moderator (Administrative Rep).



Blue Advantage Provider Portal

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

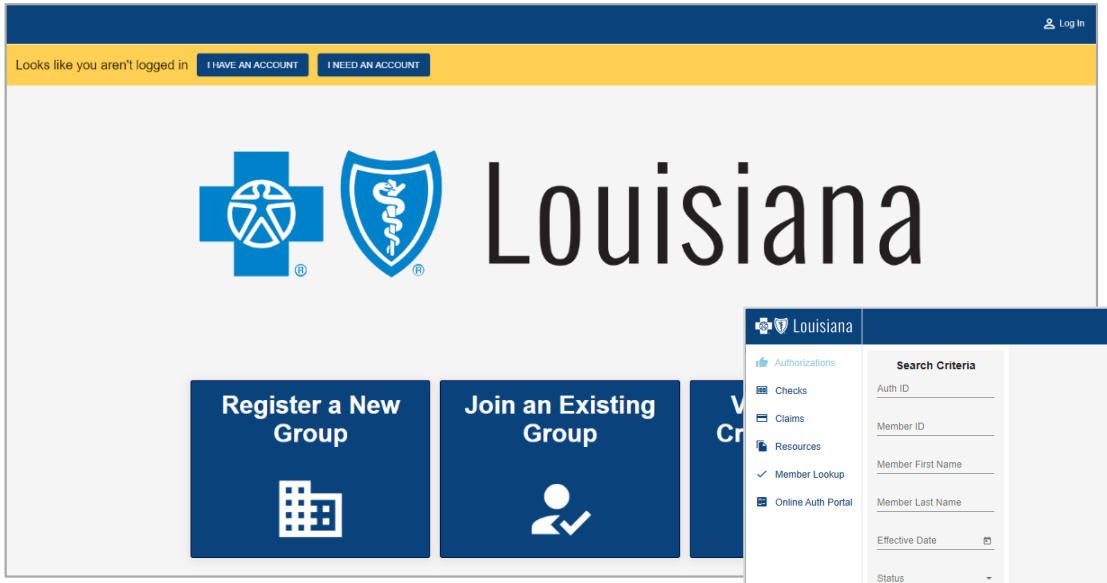
- Claims Inquiry
- Member Eligibility
- Provider/Pharmacy Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more



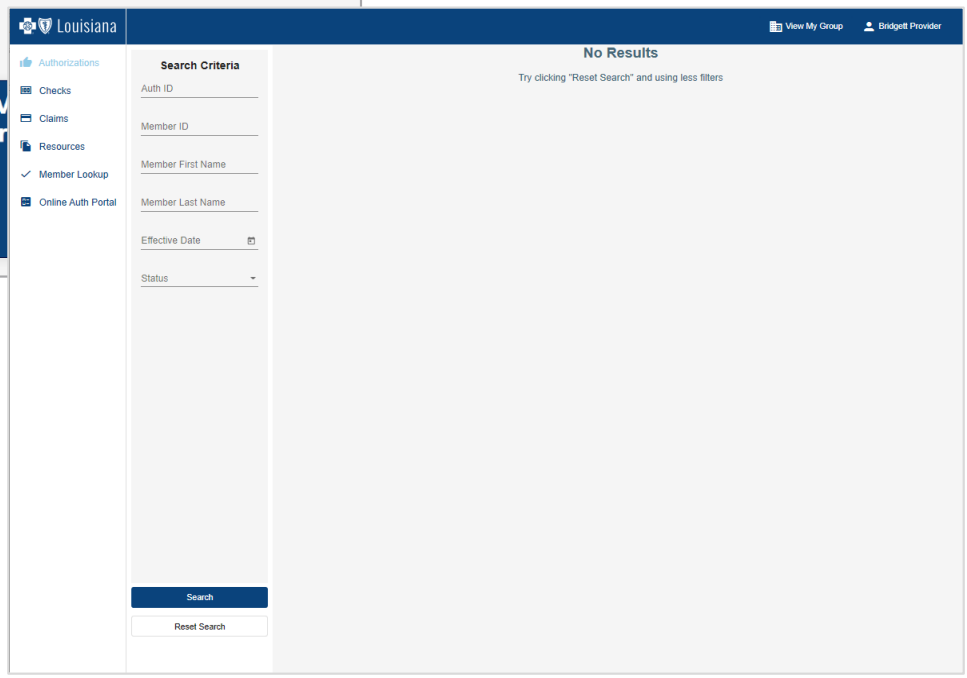
The Blue Advantage Provider Portal is available through iLinkBlue (**www.bcbsla.com/ilinkblue**) >**Blue Advantage** (under Other Sites).

Accessing the Blue Advantage Portal

Provider Portal Login

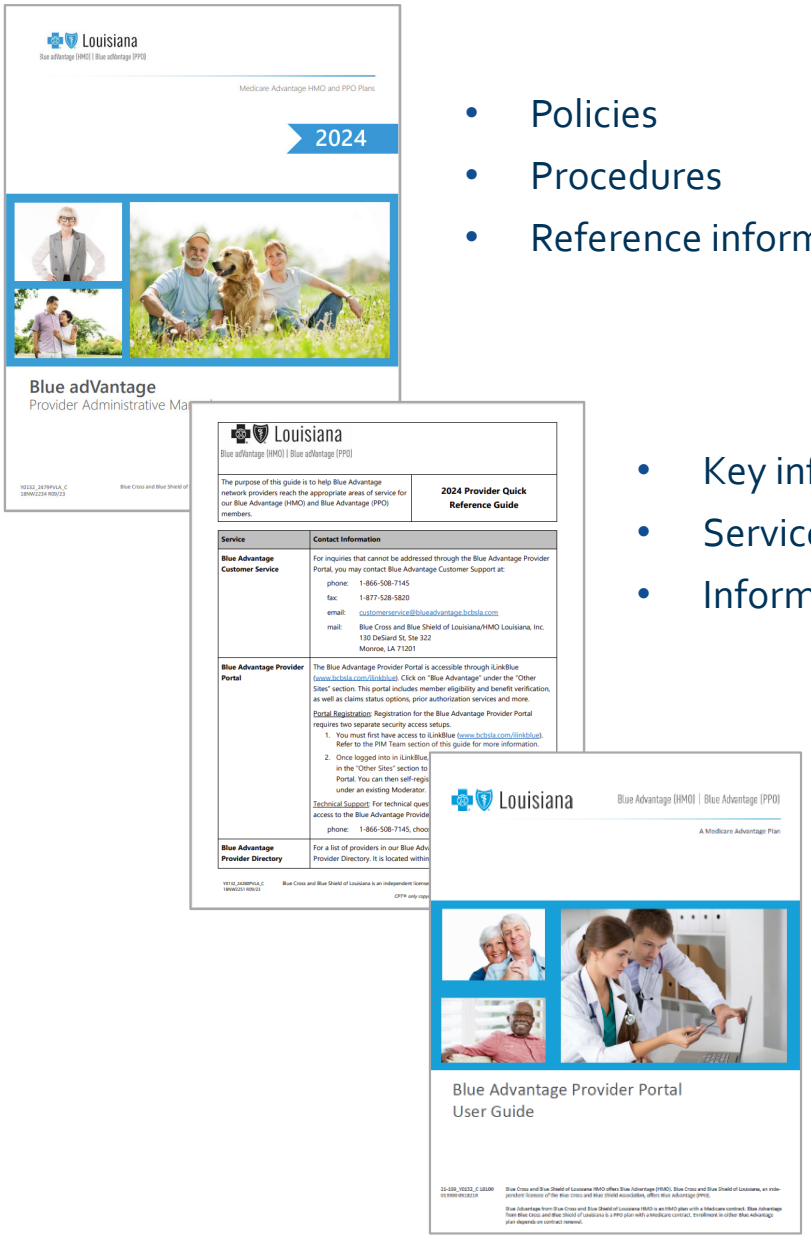


Provider Portal Home Page



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

Blue Advantage Manuals and Guides



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

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

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

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

Role of Primary Care Provider

Role of Primary Care Provider (PCP)

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

- Oversee, coordinate, discuss and direct the member's care with the member's care team, specialists and hospital staff.
- Develop and grow the provider-member relationship while being proactive and cost effective.

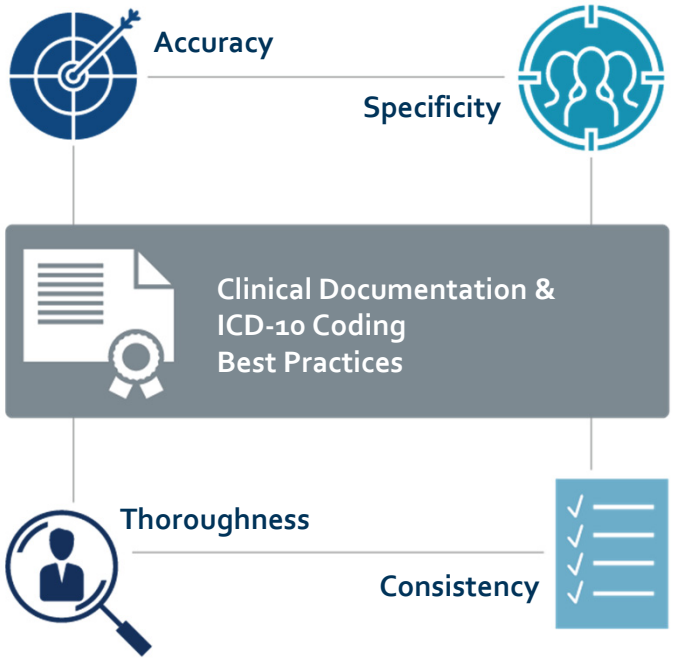
- Responsible for coordinating members' medically-necessary services.
- When a member changes PCPs, upon request, the prior PCP has 10 business days of request to submit records to new PCP.

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

Complete and Accurate Clinical Documentation & ICD-10 Coding

Best Practices in Medical Record Documentation

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



Importance of Annual Wellness Visits

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

Quality

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

Risk Adjustment

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

Blue Advantage Quality Program/Shared Value Program

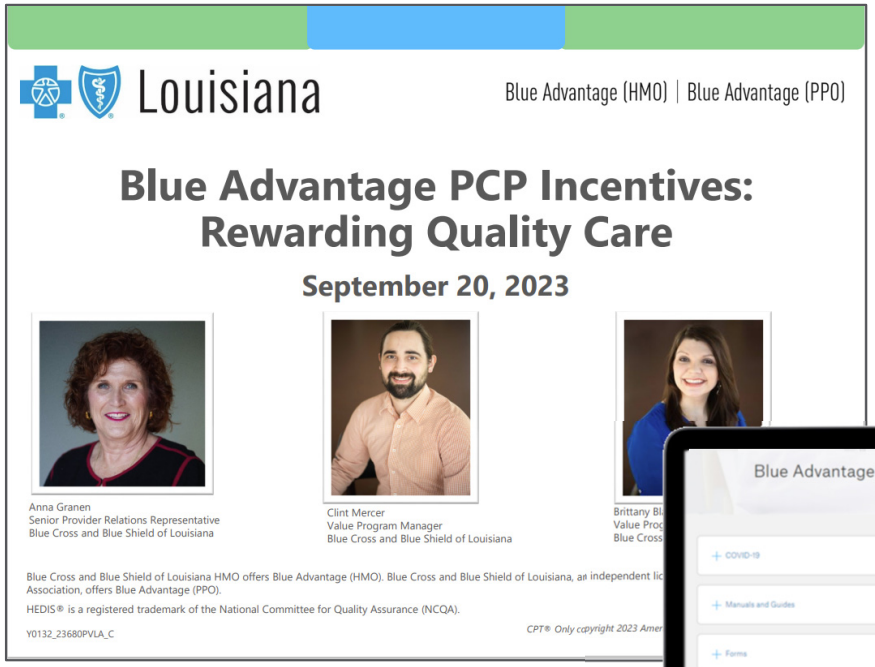
- Pay for Performance Medicare Advantage Star Rating Incentive (S7S#P D#VI) is available to all PCPs participating in BA Networks.

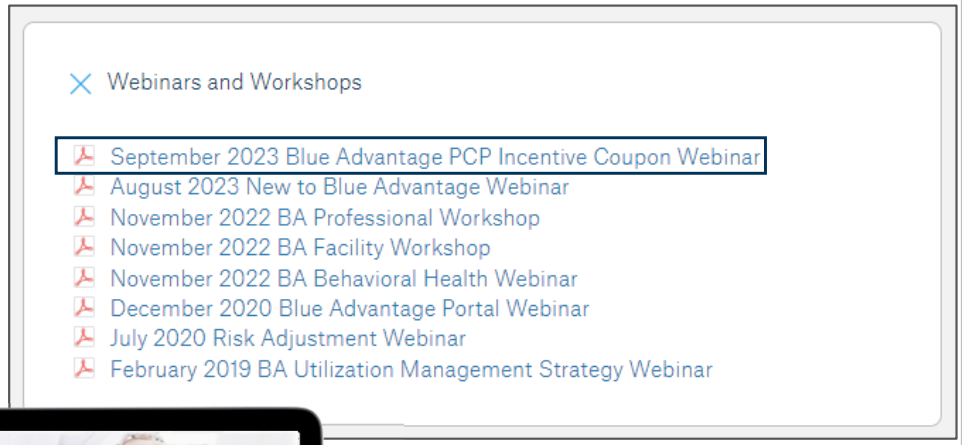
- BA members will receive a paper coupon in the mail as part of our Annual Wellness Coupon Program.
  - The coupons are for the patient's annual wellness exam, which should be provided by a primary care provider.
  - PCPs review and complete coupon at the visit.
  - PCPs will be compensated $100 for completion of the coupon above the claim's reimbursement.
- Information is then used to help build STAR rating incentive.
  - 4 Star: $50 PMPY
  - 5 Star: $100 PMPY

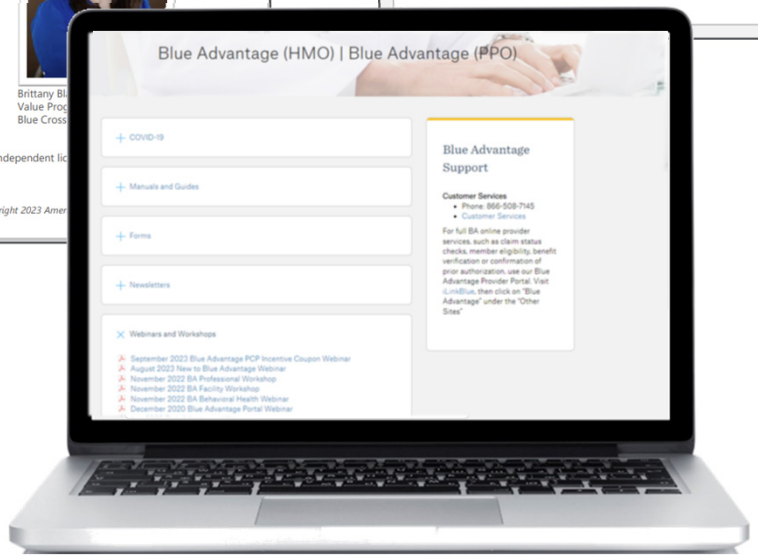
  Payments are Risk Adjusted

Learn More About Annual Wellness Coupons

For full information on Annual Wellness Coupons, view our **Blue Advantage PCP Incentives: Rewarding Quality Care** presentation. It is available online at **www.bcbsla.com/ba-resources** >Webinars and Workshops







Medical Management

Role of Medical Management

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

- Prior authorization, concurrent review, discharge planning and assistance with referrals.
- Notify PCP offices of acute discharges for PCP follow-up.
- Case and disease management programs (please see the Blue Advantage Administrative Manual for complete program list).

Authorizations & Benefit Determinations

The authorization process serves to:

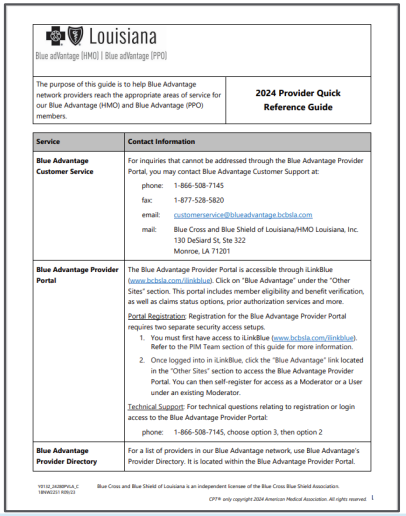
- Verify member eligibility, coverage/benefit exclusions.
- Identify if the facility is a Blue Advantage contracted provider.
- Notify the appropriate hospital case manager of the admission to begin review of continued stay appropriateness and early identification of potential discharge needs.

Hospital Authorizations

Hospital Admissions:

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

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



Louisiana
Blue adVantage (HMO) | Blue adVantage (PPO)

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

2024 Provider Quick Reference Guide

Service	Contact Information
Blue Advantage Customer Service	For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Support at: phone: 1-866-508-7145 fax: 1-877-528-5820 email: customerservice@blueadvantage.bcbsla.com mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. 130 DeSiard St, Ste 322 Monroe, LA 71201
Blue Advantage Provider Portal	The Blue Advantage Provider Portal is accessible through iLinkBlue (www.bcbsla.com/ilinkblue). Click on "Blue Advantage" under the "Other Sites" section. This portal includes member eligibility and benefit verification, as well as claims status options, prior authorization services and more. Portal Registration: Registration for the Blue Advantage Provider Portal requires two separate security access setups. 1. You must first have access to iLinkBlue (www.bcbsla.com/ilinkblue). Refer to the PIM Team section of this guide for more information. 2. Once logged into in iLinkBlue, click the "Blue Advantage" link located in the "Other Sites" section to access the Blue Advantage Provider Portal. You can then self-register for access as a Moderator or a User under an existing Moderator. Technical Support: For technical questions relating to registration or login access to the Blue Advantage Provider Portal phone: 1-866-508-7145, choose option 3, then option 2
Blue Advantage Provider Directory	For a list of providers in our Blue Advantage network, use Blue Advantage's Provider Directory. It is located within the Blue Advantage Provider Portal.

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

Hospital Authorizations

Inpatient Admission:
Plan requires notification within one business day of inpatient (IP) admission.

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

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

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

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

Medical Necessity Criteria:
- InterQual (IQ)
- Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD)

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.

Home Health/Home Infusion Services

When it is medically appropriate and a member is confined to his/her home, home health care may be an appropriate alternative.

- Prior authorization of all home health services is required.

- Initial authorizations and subsequent requests for home health services may be obtained from the Home Health Case Management Department.
  - To check the status of a request that has been submitted, you may contact the Blue Advantage Home Health Case Management Department as referenced in the *Blue Advantage Quick Reference Guide* or check on the Blue Advantage Provider Portal.
  - Agencies are allowed 5 days after the start of care date to request authorization.
  - Please fax the request with progress notes and the current plan of care to **(318) 812-6265**.
- **Beginning January 1, 2024, Blue Advantage requires one Notice of Admission (NOA) for any series of Home Health periods of care beginning with admission to home care and ending with discharge. Home Health Agencies (HHAs) shall not submit an NOA for subsequent 30-day periods of care with the exception of the one-time NOA submission for beneficiaries receiving HH services in 2023 and continuing services in 2024.**

Prior Authorizations

Standard*

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

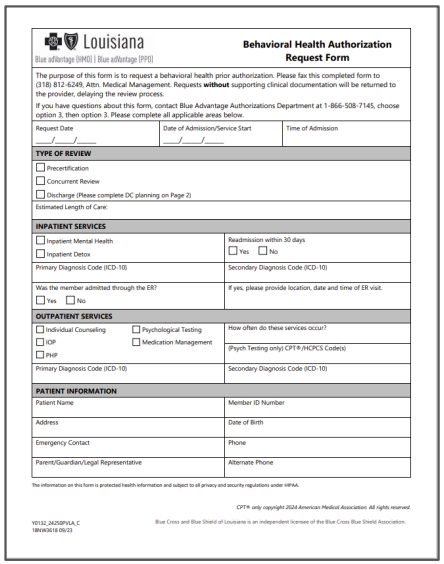
Expedited*

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

Contracted providers can submit an appeal only when it involves a pre-service request.
Member sent written Notice of Right to an Expedited Appeal.
**Part B drug authorization requests follow the Part D timeframes.*

Prior Authorizations Forms

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


Louisiana
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Behavioral Health Authorization Request Form

The purpose of this form is to request a behavioral health prior authorization. Please fax this completed form to (318) 812-6249, Attn. Medical Management. Requests **without** supporting clinical documentation will be returned to the provider, delaying the review process.

If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3. Please complete all applicable areas below.

Request Date	Date of Admission/Service Start	Time of Admission
___/___/___	___/___/___	

TYPE OF REVIEW

☐ Precertification
☐ Concurrent Review
☐ Discharge (Please complete DC planning on Page 2)

Estimated Length of Care:

INPATIENT SERVICES

☐ Inpatient Mental Health ☐ Inpatient Detox	Readmission within 30 days ☐ Yes ☐ No
Primary Diagnosis Code (ICD-10)	Secondary Diagnosis Code (ICD-10)
Was the member admitted through the ER? ☐ Yes ☐ No	If yes, please provide location, date and time of ER visit.

OUTPATIENT SERVICES

☐ Individual Counseling ☐ Psychological Testing ☐ IOP ☐ Medication Management ☐ PHP	How often do these services occur?
Primary Diagnosis Code (ICD-10)	(Psych Testing only) CPT®/HCPCS Code(s) Secondary Diagnosis Code (ICD-10)

PATIENT INFORMATION

Patient Name	Member ID Number
Address	Date of Birth
Emergency Contact	Phone
Parent/Guardian/Legal Representative	Alternate Phone

The information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

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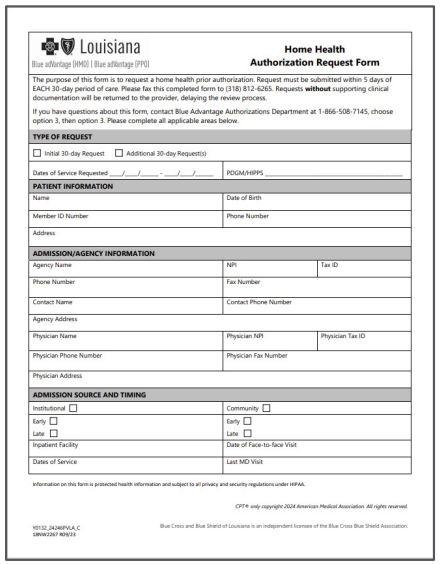
Behavioral Health Authorization Request Form


Louisiana
Blue advantage (HMO) | Blue advantage (PPO)

Home Health Authorization Request Form

The purpose of this form is to request a home health prior authorization. Request must be submitted within 5 days of EACH 30-day period of care. Please fax this completed form to (318) 812-6265. Requests **without** supporting clinical documentation will be returned to the provider, delaying the review process.

If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3. Please complete all applicable areas below.

TYPE OF REQUEST

☐ Initial 30-day Request ☐ Additional 30-day Request(s)

Dates of Service Requested ___/___/___ - ___/___/___	PDGM/HIPPS _____

PATIENT INFORMATION

Name	Date of Birth
Member ID Number	Phone Number
Address	

ADMISSION/AGENCY INFORMATION

Agency Name	NPI	Tax ID
Phone Number	Fax Number	
Contact Name	Contact Phone Number	
Agency Address		
Physician Name	Physician NPI	Physician Tax ID
Physician Phone Number	Physician Fax Number	
Physician Address		

ADMISSION SOURCE AND TIMING

Institutional ☐	Community ☐
Early ☐ Late ☐	Early ☐ Late ☐
Inpatient Facility	Date of Face-to-face Visit
Dates of Service	Last MD Visit

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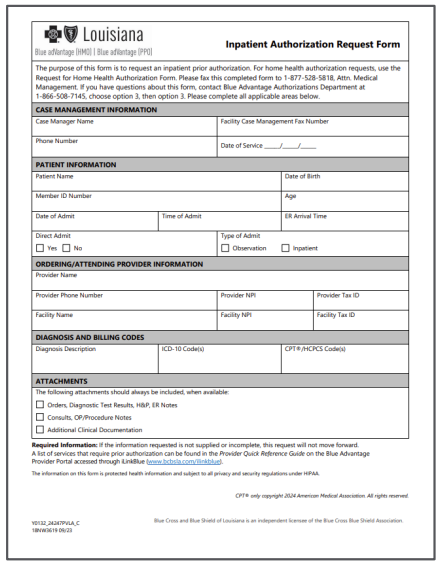
Home Health Authorization Request Form


Louisiana
Blue advantage (HMO) | Blue advantage (PPO)

Inpatient Authorization Request Form

The purpose of this form is to request an inpatient prior authorization. For home health authorization requests, use the Request for Home Health Authorization Form. Please fax this completed form to 1-877-528-5818, Attn. Medical Management. If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3. Please complete all applicable areas below.

CASE MANAGEMENT INFORMATION

Case Manager Name	Facility Case Management Fax Number
Phone Number	Date of Service ___/___/___

PATIENT INFORMATION

Patient Name		Date of Birth
Member ID Number		Age
Date of Admit	Time of Admit	ER Arrival Time
Direct Admit ☐ Yes ☐ No	Type of Admit ☐ Observation ☐ Inpatient	

ORDERING/ATTENDING PROVIDER INFORMATION

Provider Name		
Provider Phone Number	Provider NPI	Provider Tax ID
Facility Name	Facility NPI	Facility Tax ID

DIAGNOSIS AND BILLING CODES

Diagnosis Description	ICD-10 Code(s)	CPT®/HCPCS Code(s)

ATTACHMENTS

The following attachments should always be included, when available:

☐ Orders, Diagnostic Test Results, H&P, ER Notes
☐ Consults, OP/Procedure Notes
☐ Additional Clinical Documentation

Required Information: If the information requested is not supplied or incomplete, this request will not move forward.
A list of services that require prior authorization can be found in the *Provider Quick Reference Guide* on the Blue Advantage Provider Portal accessed through LinkBlue (www.bcbsla.com/linkblue).

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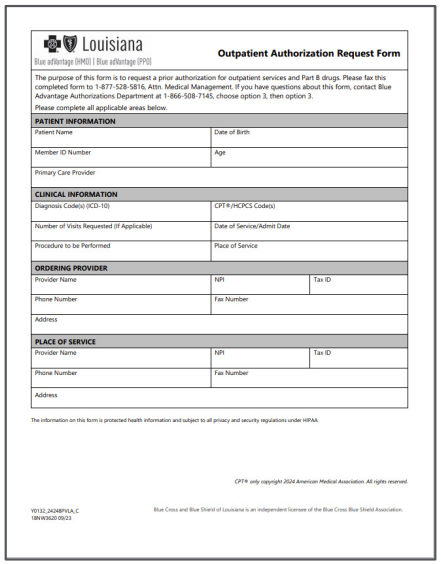
Inpatient Authorization Request Form


Louisiana
Blue advantage (HMO) | Blue advantage (PPO)

Outpatient Authorization Request Form

The purpose of this form is to request a prior authorization for outpatient services and Part B drugs. Please fax this completed form to 1-877-528-5816, Attn. Medical Management. If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3.

Please complete all applicable areas below.

PATIENT INFORMATION

Patient Name	Date of Birth
Member ID Number	Age
Primary Care Provider	

CLINICAL INFORMATION

Diagnosis Code(s) (ICD-10)	CPT®/HCPCS Code(s)
Number of Visits Requested (If Applicable)	Date of Service/Admit Date
Procedure to be Performed	Place of Service

ORDERING PROVIDER

Provider Name	NPI	Tax ID
Phone Number	Fax Number	
Address		

PLACE OF SERVICE

Provider Name	NPI	Tax ID
Phone Number	Fax Number	
Address		

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Outpatient Authorization Request Form

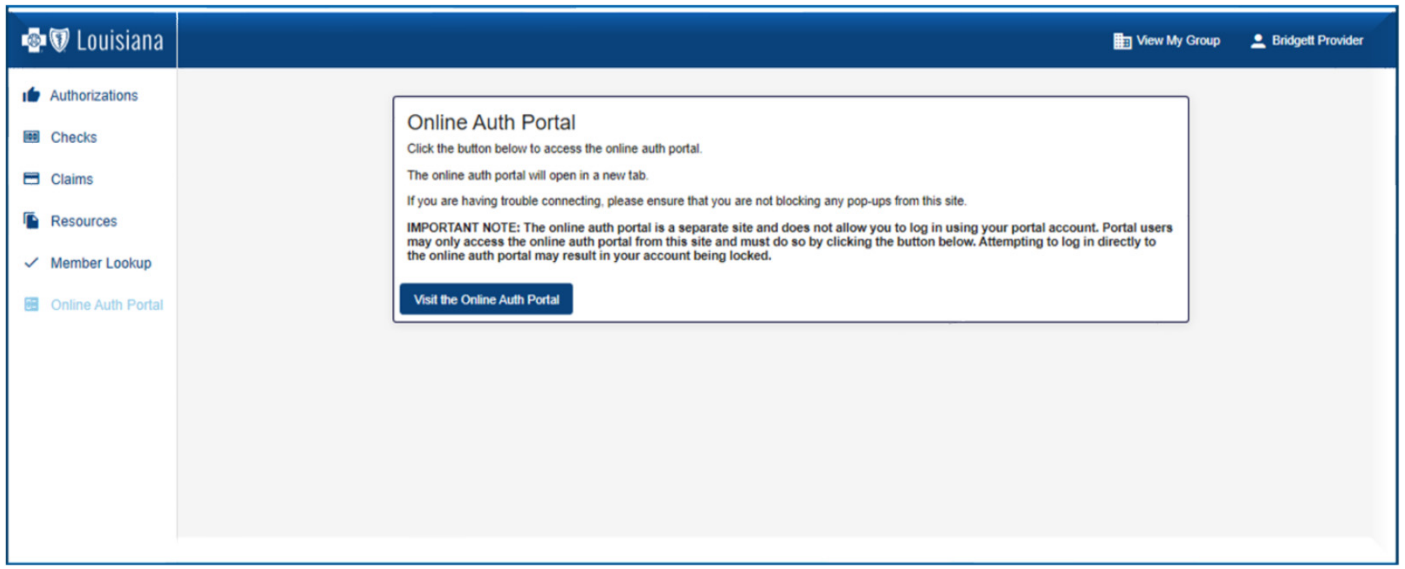
Download authorization forms by going to **www.bcbsla.com/ilinkblue,** then clicking on "Blue Advantage" under the "Other Sites" section. Click "Resources" then "Forms."

The 2024 *Provider Quick Reference Guide* includes the list of services requiring prior authorization. It is available on the Blue Advantage Resources page**, www.bcbsla.com/ilinkblue,** then click on "Blue Advantage" under the "Other Sites" section. Click " Resources" then "Reference Materials."

Prior Authorizations

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

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



ABNs Not Used for Blue Advantage

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

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

- If contracted provider knows or has reason to know that a service may not be covered, request a prior authorization from Blue Advantage.
- If the coverage request is denied, an Integrated Denial Notice (IDN) will be issued to the member and requesting provider.
- If the member desires to receive the denied services **after** the IDN has been issued, the provider may collect from the member for the specific services outlined in the IDN after services are rendered.

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

Transition of Care

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

Overall program goals are to:

- Assist in reducing avoidable hospital readmission and related costs to the member and health plan.
- Improve provider follow-up after hospital discharge (PCP offices are notified via fax of inpatient discharges and should schedule patient follow-up visits within seven days of discharge).

Case Management Services

Case management programs seek to maximize the quality of care, member satisfaction and efficiency of services through effective engagement with members and their providers.

How we do it:

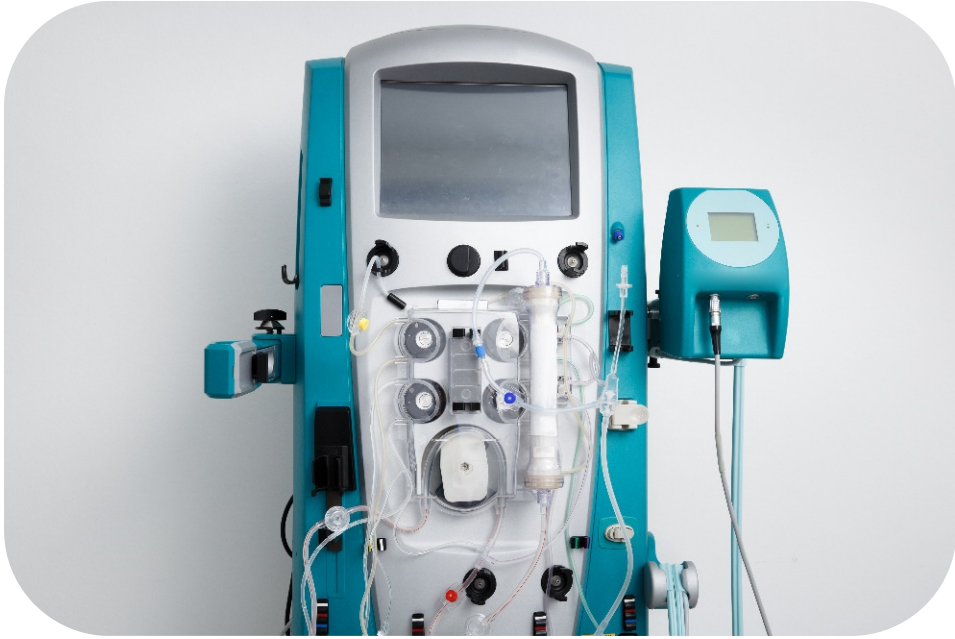
- Education and support of members and family/caregivers, including self-management
- Coordination of care
- Medication adherence
- Fall prevention and safety
- Access to community resources
- Advance care planning
- Telephonic outreach

For a list of conditions and complex diseases that often benefit from the case management program, see the *Blue Advantage Provider Administration Manual*, available on the Blue Advantage Provider Portal (**www.bcbsla.com/ilinkblue**) >Blue Advantage (under "Other Sites").

Other Services

Dialysis Patients

- Dialysis providers initiating dialysis for ESRD patients must enter the CMS-2728 form into the CMS system, CROWNWeb.
- Once entered into the system, the provider must print the form, sign it, then have the member sign and mail it to the Social Security Administration office.



The CROWNWeb is located at **https://mycrownweb.org**.

Outpatient Lab Tests

Blue Advantage network providers can:

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

Blue Advantage Preferred Labs:

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

Other Services

Liberty Dental

administers routine and comprehensive dental services

phone: 1-866-609-0424

Express Scripts

administers pharmacy benefit management

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

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

Pharmacy

The Basics: Outpatient Drug Coverage

Part D drugs

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

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

Part B drugs

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

Cost share is 20% unless it's a drug that is on the rebatable drug list where CMS reduces the cost share due to inflation.

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

Part D Exclusions: Examples

Vitamins and supplements

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

Drugs for symptomatic relief of cough and colds

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

Nonprescription/OTC drugs

- Acetaminophen
- Gas-X® (simethicone)

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

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

Drugs used for cosmetic purposes, hair growth, hair removal

- Retin-A® (tretinoin)
- Vaniqa®

Drugs to treat sexual dysfunction

- Levitra®
- Viagra®
- Addyi®

Inflation Reduction Act (IRA) Drug Coverage

Changes Coming in 2024

NEW

$0 Catastrophic Phase

- $0 member cost share on all tiers once the member enters Catastrophic Phase.

Low-Income Subsidy Expansion

- Members who would normally be eligible for partial "Extra Help" will now be eligible for full "Extra Help."

Preferred Value Pharmacy Network

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

Louisiana chain pharmacies include:

Walgreens, Sam's Club, Walmart

Many independent pharmacies also participate

Preferred Value Pharmacy Network

Benefits of Preferred Network

Cost-savings for member

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

Enhanced programs to improve adherence

- Write for three-month supply of maintenance medications.
- Improve engagement with patient and physician outreach.

Connect members to pharmacies that support Clinical Star measures

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

Benefits of Home Delivery

No-cost Shipping

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

Refill Reminders

- Refill reminders make it less likely to miss a dose.

Avoid Interactions

- Safety reviews to find possible interactions with other drugs.

Pharmacists Available

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

Express Scripts Mail-order Pharmacy

Two Steps to set up home delivery:

1) Prescribe a three-month supply directly to Express Scripts Mail Order Pharmacy.
    - Prescription can be sent electronically from the EMR or called in to Express Scripts Pharmacy.
2) Member can contact Express Scripts directly to have prescription transferred.
    - Call: 1-800-282-2881 (24 hours a day, 7 days a week)
      TTY users: 1-800-759-1089
    - Go online: **www.express-scripts.com**

To Be Safe:

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

Diabetic Testing Supplies

How members may get FREE meters and strips:

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

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

- Documents
- 2024 Diabetes Testing Supplies Coverage at Network Pharmacies

Outreach Initiatives

Therapeutic Opportunities

Provider Outreach

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

Member Outreach

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

Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

Targets members who meet the following criteria:

- 3+ chronic conditions
- 8+ select maintenance medications
- Spent $1,332 in the previous 3 months on Part D covered medications.

Members will be invited to schedule a Comprehensive Medication Review (CMR) with an MTM-certified pharmacist which includes:

- Review of the member's entire medication profile (including prescriptions, OTCs, herbal supplements and samples).
- Discuss purpose and directions for the use of each medication with documentation being provided to the member after completion of the call.
- Answer any additional questions or concerns.

After the completion of a CMR, you and the member will receive a detailed report.

The pharmacist performing the CMR may contact you directly in the event a significant drug therapy problem is identified.

Billing and Claims 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.

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.

Electronic Claims Submission

- Providers submitting directly to Blue Cross must make the system changes necessary to send their Blue Advantage claims with the Payer ID **72107**.
- Providers who do not currently send to Blue Cross, please notify your clearinghouse to do so with Payer ID **72107** for Blue Advantage claims.
- Blue Advantage routine and comprehensive dental should be filed to Liberty Dental.
- Blue Advantage routine eye exams and eyewear should be filed to Blue Advantage.
- Blue Advantage pharmacy claims should be filed to Express Scripts.

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

Reimbursement Guidelines

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.

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 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, deductibles and coinsurance, as applicable*

Endoscopies

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

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

For Physicians, 16% of total amount paid to the surgeon minus copayments, deductibles and coinsurance, as applicable.

Multiple surgery restrictions apply.

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:

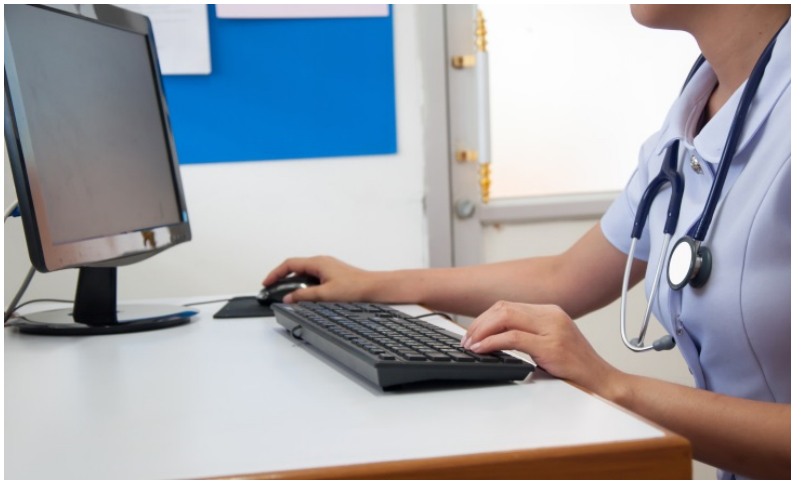
Primary Procedure	lesser of charges or 100% of fee schedule*
Secondary Procedure	lesser of charges or 50% of fee schedule*
Third-Fifth Procedures	lesser of charges or 50% of fee schedule*

** minus copayments, deductibles and coinsurance, as applicable*

Checking Claim Status

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

- Below are multiple ways to inquire about a claim:
  - Claim number
  - Date(s) of service
  - Provider name
  - Member name
  - Claim status
  - Date of claim status
  - Payment amount



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

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.

Claims Resubmission

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

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

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

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

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

Corrected Claims

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

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

Examples:

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

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

CMS-1500 Corrected Claims

EDI/1500/Professional claims can be submitted electronically as "Corrected Claims."

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

1500 paper claim forms can be submitted as "corrected claims."

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

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

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

UB-04 Corrected Claims

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

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

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

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

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

Resolving Claims Issues

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

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

When to Contact Provider Relations for Claims Help

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

It is required to document the customer service representative's name and date for each call.

Adjustments, Additional Payments, Overpayments & Voluntary Refunds

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

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

- "**A1**" "**A2**" "**A3**" etc.

If an adjustment results in additional payment, it will appear on the provider's remittance.

If you discover an overpayment you are obligated, via your contractual agreement and/or CMS regulations, to issue a voluntary refund.

Provider Pay Disputes

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

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

Once a decision has been made:

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

Provider Pay Dispute Address:

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

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.

Member Appeals

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

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

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

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

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

Blue Advantage Phone Numbers

Authorizations (including Medical Management)

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

Behavioral Health

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

Customer Service

1-866-508-7145
customerservice@blueadvantagela.com

Provider Portal

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

Provider Disputes

1-866-508-7456, choose option 3, then option 2

Pharmacy

1-800-935-6103 / TTY:711

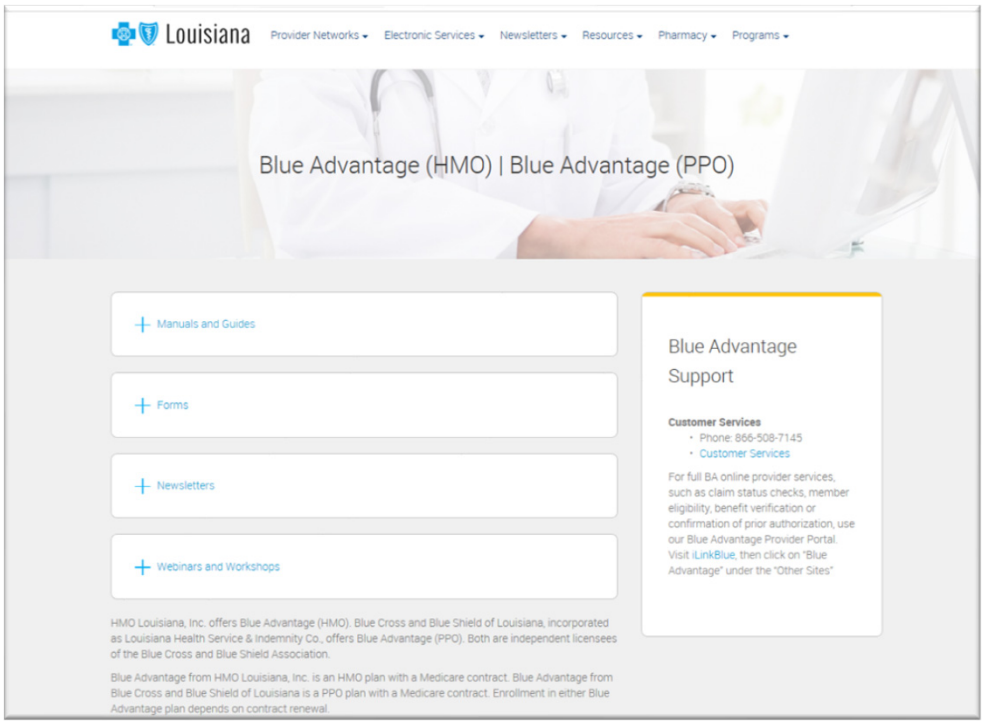
Thank You!

Addendum

Blue Advantage Resources Page

Resources that can be found on this page:

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



Designed to give providers access to the most current Blue Advantage resources **www.bcbsla.com/providers** >Blue Advantage Resources.

Use of CPT Category II Codes

What is a CPT Category II Code?

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

Why use CPT II Codes?

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

Is there additional reimbursement when I use CPT II codes?

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

Advantage of Assigning CPT II Codes

Reminder

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

Medical Record Retention and Requests

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

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

- Retained for a minimum of 10 years.
- Contain consistent and complete documentation of each member's medical history and treatment.
- When members change their PCP and request a transfer of their medical records, the provider has 10 business days of the request to forward the records.

Medical record requests can include:

- Member changing PCP
- HEDIS
- RADV

Access to Your EMR

Do you have an EMR?

Are you willing to grant access to Blue Advantage?

Medical Records Signature Requirements

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

Electronic Signatures

✓

Acceptable:

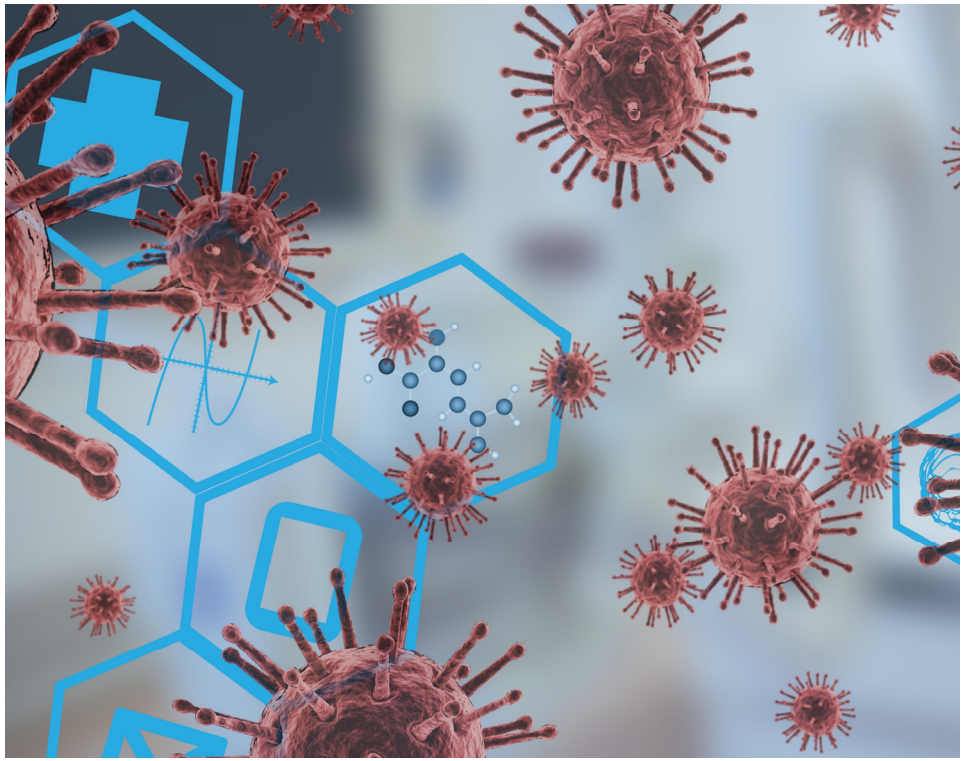
- Chart "Accepted by" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed by" with provider's name
- "Signed: John Smith MD"

X

Unacceptable:

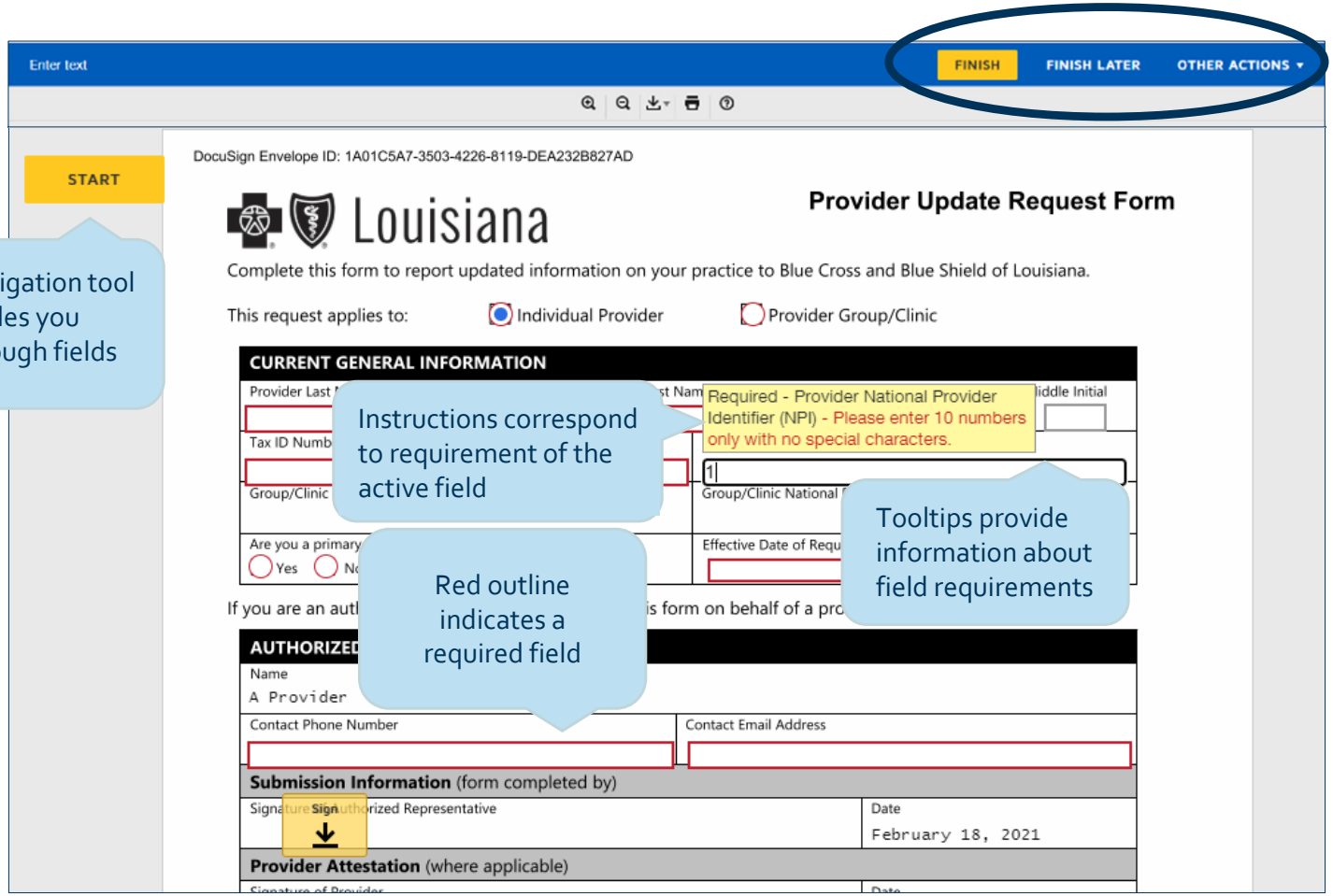
- Dictated but not read
- Signed but not read
- Auto-authentication
- Generated by

COVID-19 Emergency Changes



- In March 2023, the Louisiana Public Health Emergency (PHE) was lifted, and all COVID-19 related Louisiana state mandates expired.
- Communications were sent to providers on April 14 with more information regarding the COVID-19 emergency changes.
- Due to these changes, the following services were affected:
  - COVID-19 Testing
  - Vaccines and antiviral drugs
  - Oral antiviral medications
  - Telehealth

Easily Complete Forms with DocuSign



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

Helpful Hints

- For additional details on how to register for the Blue Advantage Provider Portal, download the *Blue Advantage Portal User Guide*. Go to **www.bcbsla.com/ilinkblue**, then click "Blue Advantage" under the "Other Sites" section.
- We recommend using Google Chrome to access the Blue Advantage Provider Portal.
- The portal uses cookies to remember your login information and you **must** enable cookies for the portal, in order to successfully log in and access all its features.
- For additional information, please see the "Troubleshooting" section of the *Blue Advantage Provider Portal User Guide* for detailed instructions.

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To check the status on your credentialing application or provider data update, please email **PCDMstatus@bcbsla.com** or call 1-800-716-2299, option 2.