SECTION 3: MEMBER ENGAGEMENT

of the Professional Provider Office Manual

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This section provides information about our member engagement initiatives. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 3: MEMBER ENGAGEMENT

OVERVIEW

Our member engagement initiative is designed to give our members the tools they need to become more active in managing their own healthcare. Our plan is to work hand-in-hand with our network providers to get our members clear, understandable and easily accessible information to make smarter healthcare choices. Two of these tools are the Estimated Treatment Cost Tool and Member Reviews. Additional tools will be launched in the future.

ESTIMATED TREATMENT COST TOOL

With this tool, Preferred Care PPO and BlueHPN members may view costs displayed on the national Blue Cross Blue Shield Association (BCBSA) National Hospital & Doctor Finder℠ website. The tool features the costs and volumes associated with 1,778 elective/planned procedures. Total cost of care estimates display bundled service and facility charges that are typically a standard part of a procedure or treatment.

Cost Estimates

Cost estimates are developed from our historical claims with updates, as needed, to reflect current arrangements and combined data that enables members to understand the total cost for a service without complications. These estimates are created in four ways:

- For inpatient procedures primary Diagnostic Related Group (DRG) codes(s) related to each treatment category should reflect the professional, diagnostic and other related costs for the category per line and the total displayed.
- For outpatient procedures primary CPT code(s) identify each treatment category and all costs for that member on the same date of service are summed to create the estimate.
- For diagnostic services both the technical and professional component are combined.
- For professional office visits, primary CPT code(s) identify each treatment category. For chiropractic and physical therapy, all costs for the visit are summed to create the estimate. For other categories, weighted average costs per CPT code(s) created the estimate.

Viewing Cost Estimates

A report of cost estimates is available to providers on iLinkBlue under the menu item "Quality & Treatment." You must have access to iLinkBlue in order to view your cost data, as this information will not be mailed. The report contains the cost ranges calculated for the facility or professional providers and frequently asked questions. Cases may be excluded from this estimate based on criteria, such as volume, network participation status, provider type, place of service and completeness.

For inpatient, outpatient and diagnostic treatment categories, figures displayed are a total cost and include facility and professional costs. For professional office visit treatment categories, the costs are average provider-specific costs for services defined to the treatment category. The member will see the approximate cost range for the selected treatment category with fees associated for the service. In addition, the member will be able to view the name, address and phone number of the provider.

Reconsideration Process

Providers have 30 days from the date of notice that the data is available to review the cost data and request a reconsideration. To request reconsideration, complete the Estimated Treatment Cost Reconsideration Form located on iLinkBlue (www.bcbsla.com/ilinkblue) >Quality & Treatment, then click on the specific treatment description in the question. Follow the instructions on the screen to complete the form. Prior to submitting the form, you will have the option to print a copy for your records. All required fields must be completed, and forms must be submitted electronically. Faxed or mailed forms will not be accepted. The Electronic Reconsideration Form will only be available to providers during the reconsideration period prior to each cost data submission. During times outside this window, the link to the form will be inactive. Resource documents are available on iLinkBlue. Click on the Quality & Treatment menu to see the following:

- Frequently Asked Questions
- Treatments Codes Listing

MEMBER REVIEWS

Patient reviews are seen as a quality and transparency domain in proposed healthcare reform measures. The market demand for member review is growing, fueled by the new and expanding individual retail health insurance market. Approximately 85 to 90% of patient reviews are positive. Encouraging all of your Blue patients to add to these reviews will help assure an overall positive score. Key components of patient reviews are:

- Members must first log in to their online account on our website.
- Members are then authenticated during login before being able to submit reviews.
- Members must access a specific claim on file to comment on an encounter with the physician.
- Members then respond to a core set of member review questions.
- Member-written comments are checked for appropriateness before posting to our website.
- The review is then displayed in the comments section on our online directory for the physician.
- Physicians are able to give one response to each patient review.

In most instances, this can be a good marketing tool for your practice given that there is such positive feedback.