SECTION 4: MEDICAL MANAGEMENT

of the Professional Provider Office Manual

TABLE OF CONTENTS

This section provides information about medical management. 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 4: MEDICAL MANAGEMENT

OVERVIEW

Medical management is a system for a comprehensive approach to healthcare delivery. Blue Cross established the Care Management Department to ensure that our members receive the highest quality healthcare that is medically appropriate and cost-effective. See the end of this section for an overview of our Quality Management Program.

UTILIZATION REVIEW ORGANIZATION

Blue Cross is authorized as an Utilization Review Organization (URO) and therefore follows the regulations promulgated by the Department of Insurance that governs these entities. However, certain employer groups, primarily self-funded employer groups and the Federal Government plan, are not subject to the legislation that created these regulations. Since Blue Cross handles a wide range of fully funded and self-funded employer groups, it is not possible to have a uniform policy in all instances. The following sections note where differences occur.

CONCURRENT REVIEW

The Concurrent Review Unit evaluates the medical and service needs of patients admitted to an inpatient facility. Concurrent review promotes and works to ensure optimal outcomes, continuity of care, development of a timely discharge plan and ongoing quality of care.

The concurrent review nurse is the central focus and link of communication between a hospitalized member, the provider and the Care Management Department. Concurrent review nurses conduct a review of all new admissions or continued care cases prior to the end of an approved length of stay. Concurrent review nurses use clinical information made available and nationally recognized criteria to authorize extensions for additional inpatient care. If the concurrent review nurse is not able to authorize an extension based on medical necessity with the clinical information made available and the criteria, the case is referred to a Blue Cross medical director for a determination.

On October 1, 2020, Blue Cross streamlined its processes for requesting authorizations by requiring all prior authorization requests for acute care facilities be submitted exclusively through the BCBSLA Authorizations tool available on iLinkBlue. Other inpatient levels of care, such as skilled nursing and rehabilitation services, will be included at a later date. This change allows for providers to request authorization for services 24 hours a day, seven days a week, in real time. Acute inpatient care facilities are required to use the BCBSLA Authorization tool to request additional services or days. A concurrent review nurse, in collaboration with the medical director, will conduct a review of the information provided to document the medical necessity for continued stay.

A decision is made within one business day of receiving all necessary information from the provider. If the decision is to approve the continued stay or course of treatment, the provider rendering the service is notified via telephone, fax or portal. If a decision to deny the continued stay or course of treatment is made, the provider rendering the service is immediately notified and given the reason for the denial and the procedure for initiating the appeal process.

Self-funded employer groups handled by Blue Cross will generally be handled in the same way as fully insured groups for operational efficiency. Insureds not subject to URO regulations may have denial determinations issued on a retrospective basis if a review is not requested prior to discharge from service or prior to receipt of the initial claim for payment.

Exceptions to Authorization Tool Mandate

There are some services that may require acute care facilities and home health agencies to still directly call the Blue Cross Authorizations Department. Please refer to the authorization number on the member ID card when calling.

- Newborn Sick Babies/Temporary Members: A newborn sick baby often requires services that cannot be attributed to the mother's hospital stay. Parents have 30 days to add babies to a current plan or to sign them up for their own plan and eligibility is often not visible right away. Providers may call Blue Cross to set up the initial authorization. Once Blue Cross completes the initial setup of the baby as a temporary member for authorization purposes only, providers must then access the BCBSLA Authorization tool to upload clinical reviews.
- Out of State Providers (OOS): Authorizations for out-of-state services performed by out-of-state providers should be requested by phone or fax.
- Physician-initiated Home Health Services: Physicians and physician's offices can initiate the authorization process for home health services by calling or faxing the request to the Authorization Department. When the home health authorization is initiated by the home health provider, they will be required to use the authorization tool.
- Blue-on-Blue Coverage: When a member has two Louisiana Blue Cross polices that require the coordination of benefits, the provider should call Blue Cross for prior authorization. Once the initial authorization has been created, the provider must access to BCBSLA Authorizations tool to upload clinical reviews.

Authorization Tool Resources

For information on how to use our BCBSLA Authorizations tool, please refer to the *BCBSLA Authorizations Applications Facility User Guide*, available on iLinkBlue under the "Resources" tab, then click "Manuals." For information on using iLinkBlue, refer to the *iLinkBlue User Guide*, available at www.BCBSLA.com/providers, click "Resources," then "Manuals."

RETROSPECTIVE REVIEW

The Blue Cross Retrospective Review Unit reviews claims to ensure that the services rendered were medically appropriate and meet the definition of covered services under the Subscriber Contract/ Certificate. A retrospective review may be performed to assess the medical need and correct billing level for services that have already been performed.

As part of this review process, staff members examine diagnoses, treatments or procedures.

For retrospective authorization requests, upload medical records and the Authorization Form in iLinkBlue, using the document upload feature. Click on the "Document Upload" link on the home page, then select "Medical Records for Retrospective or Post Claim Review" from the department drop down. The Authorization Form is available online at www.BCBSLA.com/providers, click "Resources" and then "Forms."

AUTHORIZATION PROCESS

The authorization process ensures that members receive the highest level of benefits to which they are entitled and that the most appropriate setting and level of care for a given medical condition are provided.

A Blue Cross nurse reviews all pertinent information submitted by physicians and providers and applies defined criteria to determine if a service is medically appropriate. The criteria used by the nurses is reviewed and approved by physicians at least annually, and more often if indicated. If the information received from a physician or other provider varies from the defined criteria, a nurse will forward the information for review by a Blue Cross physician.

Pre-service Authorizations - BCBSLA

A pre-service authorization is the review and authorization of a procedure prior to the service being rendered. The medical necessity and appropriateness of selected surgical procedures, selected diagnostic procedures and various other services are reviewed prior to the service being performed. A listing of services that require authorization is provided in this manual. Authorization requirements may vary slightly by product. The following describes the process and procedural steps for obtaining pre-service authorizations:

- The provider must initiate the authorization process at least 48 hours prior to the service by:

  - Submitting an authorization request using the authorization tools available on iLinkBlue, or

  - Calling the appropriate authorization number on the member ID card

  Please Note: Effective October 1, 2020, prior authorization requests from acute care facilities and home health agencies must be submitted through the BCBSLA Authorizations tool available on iLinkBlue.

- The following information is required to complete a pre-service authorization:
  1. Patient/member name, date of birth, member ID number;
  2. Physician's name, NPI, address and telephone number;
  3. Name of the facility at which the service will be rendered;
  4. Anticipated date of service;
  5. Requested length of stay (if applicable);
  6. Diagnosis (to include ICD-10-CM codes), procedures (CPT and/or HCPCS codes), plan of treatment, medical justification for services or supplies and complications or other factors requiring the requested setting; and
  7. Name and phone number of person requesting authorization.
- The initial request received prior to a scheduled inpatient admission or outpatient procedure is classified as a pre-service authorization. Decisions are made within 15 calendar days of receipt of claim, regardless of whether all information is received.
- If the request is approved, the contact person is notified within 24 hours of the determination. Confirmation for continued hospitalization or services includes the date of admission or onset of services, the number of extended days or units of service, the next anticipated review point, and the new total number of days or services approved. Types of notification include verbal (by telephone at the time of the call) voicemail, web or electronic means including email and fax. A letter of confirmation is mailed to the member and faxed to the physician and hospital, if applicable, within two working days of the decision being made.
- If the decision is to non-certify the authorization, the contact person is notified of the principal reasons for determination not to certify and appeal rights verbally (by telephone or voicemail) within 24 hours of the determination. A non-certification letter is sent to the member, physician and hospital, if applicable, within one working day of the decision. The letter will list appeal rights based on regulatory guidelines.

Urgent Care Authorizations - BCBSLA

- The initial request for authorization of an urgent illness is processed as soon as possible based on the clinical situation, or within 72 hours of the request regardless of whether all information is received.
- If the request is approved, the contact person/practitioner is notified by telephone and a confirmation letter is mailed to the member and faxed to the physician and hospital, if applicable.
- If the request is denied, the contact person is notified by telephone and is given the reason for the denial and the procedure for initiating the appeal process. A letter is sent to the member, physician and hospital, if applicable, within one business day of the determination. The notification will list appeal rights based on regulatory guidelines.

The authorization process is designed only to evaluate the medical necessity of the service. AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT OR A CONFIRMATION OF COVERAGE FOR BENEFITS. Payment of benefits remains subject to all other Subscriber Contract/Certificate terms, conditions, exclusions and the patient's eligibility for benefits at the time expenses are incurred. Providers are required to check an individual's benefits, limitations and eligibility immediately prior to providing a benefit or service. You may log into iLinkBlue or call the customer service number on the member ID card for specific information.

Notification of Admission/Status Change

Occasionally, it may be necessary to change or cancel a service, or the circumstances may require an adjustment to the anticipated length of stay. When a change in the nature, duration or reason(s) for an authorized service occurs, the provider should notify the Authorization Unit by phone or fax of the change prior to the service being rendered. This will help prevent confusion and unnecessary delay or errors when processing claims for services associated with the service.

Routine Maternity Admissions

Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for caesarean section delivery. Inpatient services for newborn well-baby services are included in the mother's stay. However, authorization is required for inpatient sick-baby services.

Home Health Authorizations

Effective October 1, 2020, home health providers are required to request all authorizations for home health services through the BCBSLA Authorizations tool on iLinkBlue. Authorizations for home health services are no longer taken via phone or fax. This includes new service requests and extensions.

Providers will need to supply the necessary clinical information in one of the three ways outlined below:

- Complete a criteria review via InterQual (IQ). Completing an IQ review is not required, but if one is completed and criteria is met the provider will receive approval online. Most cases will get an automatic approval when an IQ review is done. Some self-funded members will not get an automatic approval due to benefit limits.
- Upload clinical information to the authorization request through the BCBSLA Authorization tool.
- Document the clinical information in the notes section of the request in the BCBSLA Authorization tool. This option requires the provider to generate an activity within the case. If an activity is not generated, the clinical information will not be available for the Blue Cross staff to review.

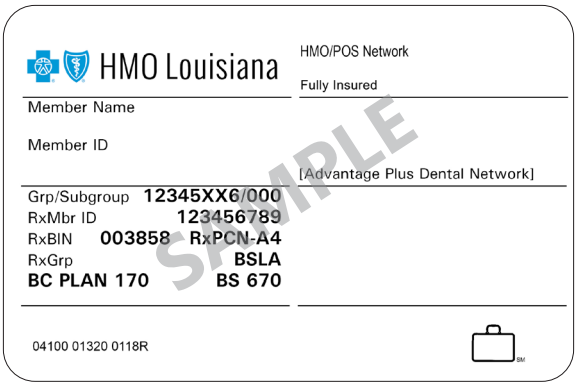
AUTHORIZATION PENALTIES FOR PROVIDERS

Outpatient Authorization Penalty

For Fully Insured BCBSLA PPO and HMO/POS Members:
A 30% penalty will be imposed for failing to obtain authorization prior to performing outpatient services that require authorization. This penalty will be applied to the network provider's benefit payment of the allowable charge. The network provider is responsible for the penalty amount. The member is responsible for any applicable copayment, deductible, coinsurance percentage and/or non-covered services. This does not apply to PPO providers of other Blue Plans.

For Fully Insured BCBSLA HMO/HMO Members and OGB Members:
Failure to obtain prior authorization of service(s) will result in a claim denial.

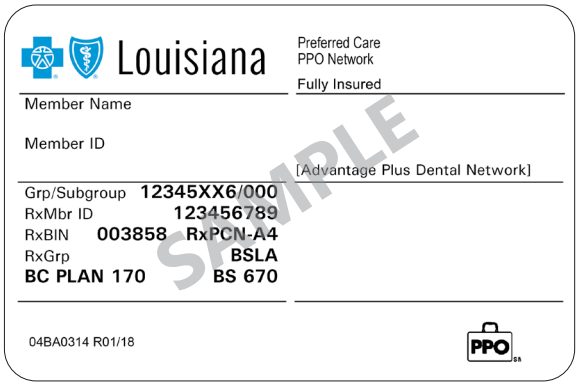
For Self-funded PPO and HMO Members:
Authorization requirements and penalties vary for self-funded members. Always verify authorization requirements and benefits on iLinkBlue, prior to rendering services.



Inpatient Authorization Penalty

For Fully Insured BCBSLA PPO and HMO/POS Members:
A $1,000 penalty will be applied to inpatient hospital claims if the member's policy requires an authorization for inpatient stays, and the network provider fails to obtain the authorization prior to the stay. This penalty will be applied to inpatient stays of members covered by any Blue Plan or subsidiary, when the member's policy requires a pre-service authorization.

When a member is covered by a policy issued by another (non-Louisiana) Blue Plan or subsidiary, and the member's policy contains a different penalty for failure to authorize an inpatient stay, this $1,000 penalty provision will be applied before the terms of the member's policy.



For Fully Insured HMO/HMO Members and OGB Members:
Failure to authorize service(s) will result in a claim denial. OGB does not authorize Blue Cross to reconsider these denials at the appeal level.

For Self-funded PPO and HMO Members:
For Blue Cross or HMO Louisiana member policies that contain a different penalty for failure to authorize an inpatient stay, the terms of the member's policy will apply.

When a member is covered by a policy issued by another (non-Louisiana) Blue Plan or subsidiary, and the member's policy contains a different penalty for failure to authorize an inpatient stay, this $1,000 penalty provision will be applied before the terms of the member's policy.

PPO SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services may require Blue Cross approval. This list may vary for self-funded groups. Dollar amounts are based on billed charges.

Preferred Care PPO

- Air Ambulance – Non-emergency (no benefit without prior authorization)
- Applied Behavior Analysis**
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Compound Drugs greater than $250
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic Testing
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000 (including but not limited to defibrillators)
- Inpatient Hospital Services (except routine maternity stays)
- Insulin Pumps (initial, replacement, supplies & accessories)
- Intensive Outpatient Programs**
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low-protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Partial Hospitalization Programs**
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.BCBSLA.com/providers >Pharmacy
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers**
- Resting Transthoracic Echocardiography*
- Sleep Studies (except for those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Erectile Dysfunction (including penile implants) (if benefits available)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography*
- Transplant Evaluation & Transplants
- Treatment of Osteochondral Defects
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations tools that are available on iLinkBlue (www.BCBSLA.com/ilinkblue). They are located under the "Authorizations" menu option. You may also call the authorization number(s) on the member ID card.

* High-tech imaging & utilization management program services are authorized through the AIM ***Provider****Portal*$_{SM}$ by clicking the "AIM Specialty Health Authorizations" link.

** Behavioral health services are authorized through the New Directions WebPass Portal by clicking the "Behavioral Health Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

HMO SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services and/or procedures may require HMO Louisiana approval. This list may vary for self-funded groups. Dollar amounts are based on billed charges.

HMO Louisiana, Blue Connect, Blue HPN, Community Blue, Precision Blue, Signature Blue and Bridge Blue

- Air Ambulance – Non-emergency (no benefit without prior authorization)
- Applied Behavior Analysis**
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation*
- Cellular Immunotherapy
- Compound Drugs greater than $250
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic Testing
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000 (including but not limited to defibrillators)
- Infusion Therapy – includes home and facility administration (exception: physician's office, unless the drug to be infused may require authorization)
- Inpatient Hospital Services (except routine maternity stays)
- Insulin Pumps (initial, replacement, supplies & accessories)
- Intensive Outpatient Programs**
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low-protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Oral Surgery (not required when performed in a physician office)
- Orthotic Devices greater than $300
- Partial Hospitalization Programs**
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.BCBSLA.com/providers >Pharmacy
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers**
- Resting Transthoracic Echocardiography*
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Erectile Dysfunction (including penile implants) (if benefits available)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography*
- Transplant Evaluation & Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations tools that are available on iLinkBlue (www.BCBSLA.com/ilinkblue). They are located under the "Authorizations" menu option. You may also call the authorization number(s) on the member ID card.

* High-tech imaging & utilization management program services are authorized through the AIM ***Provider****Portal*$_{SM}$ by clicking the "AIM Specialty Health Authorizations" link.

** Behavioral health services are authorized through the New Directions WebPass Portal by clicking the "Behavioral Health Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

OGB PLAN SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Plan authorization is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary. When Medicare is primary, an authorization is required once the combined benefit limit of 50 visits of PT/OT have been achieved. Providers may request authorization by calling our Authorization line. Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans.

INPATIENT

- Hospital Admissions (except routine maternity stays)
- Mental Health/Substance Use Disorder Admissions**
- Organ, Tissue and Bone Marrow Transplant Services
- Skilled Nursing Facility

OUTPATIENT

- Air Ambulance – Non-emergency (no benefit without prior authorization)
- Applied Behavior Analysis**
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Gene Therapy
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000 (including but not limited to defibrillators)
- Infusion Therapy – includes home and facility administration (exception: physician's office, unless the drug to be infused may require authorization)
- Insulin Pumps (initial, replacement, supplies & accessories)
- Intensive Outpatient Programs**
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Oral Surgery (not required when performed in a Physician's office)
- Orthotic Devices (greater than $300)
- Partial Hospitalization Programs**
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers**
- Resting Transthoracic Echocardiography*
- Sleep Studies (except those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplant
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations tools that are available on iLinkBlue (www.BCBSLA.com/ilinkblue). They are located under the "Authorizations" menu option. You may also call the authorization number(s) on the member ID card.

* High-tech imaging & utilization management program services are authorized through the AIM ***Provider****Portal*$_{SM}$ by clicking the "AIM Specialty Health Authorizations" link.

** Behavioral health services are authorized through the New Directions WebPass Portal by clicking the "Behavioral Health Authorizations" link.

For OGB members, failure to obtain prior authorization, when required, will result in the denial of payments for services.

FEP SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization is required for the following services for FEP members. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue.

Standard/Basic Option

- Air Ambulance (non-emergent)
- Applied Behavior Analysis*
- Blood/Marrow Stem Cell Transplants
- Certain Prescription Drugs and Supplies (including medical foods)
- Gender Reassignment Surgery
- Gene Therapy/Cellular Immunotherapy
- Genetic Testing (including BRCA/LGR services)
- Hospice Care
- Inpatient Hospital Services (except routine maternity stays)
- Intensity-Modulated Radiation Therapy (IMRT)
- Organ/Tissue Transplants and Transplant Travel (including autologous pancreas islet cell, heart, artificial heart implant, heart-lung, intestinal, liver, lung, pancreas, simultaneous liver-kidney, simultaneous pancreas-kidney; excluding cornea and kidney transplants)
- Outpatient Surgery Needed to Correct Accidental Injuries (to jaws, cheeks, lips, tongue, roof and floor of mouth)
- Residential Treatment Center*
- Skilled Nursing Facility
- Sleep Studies (when performed outside the home)
- Surgical Correction of Congenital Anomalies
- Surgical Treatment for Morbid Obesity

Failure to obtain prior authorization for these services will result in a $500 penalty for inpatient services.

FEP Blue Focus Option

- Air Ambulance (non-emergent)
- Applied Behavior Analysis*
- Blood/Marrow Stem Cell Transplants
- Breast Reduction Augmentation (not related to the treatment of cancer)
- Cardiac Rehabilitation
- Certain Prescription Drugs and Supplies (including medical foods)
- Cochlear Implants
- CT Scan
- Gender Reassignment Surgery
- Gene Therapy/Cellular Immunotherapy
- Genetic Testing (including BRCA/LGR services)
- Hospice Care
- Inpatient Hospital Services (except routine maternity stays)
- Intensity-Modulated Radiation Therapy (IMRT)
- MRI
- Oral/Maxillofacial Procedures (except when related to an accidental injury and provided within 72 hours of the accident)
- Organ/Tissue Transplants (including autologous pancreas islet cell, heart, artificial heart implant, heart-lung, intestinal, liver, lung, pancreas, simultaneous liver-kidney, simultaneous pancreas-kidney; excluding cornea and kidney transplants)
- Orthognathic Surgery Procedures
- Orthopedic Procedures
- Outpatient Residential Treatment Center*
- PET Scan
- Prosthetic Devices
- Pulmonary Rehabilitation
- Reconstructive Surgery (not related to the treatment of breast cancer)
- Rhinoplasty
- Septoplasty
- Surgical Correction of Congenital Anomalies
- Surgical Treatment for Morbid Obesity
- Specialty DME Services
- Travel Benefits
- Varicose Vein Treatment

Failure to obtain prior authorization for these services will result in a $100 penalty for outpatient services and a $500 penalty for inpatient services.

To Request Prior Authorization

Please use the authorizations tools that are available on iLinkBlue (www.BCBSLA.com/ilinkblue). They are located under the "Authorizations" menu option. You may also call the authorization number(s) on the member ID card.

* Behavioral health services are authorized through the New Directions WebPass Portal by clicking the "Behavioral Health Authorizations" link.

AIM SPECIALTY HEALTH UTILIZATION MANAGEMENT PROGRAMS

Blue Cross has several utilization management programs that are administered by AIM Specialty Health® (AIM), an independent company that serves as an authorization manager for our members. For these programs, prior authorization requests should be made directly to AIM using its ***Provider****Portal*℠, which is available under the "Authorizations" section of iLinkBlue.

Ordering physicians (whether a primary care provider or specialist) are required to provide AIM with basic clinical information and patient demographics to obtain the authorization. PCPs are not expected to obtain the authorization if a specialist orders the service. Hospitals and freestanding facilities that perform the technical component of the service(s) cannot and should not obtain authorizations for ordering physicians; however, they may check the status of an authorization request through the AIM ***Provider****Portal*℠ on iLinkBlue.

AIM Clinical Appropriateness Guidelines are available online at www.aimspecialtyhealth.com, then click on "Download Now." If a request for authorization is denied, AIM notifies the ordering physician of the denial and the process for appeals. Reconsideration of a denied authorization should be submitted directly to AIM. Please allow ample time in scheduling diagnostic services to ensure the authorization process is completed and approved before the patient receives services. Services that do not meet criteria will be denied and are not billable to the member.

High-tech Imaging Services Program

This program applies for the following office and outpatient, non-emergent imaging services:

- Computerized Tomography (CT) Scans
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI) – Please Note: authorizations for CPT 70336 are handled directly by Blue Cross. Most Blue Cross member contracts do not cover this service; however, a few large employers do provide some level of coverage.
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology Procedures
- Positron-Emission Tomography (PET) Scans

Please Note: Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or 30-hour observations are not included in this high-tech imaging program.

Cardiology Program

This program applies for the following office and outpatient non-emergent services:

- Diagnostic Services:
  - Echocardiography
  - Coronary arteriography/cardiac catheterization (Note: Coronary arteriography/cardiac catheterization for management of acute coronary syndrome is excluded from this program)
  - Arterial ultrasound
- Interventional Services:
  - Percutaneous coronary interventions (PCIs) such as coronary stents and balloon angioplasty

Musculoskeletal (MSK) Program

This program applies for the following inpatient and outpatient non-emergent services performed in certain locations:

- Interventional Pain Management (when performed in an ambulatory surgical center, physician's office or outpatient hospital)
  - Epidural steroid injections
  - Facet injections
  - Spinal cord stimulators
  - Radiofrequency ablation
- Joint Surgery (when performed in an ambulatory surgical center, inpatient hospital or outpatient hospital)
  - Joint Replacement (hip, knee and shoulder)
  - Arthroscopy and Open Procedures (shoulder and knee)
  - Hip Arthroscopy
  - Meniscal Allograft Transplantation of the Knee
  - Treatment of Osteochondral Defects
- Spine Surgery (when performed in an ambulatory surgical center, inpatient hospital or outpatient hospital)
  - Bone grafts
  - Bone growth simulators
  - Cervical/lumbar spinal fusions
  - Cervical/lumbar spinal laminectomies
  - Cervical/lumbar spinal discectomies
  - Cervical/lumbar spinal disc arthroplasty (replacement)
  - Spinal deformity (scoliosis/kyphosis)
  - Vertobroplasty/kyphoplasty

Radiation Oncology Program

This program applies for the following office, outpatient and free-standing facility services:

- 2D/3D conformational radiation therapy
- Intensity-modulated radiation therapy
- Intraoperative radiotherapy (IORT)
- Stereotactic radiosurgery
- Stereotactic body radiotherapy
- Brachytherapy
- Proton beam therapy
- Hypo fractionation for bone metastases, non-small cell lung cancer and breast cancer when requesting EBRT and IMRT
- Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
- Image Guidance Radiation Therapy (IGRT)

Who are in these programs?

Below are general guidelines to help identify the members that are a part of our utilization management programs. Always verify authorization requirements and member benefits on iLinkBlue, prior to rendering services.

- Fully insured members are a part of all programs. Fully insured members can be identified by the words "Fully Insured" on the member ID card.
- Self-Funded members (ASO plans) have an option to be in these programs or not. Self-funded member ID cards will include the group name but will NOT include the words "Fully Insured."
- Small Business Funded (SBF) members are a part of all programs. SBF members have "SBF" in the group number in the Group/Subgroup section of their member ID card.
- Office of Group Benefits (OGB) members are a part of all programs.

DRUG AUTHORIZATIONS

Authorization Requirements

As part of our drug utilization management program, prior authorization is required for certain prescription drugs. Providers may access this list of targeted medications under the Pharmacy section of our Provider page (www.BCBSLA.com/providers).

For details on how to request a prior authorization, please see the Authorizations information in the Quick Reference Guide at the front of this manual.

Appeals for drugs denied for medical necessity or experimental/investigational are handled by ESI or Blue Cross based on the member's benefit plan.

Pharmacy Benefit Drugs

Blue Cross is contracted with Express Scripts, Inc. (ESI), a pharmacy benefit manager, to perform prior authorizations for pharmacy benefit drugs. Ordering physicians are required to contact ESI to complete authorizations for pharmacy benefit drugs for members of our Preferred Care PPO and HMO Louisiana networks.

Medical Drugs

Blue Cross is contracted with Express Scripts, Inc. (ESI), a pharmacy benefit manager, to perform prior authorizations for targeted medical benefit drugs. Ordering physicians are required to contact ESI to complete authorizations for targeted medical benefit drugs for members of our Preferred Care PPO and HMO Louisiana networks.

Prior authorization for non-targeted medications are handled by Blue Cross. Please do not contact ESI for these medications.

Please refer to the Reporting National Drug Code (NDC) on Claims guidelines in the Billing and Reimbursement section of this manual for full billing and claims details.

For more information on covered drugs, go to the Pharmacy section of our Provider page.

Step Therapy Program

Step Therapy requires the member to try one or more Step 1 drugs, within select drug classes, prior to trying a more costly Step 2 drug. A benefit of this program is to lower out-of-pocket costs, ultimately decreasing the member's likelihood to stop taking medications due to the cost.

Step 1 – The member first tries one or more Step 1 drugs to treat a medical condition before Blue Cross/HMO Louisiana will cover* a Step 2 drug for that condition.

Step 2 – If Step 1 drugs are not clinically appropriate or have been tried and do not work for the member, then Blue Cross/HMO Louisiana will cover* a Step 2 drug for that condition.

The following drug categories are examples of prescription drugs that are included in the Step Therapy program:

• Acne Treatment Medications	• Oral Diabetes Medications
• Blood Pressure Medications	• Pain and Inflammation Medications
• Bone Medications	• Respiratory/Allergy Medications
• Cholesterol Medications	• Sleep Medications
• Depression Medications	• Stomach Acid Medications
• Frequent Urination Medications	• Triptan Migraine Medications
• Long-Acting Pain Medications	

For information on drug authorizations, visit the Pharmacy section of our Provider page. When a provider writes a prescription for a Step 2 drug within the classes listed above for a member with Step Therapy, the prescription will be denied at the point of sale at the pharmacy if the member has not already tried one or more Step 1 drugs. The pharmacy will inform the member and then contact the provider and advise of the member's Step Therapy benefits. If the provider determines Step 1 drugs aren't appropriate for the member, then the provider can complete the Drug Prior Authorization Form found on our Provider page for an authorization, and if approved, the provider can prescribe a Step 2 drug. If the providers' request does not meet the necessary criteria to start a Step 2 drug without first trying one or more Step 1 drugs, or if the provider or member insists on the Step 2 drug, then the member is responsible for the full cost of the drug.

For information on specific drugs under the program, visit the Pharmacy section of our Provider page.

* Coverage determination is subject to the member's eligibility and benefits. Please always verify member benefits prior to rendering services.

BEHAVIORAL HEALTH AUTHORIZATIONS

New Directions is an independent company that serves as the behavioral health manager for Blue Cross. New Directions manages behavioral health services for our members for authorizations, utilization management, case management and Applied Behavioral Analysis (ABA) case management.

Requests for behavioral health authorization should be submitted directly to New Directions via the Webpass Portal, available through iLinkBlue, under the "Authorizations" menu option. You may also contact New Directions at 1-800-991-5638.

The New Directions medical necessity criteria for behavioral health services can be found on the New Directions Behavioral Health website (www.ndbh.com) under "Policies & Manuals."

Behavioral Health Medical Necessity Appeals

First-level appeals on behavioral health services denied for medical necessity should be sent directly to New Directions at the address found on our Quick Reference Guide. If the decision is made to overturn the denial, a letter is sent to member and provider letting them know the denial was overturned and processing instructions are communicated to Blue Cross to pay the claim. If the decision is made to uphold the denial, a letter is sent to the member and provider directing them how and where to file a second-level appeal request.

Upon receipt of the second-level appeal, Blue Cross or the member's group (applies for some self-funded groups) will have an Independent Review Organization (IRO) review the case. This is a specialty-matched review. If the IRO upholds the denial, a letter is sent to the provider and member and appeals are exhausted. If the IRO overturns the denial, claims are paid.

MEDICAL RECORDS

Providers should maintain current, organized, well-documented medical records to facilitate communication, coordination and continuity of care. Records should document all care provided to members.

Blue Cross performs office reviews and Ambulatory Medical Record Review (AMRR) as a commitment to quality improvement. AMRR and site reviews may be conducted for any provider in the following circumstances:

- When requested by one of the medical directors based on quality indicator or provider corrective action processes; or
- At the discretion of the Health and Quality Management staff.

The purpose of the review will be to:

- Objectively monitor and evaluate the structural and operational aspects of the office site; and
- Conduct an overview discussion and assessment regarding the adequacy of medical record practices.

Results from the record keeping review will be used to initiate actions to improve practice management or medical record documentation.

Cloned or Template Generated Documentation

Medical record documentation must be specific to the patient's situation at the time of the service. Each patient will have a unique set of problems, symptoms and treatments, so the expectation is that documentation would not look exactly the same across patients. The expectation would also be that medical record entries for a patient would not be worded exactly alike or similar to previous entries. Please be cautious when using templates to generate the medical record to ensure that what is documented in the medical record actually occurred for that patient.

ADULT AND PEDIATRIC AMBULATORY MEDICAL REVIEW DEFINITION OF GUIDELINES

Pediatric:	Any child between infancy and puberty
Adult:	A fully grown and mature person
Time Frame:	Review all entries for the two years preceding the last visit

Part I – Demographic Guidelines

1. All pages with entries in the record contain patient identification

   Definition: Name, Social Security number or other unique patient identifier is on all pages with entries.

2. Personal biographical data

   Definition: The personal biographical data should include: address, employer, home and work telephone numbers and marital status. If the patient has no phone, the record should state "no phone." For pediatric cases, the employer of at least one parent, as well as the home and work phone numbers of at least one parent should be included.

Part II – Documentation Guidelines

1. Each entry in the record contains the author's name or initials

   Definition: An entry means documentation in the progress notes. This may include medication renewals and telephone orders. Author identification may be handwritten signature, an initialed-stamped signature or unique electronic identifier. Each entry has the author's name or initials. Documentation entered by someone other than the practitioner, must be counter-signed or counter-initialed. All signatures should be completed prior to billing for the service.

2. Each entry is dated

   Definition: This includes progress notes, problem list, medication list, assessment form, etc.

3. Each entry is legible

4. Smoking habits and history of alcohol or substance usage is noted

   Definition: For patients 14 years and older, smoking habits, ethyl alcohol (ETOH) use and substance use are noted in the history and physical progress notes. Counseling in reference to avoiding tobacco use, underage drinking and illicit drug use including, but not limited to, avoiding ETOH/drug use while swimming, boating, etc., are noted. For patients seen three or more times, query a substance use history.

5. A history and physical is noted for each visit

   Definition: The reason for the visit or chief complaint is noted. There is appropriate subjective and objective information noted pertinent to the patient's presenting complaints to include but not limited to height, weight and blood pressure.

6. Labs and other studies are ordered as appropriate
7. Each encounter has follow-up care, calls or visits noted

   Definition: Each physician encounter has a notation regarding follow-up care, calls or visits, unless there is a notation that previous problem has been resolved. The specific time of return is noted in days, weeks, months or PRN (as needed).
8. At each encounter, problems from previous visits are addressed, if applicable
9. Review of underutilization and overutilization of consultants

   Definition: There is evidence of continuity and coordination of care between primary and specialty physician. There is evidence of appropriate use of consults.
10. Consultant's report or note from consultant is received, if applicable

    Definition: If there was consult, there is a report of the consult in the record.
11. Consultation, lab and imaging reports filed in the chart are initialed and signify review
12. Immunization

    Definition: There should be an up-to-date immunization record for children. For adults, an appropriate history should be made.
13. Preventive Healthcare

    Definition: Documentation that preventive screenings and services are offered in accordance with current Preventive Medicine Guidelines. See our Provider page.

Guidelines – Critical Elements

1. The record contains an updated, completed problem list or summary of health maintenance exams

   Definition: An updated, completed problem list summarizing significant illnesses, medical conditions, past surgical procedures, or chronic health problems that is updated as new problems are encountered, as evidenced in the progress notes. The problem list can be in a separate section or can be listed as a problem in the progress notes. If no past or current illnesses, conditions or past surgical procedures, there is a statement that no current or past problems are noted. In this case, there is a summary of health maintenance exams such as well woman exam, well child exam, routine check up or complete physical exam.
2. Allergies and adverse reactions to medications are prominently displayed

   Definition: The patient's medication allergies and adverse reactions must be conspicuously listed in the ambulatory medical record or on the front or inside cover of the medical record folder. If allergies to medications are absent, "No Known Allergies" (NKA) or "NA" or "None" is conspicuously documented in the ambulatory medical record or on the front or inside cover of the medical record folder. Conspicuously means in an obvious location, e.g., upper corner or left or right side of the progress note. You should not have to search for this information.

3. There is a past medical history in the record

   Definition: For patients seen three or more times, a past history should be easily identified. "Easily identified," means it should be in one central area, not scattered throughout the chart. An inpatient history and physical taken by the provider is acceptable. For children and adolescents under the age of 18, past medical history will relate to prenatal care, operations, childhood illnesses and birth, to include, but not limited to: evidence of Hemoglobinopathy screening, Phenylalanine level, T4 and/or TSH and ocular prophylaxis. For patients seen less than three times, there is a past history noted for the current condition. For example, when there is a visit for hypertension, a family history, a patient history and a progress note for hypertension will be documented. For females more than 18 years of age, there must be an obstetrics and gynecological history. If there has been no break in the patient/physician relationship and there is a past history in the chart that was completed while the patient had another form of insurance, the guideline is satisfied.

4. Working diagnoses are consistent with findings
5. Treatment plans are consistent with diagnoses
6. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem

MEDICAL POLICY INQUIRY

Provider inquiries related to medical policy will be considered upon written request by a member's provider. All current medical policy coverage guidelines are available on iLinkBlue.

Requests for consideration must be accompanied by the supporting clinical information that is addressed within the medical policy.

Supporting Data Will be Assessed Against the Following Criteria:

- Have final approval from the appropriate government regulatory body;
- Have the scientific evidence that permits conclusions concerning the effect of the technology on health outcomes; or
- Improve the net health outcome; or
- Be as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

Procedure

Providers that contact Blue Cross to address coverage eligibility or investigational status of a treatment, procedure, device, drug or biological product addressed in a Blue Cross medical policy will be directed to submit:

- A written request that includes the nature of their inquiry; AND
- Pertinent peer-reviewed scientific evidence-based outcomes specific to the coverage eligibility guidelines or investigational status of the treatment, procedure, device, drug or biological product addressed within the medical policy.

Additionally:

- Written requests must include a return address or fax contact number.
- Supporting data will be reviewed by the medical director of the Medical Policy department and or appropriate Plan medical directors and consultants.
- Upon determination of review outcome written notification will be directed to the requesting provider within 60 days of receipt of request.

QUALITY MANAGEMENT (QM) PROGRAM

The goal of the QM Program is to continuously maximize and improve the healthcare services delivered to members and to ensure that the appropriate structures and processes are in place for a viable quality program.

The scope of the QM Program is a commitment to the continued development of ongoing systems to monitor and enhance healthcare services delivered to members in all settings. Activities reviewed, supported, performed and/or monitored by the program include, but not limited to, the following:

- Quality Blue – physician performance, hospital quality initiatives, transparency, Blue Distinction, Quality Blue Value Partnerships (QBVP) and Quality Blue Primary Care (QBPC)
- Accreditation
- Quality of care issues
- Grievance resolution
- Member satisfaction
- Credentialing and re-credentialing
- Performance measures: including Healthcare Effectiveness Data and Information Set (HEDIS), Quality Star Ratings (QRS)
- Utilization and management of services
- Health management and wellness activities to include Care Management
- Clinical, non-clinical and safety related quality improvement activities
- Preventive care guidelines
- Oversight of delegated functions including but not limited to pharmacy and radiology services as well as behavioral health

The QM Program has been established to facilitate the exchange of information and ideas for identifying opportunities for improvement as well as maintaining high standards of performance.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of healthcare performance measures developed by National Committee for Quality Assurance (NCQA) and used by Centers for Medicare & Medicare Services (CMS) for monitoring health plans and physicians to evaluate their performance in terms of clinical quality and customer service. Blue Cross participates in annual HEDIS reporting as a requirement to maintain our health plan accreditation and a subset of HEDIS measures is reported to CMS as a condition of certification and participation in the marketplace for Quality Rating System (QRS).

- HEDIS is a common set of comparable measurements that relates to current national clinical priorities. Measurement results are used for implementing interventions to close gaps in care and quality improvement projects/programs.
- QRS is a subset of HEDIS measures plus one Pharmacy Quality Alliance measure that is used for our STARS ratings.
- HEDIS data is collected in three different ways:
  - Administrative data (claims only)
  - Hybrid data (claims database and medical record review)
  - Survey data (member and provider surveys)

Provider's Role in HEDIS

- Provide appropriate care to meet the criteria and timeframes of each measure.
- Document care provided in the member's medical record.
- Submit accurate coding for claims.
- Provide medical records during the HEDIS process to help us validate the quality of care provided to our members
  - Medical record requests are faxed to providers and include a member list that indicates their assigned measures and the minimum necessary information needed
  - HEDIS data is collected and reviewed from January to May
  - Under the HIPAA Privacy Rule, data collection for HEDIS is permitted, and release of this information requires no special patient consent or authorization
  - Receiving all requested medical records (ideally in 5-7 business days) ensures that our results are an accurate reflection of care provided.
  - Provider agreements allow for the release of medical information to Blue Cross or its designee at no cost for quality improvement efforts.

QUALITY BLUE PRIMARY CARE (QBPC) OUTCOMES-BASED PROGRAM

Your patients are stronger than any diagnosis. And through the strong partnerships Blue Cross is building with healthcare providers around the state, we have a real opportunity to improve Louisiana's historically poor health outcomes and hold the line on costs. We stand strong with you, ready to support your patients on their journey toward optimal health.

The QBPC program promotes and enhances the identification and management of prevalent chronic diseases. Blue Cross contracts with primary care practices and provides, free of charge, a web-based, patient-centric information tool (MDinsight) that furnishes practices with data and resources that enable proactive, efficient, high-quality care. In addition, QBPC encourages value-based (as opposed to volume-based) practice methods by equipping providers with an outcomes-based payment structure, and helps to reduce costs through carefully managed care coordination. Practices will be financially rewarded for successfully achieving their goals as outlined in the *Quality Blue Primary Care Outcomes Program Policies and Procedures Manual* (available online at www.BCBSLA.com/Providers >Programs >Quality Blue >Quality Blue Primary Care) and in their QBPC program participation agreements. Each attribute of QBPC was designed to successfully facilitate the necessary transformation of chronic condition care.

QBPC is defined by three core elements:

1. Population Management: Integrating a health information exchange tool in practices facilitates population management by aggregating clinical and claims data.
2. Care Coordination Tools and Support: The development and integration of standardized workflows, tools, resources and best practices.
3. Process Improvement: Identify gaps in care and processes to improve closure. This includes collaborative action planning between the practice care team and Blue Cross in addition to participation in learning collaboratives and webinars.

The bottom line: QBPC will result in healthier patients, more satisfied providers and cost savings for all.

POPULATION HEALTH

The Centers for Disease Control and Prevention (CDC) views population health as an interdisciplinary customizable approach "that brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population." Blue Cross operates within this framework to establish programs that help to achieve positive health outcomes for members.

Key Components of the Population Health Improvement Model Include

- Population identification strategies and processes;
- Comprehensive needs assessments that assess physical, psychological, economic and environmental needs;
- Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles;
- Patient-centric health management goals and education, which may include primary prevention, behavior modification programs and support for concordance between the patient and the primary care provider;
- Self-management interventions aimed at influencing the targeted population to make behavioral changes;
- Routine reporting and feedback loops which may include communications with patient, physicians, health plan and ancillary providers;
- Evaluation of clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health.

The Population Health Improvement Model

- Encourages patients to have a provider relationship where they receive ongoing primary care in addition to specialty care;
- Complements the physician/practitioner and patient relationship and plan of care across all stages, including wellness, prevention, chronic, acute and end-of-life care;
- Assists unpaid caregivers, such as family and friends, by providing relevant information and care coordination;
- Offers physicians additional resources to address gaps in patient healthcare literacy, knowledge of the healthcare system and timeliness of treatment;
- Assists physicians in collecting, coordinating and analyzing patient specific information and data from multiple members of the healthcare team including the patients themselves;
- Assists physicians in analyzing data across entire patient populations;

- Addresses cultural sensitivities and preferences of individuals from disparate backgrounds;
- Promotes complementary care settings and techniques such as group visits, remote patient monitoring, telemedicine, telehealth and behavior modification and motivation techniques for appropriate patient populations.

CARE MANAGEMENT PROGRAMS

Your patients are stronger than any disease or diagnosis. Blue Cross' clinical team stands with you, ready to support your patients on their journey to optimal health. We have multi-disciplinary teams of clinical professionals, including doctors, nurses, pharmacists, dietitians and social workers. We also offer many long-standing, results-driven programs to support your patient relationships and help our mutual customers—your patients, our members—achieve their health and wellness goals.

These programs include:

- Case Management
- Disease Management
- Rare Condition Management in partnership with Accordant, an independent health management company
- Preventative and Wellness Services
- Behavioral Health Management in partnership with New Directions, an independent behavioral health management company
- Utilization Review
- Pharmacy

Help your patients be stronger than their diagnosis. There is no out-of-pocket cost to a patient to work with a Blue Cross health coach. Patients can learn more about our available programs and clinical staff at www.bcbsla.com/Stronger.

For details on how to make referrals to a program or on how patients enrolled in a Blue Cross Care Management Program can opt out, please see the Care Management information in the Quick Reference Guide at the front of this manual.

Case Management

Case Management programs encourage collaborative relationships among a member's healthcare providers, and help members and their families maximize efficient utilization of available healthcare resources. These programs include:

- **Discharge Outreach**: Nurses engage select patients at high risk of readmission within 48-72 hours of discharge to assess their needs, make sure they are taking any medication as directed, coordinate care and help them lower their risks of complications and/or readmissions.
- **ER Outreach**: Our health coaches work with your patients who go to the ER often to connect them with primary care providers who can handle most of their health needs when they are sick or injured. We want to help your patients access care in the right setting outside of office visits with you and save on their out-of-pocket cost so they get the most value out of their health plan benefits.

- **Healthy Blue Beginnings**: All pregnant women have access to educational information and resources through Text 4 Baby, a program that helps moms-to-be improve pregnancy and birth outcomes. We work with pregnant patients who are at-risk for premature births to educate them on their conditions and the risks involved, promote safety and support optimal health for mother and baby. This helps improve pregnancy/birth outcomes, reduce NICU stays and lower overall costs associated with pre-term births and pregnancy complications.
- **High Utilizers/High Cost**: Blue Cross encourages all of its members to have a primary care provider who handles most of their health needs when they are sick or injured. We particularly emphasize this for patients who have a lot of healthcare needs. The overall goal is to help these patients with care coordination and lower their risks of admissions and readmissions.
- **Oncology Management**: We support patients who are in active cancer treatment to help them manage treatment side effects and symptoms, assess access to care and coordinate services. We also offer education on Louisiana Physician Orders for Scope of Treatment (LaPOST) and other life care-planning legal documents.
- **Tobacco Cessation**: Nurses help patients who are trying to quit smoking or using tobacco to work through the stages of this change, set and meet goals and stick to quitting. Nurses also connect these patients with primary care doctors, community resources and other support services.
- **Transplant Care Management**: We work with patients who have had organ/tissue transplants to educate them on risks, promote safety, manage comorbidities and offer support throughout their care experience. This program helps improve transplant outcomes, lower the risk for hospitalizations and readmission, and lower overall costs associated with the transplant.

Disease Management

Blue Cross health coaches are here to help your patients stay on top of their long-term health needs. These programs aim to improve the physical and psychosocial well-being of patients through cost-effective, personalized solutions. Your patients are stronger than any diagnosis, and we will empower them to reach their best health.

Blue Cross Disease Management programs are here to support your patients who have any of the following health conditions:

- Asthma
- Chronic Kidney Disease (also part of Quality Blue Primary Care)
- Chronic Obstructive Pulmonary Disease

- Congestive Heart Failure
- Coronary Artery Disease/Hypertension (also part of Quality Blue Primary Care)
- Diabetes (also part of Quality Blue Primary Care)
- End Stage Renal Disease
- Pre-diabetes/Metabolic Syndrome

Please Note: Blue Cross is constantly assessing the market and may add Disease Management Programs for other conditions as appropriate.

Rare Condition Management

Blue Cross offers the My Health, My Way program* in partnership with Accordant, an independent health management company, to support patients who have any of 17 rare conditions with health coaching, follow-up and education.

My Health, My Way supports patients who have any of the following 17 rare chronic conditions:

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Crohn's Disease
- Ulcerative Colitis
- Cystic Fibrosis (CF)
- Dermatomyositis
- Gaucher Disease
- Hemophilia
- Multiple Sclerosis (MS)
- Myasthenia Gravis (MG)
- Parkinson's Disease (PD)
- Polymyositis
- Rheumatoid Arthritis (RA)
- Scleroderma
- Epilepsy (Seizures)
- Sickle Cell Disease
- Systemic Lupus Erythematosus (SLE or Lupus)

*To see if your patient is eligible for this program, please contact the Blue Cross Care Management team at the number found on our Quick Reference Guide in the front of this manual.

MATERNITY MANAGEMENT PROGRAM - HEALTHY BLUE BEGINNINGS

Our maternity management program, Healthy Blue Beginnings, helps promote early and compliant prenatal care and offers case management support when required. If a provider has patients who are pregnant or are thinking of becoming pregnant, they should notify our maternity program staff who will assess the patient for risks and provide lifestyle risk modification coaching, and reliable information resources. Locate the Care Management Disease Management (CMDM) Referral Form online at www.BCBSLA.com/providers >Programs >Care Management. Providers should complete and fax it to (225) 298-3184 to have a patient enrolled. Providers may also contact us directly or have the patient call Blue Cross and ask to speak with a nurse. Once a patient is enrolled, providers will receive the following:

- Written or telephonic notification of the patient's enrollment along with the nurse's contact information.
- Notification when the Blue Cross nurse identifies the patient may be in need of healthcare services via a care coordination nurse call.
- Access to claims-based Blue Health Records with up to three years of claims history (through iLinkBlue).
- When members self-refer to the program who do not have an established physician relationship, providers receive a patient referral by Blue Cross nurses.

A successful maternity management program is dependent on early identification of patients planning to become pregnant, or who have recently identified they are pregnant. The physician plays a key role in the delivery of the program and this program is intended only to complement the medical care received from providers.