SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.23 MEDICATION SUBSTITUTION

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection 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.

MEDICATION SUBSTITUTION

Louisiana Senate Bill 545 of Act 396, R.S. 22: 1007 (J) states that network providers will be reimbursed when there is a need to substitute a specific medication. This only applies to brand drug substitutions required by Blue Cross, for which the provider executes the substitution. This does not apply to generic substitutions or Step Therapy Programs.

To receive reimbursement, the provider should submit the CPT code 99499 with Modifier TS appended. The use of this code must be supported in the member's medical records and is payable once per date of service to include all substitutions made. This fee is not applicable to non-participating providers. Claims submitted for this fee from providers who are non-participating will be rejected. There is no member cost share associated with this fee. The fee is subject to routine audit.