You Need an Administrative Representative

In early 2017, the iLinkBLUE Provider Suite will be enhanced and moved under a higher level of security to meet additional compliance requirements. We know iLinkBLUE is such an important tool for many offices, offering online access to benefits, eligibility, claims information, electronic fund transfers and more.

To access the enhanced iLinkBLUE, providers must have an administrative representative. This makes it critical for providers to designate an administrative representative by the end of 2016. You will lose access to iLinkBLUE if your organization does not have an administrative representative.

Currently, administrative representatives delegate access to clinical users for our Authorizations Portal and the Blue Advantage (HMO) Provider Portal. By the end of 2016, administrative representatives will delegate access to all iLinkBLUE users. For this reason, it is important to make sure your administrative representatives are the appropriate staff members. You may have or require more than one administrative representative at a location, as needed.

Find out how to setup an adminitrative representative on Page 2 of this newsletter.

What is an administrative representative?

- A person designated to serve as the key person for delegating access to appropriate users for the provider
- A person who agrees to adhere to Blue Cross’ guidelines
- A person who will only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities
- A person who promptly terminates employee access when an employee changes roles or terminates employment
Removing the PCP Name from ID Cards

As of July 1, 2016, member ID cards no longer include the name of the member’s primary care physician (PCP). New members will continue to select a PCP as usual. The difference is they receive an ID card without the PCP’s name on it. If an existing Community Blue or BlueConnect member calls customer service and requests a PCP change, the customer service advisor informs the member that the PCP change will be made, and the current ID card is still good.

If a member presents an ID card and you are not listed as the PCP, you may see the member as long as you participate in the network shown on the ID card.

Individual Coordination of Benefits Update

We are now applying coordination of benefits between individual members and Medicare, as well as between individual members and group coverage for both commercial and other Blue Cross and Blue Shield coverage. Previously, coordination of benefits only applied for group members, not individual members.

Coordination between two individual contracts is not currently allowed under Louisiana law.

When coordinating benefits between individual contracts and group coverage, the individual contract is always secondary. This change does not affect group benefits or the order of benefit determination for members with group coverage.

How to Designate an Administrative Representative

1. Determine who at your office or facility should be an administrative representative, then send an email to Blue Cross’ Provider Identity Management Team at ProviderIdentMgmt@bcbsla.com to request a profile setup for your designated administrative representative(s).

2. You will receive an email from ProviderIdentMgmt@bcbsla.com that includes the Administrative Representative Acknowledgment Form and Administrative Representative Profile Setup spreadsheet.

3. Email completed documents to ProviderIdentMgmt@bcbsla.com.

4. Blue Cross will thereafter set up each administrative representative with access to our Security Setup Tool.

5. You will then receive an email with detailed instructions on how to log into the Security Setup Tool.

6. Once set up, designated administrative representatives will delegate access to appropriate employees at your office or facility so they may access all our available online tools.
Jode Burkett New Network Development Manager

We are pleased to announce Jode Burkett as the new Blue Cross network development manager. Jode manages all projects involving network adequacy reviews and tracking, Blue Cross Association initiatives including Blue Distinction certifications and supervises our Network Specialist Team.

Jode Burkett comes to Blue Cross with 12 years of experience in the Medicaid program. Most recently he was the Medicaid program manager of network adequacy, provider services and transportation at the Louisiana Department of Health and Hospitals.

Jode obtained his Bachelor of Science in psychology from LSU and enjoys economics, history, wildlife and health and wellness.

Requests for Medical Records

Reviewing medical chart documentation is a key component of medical audits. For example, it enables us to identify conditions you have noted in the progress notes, but were:

- Not included on the claim at the time of the visit
- Not coded to the highest degree of specificity at the time of the visit

You are required to provide us with medical records at no charge as outlined in your Blue Cross network agreement:

*Provider shall provide Blue Cross, upon request and without charge to Blue Cross or Member, information including medical records of a Member reasonably required by Blue Cross to determine benefits and verify services related to provider's attendance, examination, and/or treatment and allow Blue Cross on-site audit of such records.*

For questions about your Blue Cross and HMO Louisiana contract obligations, please contact Provider Relations at provider.relations@bcbsla.com or 1-800-716-2299, option 4.

Receive Network News via Email

If you received this newsletter via hardcopy, it is because we do not have your correspondence email address on file. To receive the newsletter via email, please use the Provider Update Request Form to send us your current correspondence information.

The form is available online at www.bcbsla.com/providers >Forms for Providers.

Missed Our Webinars and Workshops? Don’t Worry!

If you missed one of our webinars or provider workshops, you can still view the presentations on our website. They are available at www.bcbsla.com/providers >Education on Demand >Provider Workshops and Webinars.
Blue Cross to Implement a Closed Formulary in 2017

Blue Cross will update its list of covered drugs—or formulary—to support safe, effective, lower-cost drugs. The change begins January 1, 2017, and goes into effect when individual and small group members renew their plans throughout the year. The new drug list includes thousands of generic and brand drugs. Independent Louisiana doctors and pharmacists, with input from Blue Cross clinical staff, advised which drugs to include in the new formulary.

The key changes to drug coverage in 2017 include:

- Non-formulary drugs will not be covered.
- Drugs with over-the-counter options will not be covered.
- Drug kits that include or are packaged with a non-prescription product will not be covered, but the prescription drug may be covered when purchased alone.

The new drug lists will be posted at www.bcbsla.com/pharmacy by November 1, 2016.

Most Blue Cross and HMO Louisiana individual and small group members whose pharmacy benefits are administered by Express Scripts will have a more selective covered drug list.

Please keep these changes in mind when ordering prescriptions for your patients to help keep their costs down.

Behavioral Health Authorizations Portal Now Available

Blue Cross has partnered with New Directions to manage authorizations for our members, perform all utilization and case management activities, as well as ABA case management. The Behavioral Health Authorizations application is a web-based tool offered by New Directions called the Webpass Portal. It is now available to facilities through the Authorizations Portal on iLinkBLUE (www.bcbsla.com/iLinkBLUE). This application allows network providers to submit authorizations and provide clinical information.

Blue Cross requires an authorization for the following behavioral health services:

- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)
- Applied Behavior Analysis (ABA)*

*Online authorizations are not available for this service.

You must have an administrative representative to access the portal and this application. Please refer to Page 2 in this newsletter on how to designate an administrative representative.

Didn’t get an invite to our Behavioral Health Workshop?

Send us an email: provider.communications@bcbsla.com

New Directions is an independent company that serves as the behavioral health manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.
Billing & Coding

Reporting National Drug Codes (NDCs) on Claims

We require all clinician-administered drugs billed on professional and outpatient hospital claims to be processed through the member’s medical benefits to include the NDCs for the drugs. Providers are required to report NDCs on claims with any associated HCPCS or CPT® codes including immunizations. (HCPCS codes beginning with the letter “A” are excluded from this requirement). Failure to report NDCs on claims will result in automatic rejections.

Providers should use the following billing guidelines to report NDCs on professional CMS-1500 claims and outpatient facility UB-04 claims:

- NDC code editing will apply to any clinician-administered drug billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter “A”).
- Each clinician-administered drug must be billed on a separate line item.
- Claims that do not meet the requirements will be rejected and returned on your “Not Accepted” report. Units indicated would be “1” or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs.

The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim:

- NDCREQD – NDC CODE REQUIRED
- INVNDC – INVALID NDC

For complete NDC reporting guidelines on professional and facility claims, consult our provider manuals available under the Manual section of iLinkBLUE (www.bcbsla.com/ilinkblue) and at www.bcbsla.com/providers >Education on Demand.

NDC Reporting Clarification

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format. If the NDC is not submitted in the correct format, the claim will be denied.

See the examples below:

<table>
<thead>
<tr>
<th>10-Digit Format on Package</th>
<th>10-Digit label format Example</th>
<th>11-Digit Format</th>
<th>11-Digit Format Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-4-2</td>
<td>99999-9999-99</td>
<td>5-4-2</td>
<td>09999-9999-99</td>
</tr>
<tr>
<td>5-3-2</td>
<td>99999-999-99</td>
<td>5-4-2</td>
<td>99999-0999-99</td>
</tr>
<tr>
<td>5-4-1</td>
<td>999999-9999-99</td>
<td>5-4-2</td>
<td>999999-9999-09</td>
</tr>
</tbody>
</table>
New Billing Guidelines for Therapy Services

We recently made significant changes to the billing guidelines for therapy services. These changes include multiple procedure reductions and the bundling of hot and cold packs. The new billing guidelines for Blue Cross and HMO Louisiana will be effective for claims with dates of service on and after November 1, 2016.

Multiple Procedure Reduction

We will apply multiple procedure reductions to codes 64550, 95831-95852, 97005-97799 and G0283 when billed on the same day. If services are provided on the same day by providers in different specialties (i.e. physical therapy and occupational therapy), the multiple procedure reduction applies separately for each provider specialty.

Individual CPT® or HCPCS codes billed with multiple units will be reimbursed based on the allowable charge at:

- 100% for the first unit
- 90% for the second, third and fourth unit
- 5% for five or more units

Each CPT or HCPCS will be reduced as follows:

- 100% for the primary, secondary and tertiary procedure
- 50% for the fourth procedure
- 5% for any additional procedures

Hot and Cold Packs

Hot and cold packs will not be reimbursed separately. They are included in the therapy service.

Remind Your Patients to Get Their Flu Shot

Each year, millions of people suffer from the flu, a highly contagious infection. It spreads easily from person to person and can be life threatening in older adults and in people of any age who have a chronic illness such as heart, kidney or lung disease.

The Centers for Disease Control (CDC) recommends that everyone six months old and older get a flu shot each year. Vaccines are safe and the most effective flu prevention.

Please encourage your patients to get their annual flu shot. We will cover the flu shot at 100 percent when members receive their flu vaccine from a network provider or participating retail pharmacy. This means our members will pay no copayment, no coinsurance and no deductible for their flu shot.

(Note: if providers file the flu shot with a sick or regular visit, members must still pay their copayment or deductible as applicable for the sick services).

Please use appropriate HCPCS and CPT codes when billing for the flu vaccine:

- Administration of vaccine: G0008
- Vaccine: 90655-90660, 90662

Specificity of Codes

It is important to file ALL applicable diagnosis codes (supported by the patient’s medical records) on a claim. It is equally important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing "not otherwise specified" (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.
Updated Code Ranges

As a reminder from previous communications, based on reviews of new 2016 CPT and HCPCS codes, we have updated the Outpatient Procedure Services and Diagnostic and Therapeutic Services code ranges as follows:

Effective **April 1, 2016**, the following HCPCS codes were added to the Diagnostic and Therapeutic Services code range and the Outpatient Hospital Drug list:

<table>
<thead>
<tr>
<th>C9137</th>
<th>C9470</th>
<th>C9473</th>
<th>G9481</th>
<th>G9484</th>
<th>G9487</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9138</td>
<td>C9471</td>
<td>C9474</td>
<td>G9482</td>
<td>G9485</td>
<td>G9488</td>
</tr>
<tr>
<td>C9461</td>
<td>C9472</td>
<td>C9475</td>
<td>G9483</td>
<td>G9486</td>
<td>G9489</td>
</tr>
</tbody>
</table>

Effective **June 1, 2016**, the following CPT codes were moved from the Diagnostic and Therapeutic Services code range to the Outpatient Procedure Services code payment categorizations.

| 93650 | 93654 | 93656 | 93653 | 93655 | 93657 |

Effective **July 1, 2016**, the following CPT codes were added to the Outpatient Procedure Services code list:

| 0437T | 0440T | 0442T | 0438T | 0441T | 0443T |

Effective **July 1, 2016**, the following CPT and HCPCS codes were added to the Diagnostic and Therapeutic Services code range and the Outpatient Hospital Drug list:

<table>
<thead>
<tr>
<th>0439T</th>
<th>0445T</th>
<th>C9477</th>
<th>C9479</th>
<th>Q5102</th>
<th>Q9982</th>
</tr>
</thead>
<tbody>
<tr>
<td>0444T</td>
<td>C9476</td>
<td>C9478</td>
<td>C9480</td>
<td>Q9981</td>
<td>Q9983</td>
</tr>
</tbody>
</table>

Effective **October 1, 2016**, the following HCPCS codes are being added to the Diagnostic and Therapeutic Services code range:

<table>
<thead>
<tr>
<th>C9139</th>
<th>C9481</th>
<th>C9482</th>
<th>C9483</th>
<th>C9744</th>
<th>G0490</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0498</td>
<td></td>
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</tbody>
</table>

These changes do not affect existing codes and allowable charges on the Diagnostic and Therapeutic Services schedules; it simply allows our system to accept these codes appropriately for claims adjudication. The above changes also apply to the HMO Louisiana, Inc. Diagnostic and Therapeutic Services schedule.

Sick (Boarder) Baby Billing Protocol

Blue Cross, including HMO Louisiana, recently updated our sick (boarder) baby billing protocol.

Upon delivery of a newborn, if the baby’s discharge date is prior or equal to the mother’s discharge date, the newborn’s charges are generally combined with the mother’s inpatient hospital claim.

If the baby is sick and the discharge date is after the mother’s discharge date, the sick (boarder) baby charges should be filed as a separate claim.

- These charges should not be combined with the mother’s claim. The admit date of the baby’s claim should be the baby’s date of birth, not the mother’s discharge date.

The facility should request a “temporary” authorization for the baby’s stay under “baby girl” or “baby boy.” A temporary authorization can be requested within 48 hours of admission or when mom is discharged.
**Medical Policy Update**

Blue Cross regularly develops and revises medical policies in response to rapidly changing medical technology. Our commitment is to update the provider community as medical policies are adopted and/or revised. Benefit determinations are made based on the medical policy in effect at the time of the provision of services. Please view the following updated medical policies, all of which can be found on iLinkBLUE at [www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue).

### New Medical Policies

<table>
<thead>
<tr>
<th>Policy No.</th>
<th>Policy Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective June 20, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00505</td>
<td>Transtympanic Micropressure Applications as a Treatment of Meniere Disease</td>
</tr>
<tr>
<td><strong>Effective July 20, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00497</td>
<td>Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy)</td>
</tr>
<tr>
<td>00504</td>
<td>Genetic Testing for PALB2 Mutations</td>
</tr>
<tr>
<td>00510</td>
<td>Genetic Testing for Heterozygous Familial Hypercholesterolemia</td>
</tr>
<tr>
<td>00511</td>
<td>reslizumab (Cinqair®)</td>
</tr>
<tr>
<td><strong>Effective August 17, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00512</td>
<td>Proteogenomic Testing for Patients With Cancer (GPS Cancer™ Test)</td>
</tr>
<tr>
<td>00514</td>
<td>Treatment of Hepatitis C with sofosbuvir/velpatasvir (Epclusa®)</td>
</tr>
<tr>
<td><strong>Effective September 1, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00513</td>
<td>ixekizumab (Taltz®)</td>
</tr>
</tbody>
</table>

### Recently Updated Medical Policies

<table>
<thead>
<tr>
<th>Policy No.</th>
<th>Policy Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes Effective June 20, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00075</td>
<td>Intra-articular Hyaluronan Injections for Osteoarthritis of the Knee</td>
</tr>
<tr>
<td>00108</td>
<td>Sacral Nerve Neuromodulation/Stimulation</td>
</tr>
<tr>
<td>00215</td>
<td>Advanced Therapies for Pharmacological Treatment of Pulmonary Hypertension</td>
</tr>
<tr>
<td>00287</td>
<td>Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting</td>
</tr>
<tr>
<td>00323</td>
<td>Long-Acting Oral Opioids</td>
</tr>
<tr>
<td>00403</td>
<td>Gene Expression Profiling and Protein Biomarkers for Prostate Cancer Management</td>
</tr>
<tr>
<td><strong>Changes Effective July 20, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00233</td>
<td>KRAS, NRAS and BRAF Mutation Analysis in Metastatic Colorectal Cancer</td>
</tr>
<tr>
<td>00260</td>
<td>Spinal Cord Stimulation</td>
</tr>
<tr>
<td>00306</td>
<td>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors, DPP-4 Inhibitor Combination Drugs, Cycloset® (bromocriptine)</td>
</tr>
<tr>
<td>00357</td>
<td>Overactive Bladder Medications (Branded)</td>
</tr>
<tr>
<td><strong>Changes Effective August 17, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00291</td>
<td>Laboratory and Genetic Testing for Use of 5-Fluorouracil in Patients With Cancer</td>
</tr>
<tr>
<td>00359</td>
<td>Sedative Hypnotics</td>
</tr>
<tr>
<td>00360</td>
<td>Selective Serotonin Reuptake Inhibitors (SSRIs)/Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)</td>
</tr>
<tr>
<td>00385</td>
<td>Sodium-Glucose Co-Transporter-2 (SGLT-2) Inhibitors and Combination Products</td>
</tr>
<tr>
<td>00455</td>
<td>Treatment of Hepatitis C with sofosbuvir/ledipasvir (Harvoni®)</td>
</tr>
<tr>
<td>00479</td>
<td>Treatment of Hepatitis C with daclatasvir (Daklinza™) plus sofosbuvir (Sovaldi®)</td>
</tr>
<tr>
<td><strong>Changes Effective September 21, 2016</strong></td>
<td></td>
</tr>
<tr>
<td>00292</td>
<td>Sinus Ostial Dilatation with Balloon Catheter for Rhinosinusitis</td>
</tr>
</tbody>
</table>

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**Medical Policy Coverage Legend**

These symbols are referenced next to medical policies listed on this page and indicate Blue Cross’ coverage indications as follows:

- **I** Investigational
- **C** Eligible for coverage with medical criteria
- **N** Not medically necessary

Provider inquiries for reconsideration of medical policy coverage, eligibility guidelines or investigational status determinations will be reviewed upon written request. Requests for reconsideration must be accompanied by peer-reviewed, scientific evidence-based literature that substantiates why a technology referenced in an established medical policy should be reviewed. Supporting data will be reviewed in accordance with medical policy assessment criteria. If you have questions about our medical policies or if you would like to receive a copy of a specific policy, log on to iLinkBLUE at [www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue) or call Provider Services at (800) 922-8866.
**Help Your Patients Quit for a Day with the Great American Smokeout, November 17**

The American Cancer Society (ACS) marks the Great American Smokeout on the third Thursday of November each year by encouraging smokers to use the date to make a plan to quit, or to plan in advance and quit smoking that day. Providers may wish to use this event to help their patients who use tobacco try to quit—even for one day—and take an important step toward a healthier life.

Through observances like this, and in addition to its work with statewide healthcare providers and hospital systems, the Louisiana Smoking Cessation Trust shares its message with Louisiana smokers that applying now to be an approved Trust Member is one of the best free things they can do for themselves and their loved ones. Earlier this year the Trust ([smokefreela.org](http://smokefreela.org)) hit a major milestone, with 50,000 Louisiana smokers signed up to quit.

The Smoking Cessation Trust began in 2012 as the result of a court judgment in a class action lawsuit ordering certain tobacco companies to fund a statewide smoking cessation program to benefit Louisiana residents who smoked a cigarette before September 1, 1988.

Applicants who register for the smoking cessation program and are approved (usually in one day) as qualified recipients will be eligible to receive any of the following cessation services completely free: cessation medications (such as Zyban® and Chantix®), nicotine replacement therapy (gum, patch, lozenge, inhaler, nasal spray), individual or group cessation counseling, telephone quit-line support or intensive cessation support services. Evidence suggests that using these services will increase participants’ success rates in their attempts to stop smoking.

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**Medical Policy Highlight**

**Policy No. 00292**

Effective for dates of service on and after September 21, 2016, we have updated the patient selection criteria for our Sinus Ostial Dilation with Balloon Catheter for Rhinosinusitis medical policy.

Coverage eligibility will be met when the following criteria are present for chronic rhinosinusitis:

- Chronic rhinosinusitis in an adult which has persisted for a minimum of 12 weeks despite failure of aggressive medical therapy. This should include documentation of treatment with all of the following:
  - Saline nasal irrigations or saline nasal spray
  - Intranasal corticosteroids for at least 8 weeks
  - Two courses of antibiotics or one prolonged course of oral antibiotic for at least 21 days
  - Chronic rhinosinusitis of the sinus to be dilated is confirmed on computed tomography as evidenced by significant mucosal thickening of greater than 3 mm, opacification, or air-fluid levels documented by a formal CT scan report from an independent radiologist.

Coverage eligibility will be met when the following criteria are present for recurrent acute rhinosinusitis:

- Four or more documented and treated episodes in a 12 month period; and
- CT imaging performed during the fourth episode should demonstrate pathology in the sinus to be dilated that meets the same CT imaging criteria (significant mucosal thickening of greater than 3 mm, opacification, or air-fluid levels documented by a formal CT scan report from an independent radiologist.)
**HEDIS: Well-child Visit (Ages 3-6 years)**

This measure is the percentage of members, 3-6 years of age, who received one or more well-child visits with a primary care physician (PCP) or pediatrician during the measurement year. As a reminder, continue to use appropriate procedure and diagnosis codes, which may include the following codes for children’s annual wellness visits:

**CPT® Codes for Well-child Visits:** 99382, 99383, 99392 and 99393  

**ICD-10 Codes for Well-child Visits:** Z00.121, Z00.129, and Z00.8

Remember, you may bill for a preventative evaluation and management (E&M) service (well-child visit) and a problem-oriented E&M service (sick visit) on the same day and be reimbursed for both by filing the well-child CPT code and the sick-visit CPT code with Modifier 25.

Our HEDIS rates for the well-child visits (3-6 years) measure continue to increase; however, we have identified a gap in critical documentation in the medical records. Insufficient documentation from a well-child or preventative care visit in a patient’s medical record cannot only negatively impact the well-child 3-6 years HEDIS measure, but also other HEDIS measures such as “Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).” It is crucial that the patient’s medical record from a well-child visit include documentation of key aspects of the visit such as a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of the following:

- A health, physical and mental developmental history including a physical exam.  
- BMI percentile – Documentation must include height, weight and BMI percentile during the measurement year from the same data source. Documenting only the BMI is not acceptable; the BMI percentile must be documented in the medical record.  
- Counseling for nutrition – Documentation must include a note indicating the date and at least one of the following:  
  - Discussion of current nutrition behaviors (i.e. eating habits, dieting behaviors) or using to a checklist to indicate nutrition was addressed  
  - Counseling on nutrition, weight or obesity or referral for nutrition education  
  - Giving the patient educational materials and anticipatory guidance on nutrition during a visit  
- Counseling for physical activity – Documentation must include a note indicating the date and at least one of the following:  
  - Current physical activity behaviors (i.e. exercise routine, participation in sports) or using a checklist to indicate physical activity was addressed  
  - Giving the patient educational materials or anticipatory guidance on physical activity during visit  
  - Counseling about weight, obesity or physical activity

If your patients want more information about why a yearly checkup with a PCP is important for their overall health, they can visit [www.bcbsla.com/PCP](http://www.bcbsla.com/PCP).

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Member Gaps Report for QB Providers

Blue Cross has a new tool in iLinkBLUE (www.bcbsla.com/ilinkblue) called the Member Gaps Report, which is available to Quality Blue providers only. The Member Gaps Report provides information on members with suspected documentation coding gaps (GAPS) for commercial risk adjustment. Chronic conditions must be documented for a member every calendar year. GAPS are generated when a suspected chronic condition is not documented in the current calendar year.

The members included in this report are enrolled in individual and small group Affordable Care Act (ACA) approved plans offered both on and off of the healthcare exchange. Providers should review this report at least quarterly to identify their attributed members with suspected GAPS.

Quality Blue providers can learn more about this report by viewing our Member Gaps Report Tidbit, located online at www.bcbsla.com/providers > Education on Demand > Tidbits.

Are You Ready for Hurricane Season?

It’s always smart to be ready for hurricanes during the months of June to November, but severe weather could strike at any time.

Your members start by taking this smart step:

• Sign up for an online account on www.bcbsla.com/activate. No matter where your patients are, they can get their claims or drug history, which they can share with their doctors or the pharmacy while they are away from home.

Visit www.bcbsla.com/hurricane for more information about hurricane and severe weather preparedness with regard to your patients’ healthcare.

Get Paperless EOBs Today!

Did you know your patients can get their explanation of benefits (EOB) forms online instead of through the mail? They can and it’s really easy to do!

Here’s how to get paperless EOBs:

1. Log in to your online account at www.bcbsla.com.
2. Under Account Management, click "My Preferences."
3. Under My Services, click "Paperless."

After they have changed their settings, we’ll stop mailing paper copies of their EOBs. Instead, we’ll post each one to their account and send them an email when one is ready to view.

Go Paperless Today!

*Members can change back to paper EOBs at any time. They just need to click “U.S. Mail" in their account settings to begin receiving paper copies of their EOB by mail. They can always print one from their online account or call Customer Service using the number on their ID card to request a paper copy free of charge.

Please share the information in this newsletter with your billing staff and those at your office who work with Blue Cross reimbursement.
What's New on the Web

www.bcbsla.com/providers

- **UPDATED** In-office Lab Lists are available on our HMO Louisiana Preferred Lab, Blue Connect, Community Blue and OGB speed guides under the Education on Demand section

- **UPDATED** Utilization Management Approval and Denial Fax Form is available under the Forms for Providers section

Important Contact Information

Authorization
See member’s ID card

BlueCard® Eligibility
(800) 676-BLUE (800-676-2583)

EDI Clearinghouse
(225) 291-4334
EDICH@bcbsla.com

FEP
(800) 272-3029

Fraud & Abuse
(800) 392-9249
Fraud@bcbsla.com

iLinkBLUE & EFT
(800) 216-BLUE (800-216-2583)
iLinkBLUE.ProviderInfo@bcbsla.com

Network Administration
(800) 716-2299  Fax: (225) 297-2750
Network.Administration@bcbsla.com

Provider Services Call Center
(800) 922-8866

Claims Filing Address
P.O. Box 98029
Baton Rouge, LA 70898

Get This Newsletter Electronically

Your correspondence email address allows us to electronically keep you abreast of the latest Blue Cross news and some communications that are sent via email only. Email provider.communications@bcbsla.com and please include a contact name, phone number and your provider number.

Network News

Network News is a quarterly newsletter for Blue Cross and Blue Shield of Louisiana network providers. We encourage you to share this newsletter with your staff.

The content in this newsletter is for informational purposes only. Diagnosis, treatment recommendations and the provision of medical care services for Blue Cross members are the responsibilities of healthcare professionals and facility providers.

View this newsletter online at www.bcbsla.com/providers, then click on News.

The content in this newsletter may not be applicable for Blue Advantage (HMO), our Medicare Advantage product and provider network. For Blue Advantage, we follow CMS guidelines, which are outlined in the Blue Advantage (HMO) Provider Administration Manual, available on the Blue Advantage Provider Portal through iLinkBLUE (www.bcbsla.com/iLinkBLUE).