

March 2006

Gearing up for the NPI

The deadline for required use of National Provider Identifiers (NPIs) is merely a year away. Blue Cross is committed to keeping our providers informed of the changes that will take place from now until the NPI is required for filing all claims on May 23, 2007. This includes informing you on how changing to the NPI will affect filing claims with Blue Cross before the deadline.

Currently, you can apply for your NPI in either of the following ways:

1. Through a web-based application process at www.nppes.cms.hhs.gov.
2. By sending a paper application form to the Enumerator. Application forms can be found at www.nppes.cms.hhs.gov or call (800) 465-3203.

Currently, we do not require NPIs; however, in order to remain compliant with HIPAA guidelines, we will require NPIs by the official deadline of May 23, 2007. We will give you prior notice before we begin accepting claims with your NPI. Initially, we will require that you submit claims with both your NPI and your Blue Cross provider number.

Once we completely transition our claims processing to accept only NPIs, we will again send you prior notice letting you know that you can submit claims with just your NPI. At that time, Blue Cross will require an NPI for both electronic and paper claims. Additionally, Blue Cross will begin accepting the new HCFA 1500 forms by October 1, 2006, and the new UB-04 forms by March 1, 2007, in accordance with CMS guidelines.

Upon receiving your NPI, we urge you to notify us so that we may record your NPI in your Blue Cross provider file. Please be aware that we will not accept your existing Blue Cross provider number after May 23, 2007.

For more information on NPIs visit www.cms.hhs.gov/NationalProvIdentStand. If you have questions about the NPI in association with your Blue Cross participation, please contact us (800) 716-2299, option 3. For up-to-date information, please visit the provider section at www.bcbsla.com and look for more information regarding the National Provider Identifier coming soon.

NPI Fast Facts

- ★ 10-digit, intelligence-free (no personal information included) numeric identifier
- ★ Replaces health care provider identifiers used today in HIPAA standard transactions
- ★ Stays the same regardless of job or relocation
- ★ A standard unique health identifier for health care providers, plans, and employers
- ★ Creates more efficient coordination of benefits transactions and simplifies electronic transmission

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**BlueCross BlueShield
of Louisiana**

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Baby Bill implementation

Act 269 of the 2004 Regular Session of the Louisiana Legislature, known as the "Baby Bill," requires that hospitals notify the mother and/or father's private insurance company and the Louisiana Department of Health and Hospitals (DHH) when a newborn meets certain established qualifications required under Medicaid.

When at least one parent of a qualifying newborn is a Blue Cross member, hospitals should send Blue Cross a copy of the completed DHH Third Party Liability (TPL) Notification of Newborn Children form that they also submit to DHH.

Hospitals can e-mail completed forms to Newborn@bcbsla.com or fax to (225) 298-2988, Attention: Newborn/M&B Unit Lead. All hardcopy forms should be mailed to Blue Cross and Blue Shield of Louisiana, Attention: Newborn/M&B Unit Lead, P. O. Box 98029, Baton Rouge, LA 70898-9029.

Note: Act 269 of the 2004 Regular Session of the Louisiana Legislature is the same as DOI's Regulation 86 - Dependent Coverage of Newborn Children in the Group and Individual Market and a similar regulation promulgated by the DHH.

Tool helps members make decisions

Healthcare Advisor™* is a tool that provides online information about health care providers such as demographic, provider types/specialties and hospital affiliations. This tool is available to members registered for *AccessBlue*.

With this tool, members can also access decision support tools on Cost and Profile information such as cost ranges by episode treatment groupings by conditions, profile data on length of stay, hospital volumes and complications by procedure.

*Powered by Subimo, LLC

The latest in iLinkBLUE

WHAT'S NEW!

- ◆ We have recently updated our provider manuals. Visit the Manuals section to view and/or print copies of the 2006 versions of these provider manuals.
- ◆ The new pricing lists for Standard Drug, Drug Administration, DME Drug and Infusion Therapy Drug codes, effective March 15, 2006, are now available under the Manuals section.
- ◆ Professional Accepted/Not Accepted Reports for FACETS claims.

COMING SOON!

- ◆ Hospitals will soon have online access to their daily facility utilization/discharge reports through iLinkBLUE.
- ◆ iLinkBLUE is being enhanced with a new application that gives physicians online access to their allowables on a code-by-code basis.
- ◆ **NO MORE PAPER SECURITY FORMS** – New iLinkBLUE users will be able to register for a user name and password via the internet.

Continue to watch the iLinkBLUE message board for up-to-date information on new features.

If you aren't already using iLinkBLUE, you can apply for this free service by calling our EDI Services at (225) 293-LINK (5465) or email us at iLinkBLUE.providerinfo@bcbsla.com.

WE APPRECIATE YOU

You may have noticed instabilities with iLinkBLUE over the past few months. This is due to needed upgrades that were taking place at Blue Cross. We apologize for any setbacks you may have experienced. We truly appreciate your continued patience and loyalty as we work to improve our systems to be more efficient for our providers.

*Sincerely,
EDI iLinkBLUE Team*

*Jeri Andy
Debbie Krista*

FACETS WORKSHOP Q&A

Recently, we sponsored a series of successful provider workshops throughout the state. These workshops addressed provider concerns about the changes involved with Facets, our new operating system. Below are responses to some of the main questions asked by provider office staff who attended our workshops.

Q. Why do you have to constantly update your user name and passwords?

A. Passwords periodically expire for security reasons. You may contact the Help Desk at (225) 295-2058 to have your password reset.

Q. When BCBSLA implements the Facets program, will you please put a tutorial on the corporate website?

A. The Facets program has been implemented and was effective for claims with dates of service on and after December 1, 2005. The November 2005 Special Edition Provider Network Newsletter can be found on our Provider page at www.bcbsla.com. Future changes will be communicated on the iLinkBLUE message board and in another special edition newsletter due out this fall.

Q. How are the new cardiac CPT codes going to be handled (i.e. 0147T)?

A. 2006 code updates have been installed in front-end programs for Legacy and Facets and were effective January 1, 2006.

Q. Does iLinkBLUE show routine eye care eligibility and benefits?

A. Information on this benefit is limited at this time. Look for future enhancements.

Q. Can Medicaid benefits be verified through iLinkBLUE? Can all procedure codes be verified through iLinkBLUE (i.e. allow/disallow)?

A. Medicaid benefits are not available through iLinkBLUE; however, professional providers may use Clear Claims Connection for an explanation of bundled charges. In addition, we currently have fee schedules available under the Manual section of iLinkBLUE for the new Drug, Drug Administration, Infusion Therapy and Durable Medical Equipment drug codes that are effective for claims with a date of service on and after March 15, 2006.

2006 CPT Code Update Notes

CPT Drug/Chemotherapy Administration Codes

For claims with dates of service on and after January 1, 2006, providers are required to use the new CPT codes for drug and chemotherapy administration.

- ◆ **Initial versus Add-On Codes** – The initial code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur.
- ◆ **Push versus Infusion Codes** – Intravenous or intra-arterial push: a) an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or b) an infusion of 15 minutes or less.
- ◆ **Chemotherapeutic versus Therapeutic Codes** – Chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for the treatment of non-cancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers.
- ◆ **Concurrent Drug Administration** – Only one concurrent infusion per encounter should be billed.

Moderate Sedation

The CPT Moderate (Conscious) Sedation section has been totally revised for 2006. Blue Cross policy for moderate (conscious) sedation remains unchanged; therefore, moderate sedation is considered part of the surgical package

Debit cards for BlueCard members

Be on the lookout for BlueCard members with health debit cards. Other Blue Plans are using these new cards as they have value-added features to assist providers in collecting members' cost sharing amount. These medical ID cards are easy to recognize and simple to use. Look for nationally recognized Blue Cross and/or Blue Shield logos, along with a major debit card logo such as MasterCard® or Visa®.

Some cards serve as member ID cards, while others are "stand-alone" debit cards and are simply used to cover out-of-pocket expenses. Members are able to pay for out-of-pocket costs upfront using funds from their health reimbursement arrangement (HRA), health savings account (HSA) or flexible spending account (FSA).

Much like the debit cards used with our **BlueSaver** benefit plan, these health care debit cards help simplify administration processes and can help reduce bad debt and paperwork for billing statements. This helps minimize bookkeeping and patient account functions for handling cash and checks, thus avoiding unnecessary claim payment delays.

With the health debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card.

If the member presents a debit card (stand-alone or combined), be sure to verify the copayment amounts before processing payment. Do not use the card to process full payment upfront.

If you have any questions about a member's benefits or eligibility, please call BlueCard *Eligibility*®, (800) 676-BLUE (2583), and provide the member's alpha prefix. For questions about debit card processing instructions or payment issues, please call the debit card administrator's number listed on the back of the member's debit card.

Blue Cross continues to offer hurricane relief to providers

The Louisiana Department of Insurance ended health insurance premium grace periods on December 1, 2005, allowing insurers to collect past due premiums from customers and giving them the right to cancel the policies of customers with unpaid account balances. Since the day after Hurricane Katrina hit, Blue Cross has been working with our hurricane-affected members and paying their claims at the highest benefit level – regardless of their ability to pay their premiums. Our senior management team recently made the decision to continue this relief by paying all outstanding Blue Cross claims from December 2005 and January 2006 at 100 percent of the contracted reimbursement level. These claims represent over \$1 million in payments to providers and will appear on your regular provider payment registers.

Hurricanes Katrina and Rita continue to take their toll on the lives of Louisianians in so many ways. As a company deeply rooted in this state, Blue Cross is committed to our customers and partners in health care. This is one way we can stay true to our mission of improving the lives of Louisianians by providing health guidance and affordable access to quality care.

RxBLUE formulary available to ePocrates users

On January 1, 2006, Blue Cross and Blue Shield of Louisiana began administering its Medicare Part D prescription drug plan, RxBLUE.



The RxBLUE formulary is now listed on ePocrates at www.epocrates.com. To access the RxBLUE formulary at the ePocrates website, go to the "Add Formularies" page and simply select the Medicare Part D PDP category and scroll to BCBSLA-RxBLUE (Medicare PDP), then select the "Add" option.

Learn more about Medicare Part D and RxBLUE by visiting the RxBLUE page of our website at www.bcbsla.com. Here you'll find important information about eligibility and enrollment, covered drugs, excluded drugs, low income subsidy, disenrollment, changing plans and much more.

Provider information gets top scores

Blue Cross and Blue Shield of Louisiana was ranked in the **Top 10** among Blue Plans for the accuracy of our provider directories. We want to thank you for helping us keep your provider information both current and accurate in 2005. This ensures that our members – your patients – are able to locate you when health care needs arise. Quickly notifying us with changes in your contact information has paid off!



The Blue Cross and Blue Shield Association reviews our provider directories quarterly to ensure that provider information is both current and accurate.

Help us stay on top again for 2006! We routinely update our provider directories based on the information in your Blue Cross provider record. This is why it is important for you to let us know if you have a new phone number, fax number, e-mail or physical address, whether you have moved temporarily or permanently.

Changing your provider information is easy. Simply fill out our online provider update form available on the Provider page under Forms at www.bcbsla.com. If you have questions about updating your provider contact information, you can e-mail us at network.administration@bcbsla.com or contact Provider Network Administration at (800) 716-2299, option 3 or (225) 297-2758.

Member Satisfaction Survey

Each year, Blue Cross conducts the Consumer Access to Healthcare Providers and Systems Survey (CAHPS). The 2005 CAHPS was conducted between January and May of 2005. From that survey, we received more than 1,100 responses from Blue Cross members.

The survey asked members to rate their satisfaction in several different categories, including getting care quickly, getting needed care, doctor communication skills, courteous and helpful office staff, customer service and claims processing.

The results from the survey help us gauge how well we are meeting our members' expectations and needs. It also enables us to assess the patient-centeredness of care, compare and report on performance and improve quality of care.

Blue Cross' health plan rating was based on member satisfaction influenced by:

- ❶ getting care from providers when needed
- ❷ our ability to quickly and accurately process claims
- ❸ their customer service experiences

Overall, the health plan rating given to Blue Cross for our PPO, HMO and POS networks has remained strong with more than two-thirds of responders ranking their satisfaction with Blue Cross as high. According to this survey, our scores remain higher than the national benchmark. To ensure that our members continue to remain satisfied, we are addressing opportunities for improvement through an action committee consisting of cross-functional employees within the organization.

Thank you, once again, for your commitment to our members' health care. We appreciate your partnership with Blue Cross in striving to provide the highest quality of care to our members—your patients.

Provider Availability Standards

Blue Cross is committed to providing access to high quality health care to all members, promoting healthier lifestyles and ensuring member satisfaction with the delivery of care. Within this context and with input and approval from various network providers who serve on our Medical Quality Management Committee, we developed the Provider Availability Standards and Acute Care Hospital Availability Standards.

Type	Definition	Access Standard	Examples
Emergency	Medical situations in which a member would reasonably believe his/her life to be in danger or that permanent disability might result if the condition is not treated.	Immediate access, 24 hours a day, 7 days a week	Loss of consciousness Seizures Chest pain Severe bleeding Trauma
Urgent	Medical condition that could result in serious injury or disability if medical attention is not received	30 hours or less	Severe or acute pain High fever in relation to age and condition
Routine Primary (non urgent, symptomatic visits)	Problems that could develop if left untreated but do not substantially restrict a member's normal activity	5 to 14 days	Back ache Suspicious mole
Preventive Care		6 weeks or less	Routine physical Well baby exam Annual Pap smear

Additional Availability Standards

- ❖ Network physicians are responsible for assuring access to services 24 hours a day, 365 days a year. This includes arrangements to assure coverage after hours by another participating physician.
- ❖ All network providers must offer services during normal working hours, typically between 9 a.m. and 5 p.m.
- ❖ Average office waiting times should be no more than 30 minutes for patients who arrive on time for a scheduled appointment.
- ❖ The physician's office should return a patient's call within four to six hours for an urgent/acute medical question and within 24 hours for a non-urgent issue.

Acute Care Hospital Availability Standards

- ❖ Acute care hospitals are responsible for assuring access to services 24 hours a day, 365 days a year.
- ❖ All contracted hospitals must maintain emergency room or urgent care services on a 24-hour basis and must offer outpatient services during regular business hours, if applicable. Hospital outpatient services are furnished only on referral or for emergency needs.



For up-to-date provider information visit our Provider page at www.bcbsla.com.



medical policies update

Blue Cross continuously develops and revises medical policies in response to rapidly changing medical technology. Listed below are medical policies that we are adopting and/or revising.

New medical policy guidelines

Effective Date	Medical Policy Coverage Guideline	Coverage Eligibility
Jan. 1, 2006	Charged-Particle (Proton or Helium Ion) Radiation Therapy	Eligible for coverage with criteria Investigational
Jan. 1, 2006	Conjunctival Incision with Posterior Juxtasclear Placement of Anectortave Acetate Depot Suspension	Investigational
Jan. 1, 2006	CT Scanning for Lung Cancer Screening	Investigational
Jan. 1, 2006	Dynamic Range of Motion	Eligible for coverage with criteria Investigational
Jan. 1, 2006	Lipoprotein(a) Enzyme Immunoassay in the Management of Cardiovascular Disease	Investigational
Jan. 1, 2006	Surgical Ventricular Restoration	Investigational
Jan. 1, 2006	Transciliary Fistulization for Treatment of Glaucoma	Investigational
May 15, 2006	Low Level Laser	Investigational
May 15, 2006	Neurodiagnostics (EMG, NCV, etc.)	Eligible for coverage with criteria Investigational Non-covered if performed by ineligible provider
May 15, 2006	Spinal Ultrasound	Investigational

Coverage eligibility changes to existing medical policy guidelines

Effective Date	Medical Policy Coverage Guideline	Coverage Eligibility
Jan. 26, 2006	Immune Prophylaxis for Respiratory Syncytial Virus	Eligibility criteria for the administration of Immune Prophylaxis for Respiratory Syncytial Virus for children with heart disease after a surgical procedure requiring cardiopulmonary bypass was clarified: Based on review of data, Blue Cross may consider an additional postoperative dose of palivizumab during RSV season for children with heart disease, who would otherwise qualify for and are receiving administration of immune prophylaxis for RSV, after a surgical procedure requiring cardiopulmonary bypass to be eligible for coverage.
Jan. 26, 2006	Intravenous Immune Globulin	The following indications for the use of IVIG were added: Hyperimmunoglobulinemia E syndrome and Parvovirus B-19.
Jan. 26, 2006	Ultraviolet Light, including Laser Therapy, for skin conditions	Coverage eligibility expanded to include coverage for treatment of psoriasis with UVB light therapy for psoriasis which does not respond to standard treatment.
Jan. 26, 2006	PET for Oncology Applications	Coverage eligibility for the use of PET in colorectal cancer expanded to include restaging: "To detect recurrence of colorectal cancer in patients with rising CEA levels and/or in patients who present with signs and symptoms of recurrence."
May 15, 2006	Intra-Articular Injections (Hyaluronan, and others)	Additional criteria added: <ol style="list-style-type: none"> 1. Evidence of X-ray for confirmation of the diagnosis of osteoarthritis of the knee 2. Documented evidence of minimum of 3 months trial of acetaminophen or NSAIDs 3. Documented evidence of at least 1 steroid injection prior to use of intra-articular hyaluronan injection

Provider inquiries related to medical policy coverage, eligibility guidelines or investigational status determinations will be considered upon written request. Requests for reconsideration must be accompanied by peer-reviewed, scientific evidence-based literature that substantiates why a technology referenced in a medical policy should be considered. 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, please call the **BlueLine** at (800) 392-4076.

Reminder: Member ID cards not to include Social Security numbers

Blue Plans, including Blue Cross and Blue Shield of Louisiana, are sensitive to member concerns about identity theft. We also support legislative efforts toward protecting member privacy.

As of January 1, 2006, nearly all Blue Plans successfully completed the conversion process of replacing Social Security numbers on member ID cards with an alternate unique identifier. The new identifiers begin with a three-character alpha prefix, which identifies the member's Blue Plan and is critical for eligibility/benefits verification and claims processing.

You should increasingly see new Blue ID cards reflecting the above changes and may find the following information helpful in educating your staff:

- ❖ Make copies of the front and back of the member's ID card. To ensure that the member gives you the most current ID card, you may want to request the card at every visit.
- ❖ Whether the most current ID card contains the Social Security number or an alternate unique identification number, please enter the identification number exactly as it appears on the member's card, including the three-character alpha prefix.
- ❖ The member ID will always include the alpha prefix in the first three positions.
- ❖ Following the three-character alpha prefix, the ID card may include any combination of alpha/numeric characters (letters or numbers) for a maximum length of 17 characters.
- ❖ Member ID numbers must not be changed or altered.

Please **do not** assume that the member's ID number is the Social Security number.

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