

July 2007

BlueCard® provider satisfaction remains high

Blue Cross and Blue Shield of Louisiana would like to thank those providers who participated in the 2006 Provider Satisfaction Survey. We were again ranked No. 1 in BlueCard provider satisfaction among Blue Plans, making 2006 our fourth consecutive year to receive this honor. Each year the Blue Cross and Blue Shield Association (BCBSA) conducts a provider survey to determine what we can do to better satisfy and meet the needs of our network providers. Your suggestions and comments help us make the BlueCard® program better.

We are happy to report that BlueCard services delivery for providers continues to improve. Feedback from the 2006 BlueCard provider survey indicates that providers noticed improvements in claims accuracy, timeliness and resolution of out-of-area claims. We will continue working hard to bring you additional improvements, including:

- Improved claims processing accuracy and timeliness
- Timely problem claims resolution
- Expanded electronic eligibility and claims status response
- Enhanced provider service
- Enhanced provider education tools and resources development

If you need information about BlueCard or have suggestions for improvement, please let your Provider Relations representative know. As always, we appreciate your feedback.

2007 Survey is underway

The 2007 Provider Satisfaction Survey is being conducted in two waves. Wave I began in early March and concluded in mid-April. Wave II will begin in early August and continue through mid-September. If your office is contacted, we encourage you to participate as your feedback is important to us.

We are listening and making changes based on your feedback!

Many providers surveyed stated they did not know or have never met their Blue Cross Provider Relations representative. To make improvements in this area, we are offering the following enhancements:

1. Who is my Provider Relations representative?

We now have an interactive map that is available under the Provider Tools section of the Provider page at www.bcbsla.com. This map provides the name and phone number for our Provider Relations and Network Development representatives by parish.

2. Can I meet my Provider Relations representative?

Provider Relations is working to call on more network providers throughout the state. Their goal is to meet with all network providers who file claims with Blue Cross and Blue Shield of Louisiana.

Evaluation and management (E/M) codes: preventive vs. problem-oriented services

In order to bill a preventive evaluation and management (E/M) service (99381-99397) on the same day as a problem-oriented E/M service (99201-99215), an abnormality or pre-existing problem found during the preventive exam must be significant enough to require additional work to perform the key components of the problem-oriented E/M service.

Medical records must have separate and distinct notes to justify both services and modifier 25 must be appended to the office/outpatient code. CPT guidelines state, “An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine E/M service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.” In addition, if a preventive E/M service is being rendered to a new patient and a problem-oriented E/M service is also being performed, the problem-oriented E/M must be billed with an established E/M service code (99211-99215). ■

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Are you overcharging your patients?

Health debit cards are becoming increasingly common among Blue Cross members and are easy to recognize because they have the Blue Cross and/or Blue Shield logos. These cards work like any other debit card and allow members to pay for qualified medical expenses using funds from their health savings accounts (HSAs) or health reimbursement arrangements (HRAs).

When a patient presents a health debit card to pay for their medical expenses, please make sure you are not overcharging them. It’s important to remember that you should only charge the member the Blue Cross allowable amount. It is equally important to know the member’s benefits and if the member has met their deductible and/or out-of-pocket amount.

You should not collect billed charges up-front, and any refunds owed members should be given to them within 30 days of discovering the overpayment. ■

Hold Harmless – it’s in your contract

Hold harmless—two small words in your Blue Cross contract that have big meaning to your patients. No matter how they are worded, the hold harmless provisions in your contract mean that your patients are not liable for any amounts which you have agreed to write off, e.g., services determined to be not medically necessary, and amounts in excess of Blue Cross’ allowable charges for covered services. In addition, you may not ask your patients to sign a document “waiving” balance billing and hold harmless provisions for amounts above the allowable charge. To assist in timely processing of claims, please respond to requests for additional information and medical records in a timely manner.

Thank you for helping us better serve our members—your patients—by adhering to the hold harmless provisions in your contract. If you have any questions regarding these provisions, please call Network Operations at (800) 716-2299, option 3. ■

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Don’t leave your help out on a limb



More than ever before, providers are outsourcing claims services to clearinghouses and billing agencies. Remember to regularly give them Blue Cross’ billing guidelines, coding updates and other claims filing information we send to you. They represent you and often do business directly with Blue Cross on your behalf, so it’s up to you to keep them informed.

Did you know that outside clearinghouses and billing agencies can get access to iLinkBLUE for checking claim status, viewing allowables, medical policies, provider manuals and submitting requests for review when you have questions on claims? For more information on obtaining access to iLinkBLUE, call the *LinkLine* at (800) 216-2583.

We also provide up-to-date information on the Provider page of our website at www.bcbsla.com. Don’t leave your outside help “out on a limb.” Instead, keep them in the “Blue Cross know.” ■

Specialty pharmacy for FEP members

Caremark is the preferred specialty pharmacy of choice for Federal Employee Program (FEP) members. Please make sure that all specialty pharmacy drug requests are sent to Caremark. This ensures that the FEP member is receiving the maximum level of benefits available through his/her FEP pharmacy program. FEP members are easy to recognize because their member number begins with the letter 'R' followed by an eight-digit number.

Physicians can order speciality drugs for FEP members by calling the FEP speciality pharmacy dedicated unit at (866) 441-9020, between 6:30 a.m. and 8 p.m., CST. Pharmacists are available daily until 5 p.m. Prescriptions may also be faxed to (866) 441-9005. Please include your NPI number, the patient's information (name, date of birth, address and member number) and the name of the drug.

To learn more about the FEP pharmacy program, visit www.fepblue.org and click on the pharmacy program link.

Other helpful FEP pharmacy phone numbers:

- Mail Service New Rx Line - (800) 378-5697 (*physicians only*)
- Retail Pharmacy Customer Service Unit - (800) 624-5060
- Prior Approval Rx Line - (877) 727-3784 (*physicians only*)

More than just a request

When processing claims, medical records are sometimes needed to make coverage or level of payment decisions and to substantiate the use of certain modifiers or unlisted codes on a claim. Please help us expedite payment by responding to our requests for medical records in a timely manner. This allows us to complete the processing of your claims without long delays.

One possible reason for not receiving medical records timely is that our requests may not be reaching the right person in your office. Currently, Blue Cross sends requests for medical records to the correspondence address or fax number listed on your provider record. If you have an alternate address or change in fax number for where you'd like us to send requests for medical records, please contact Network Administration at (800) 716-2299, option 3.

Don't be a victim of fraud

Identity theft is on the rise. Blue Cross has been notified that scammers are contacting members stating that additional information is needed to activate their prescription cards, that an additional ID is required or that more money is owed.

If someone calls you claiming to be a Blue Cross or "Medicare" employee and asks for banking information, do not release this information. Blue Cross will never call you on the telephone to ask for banking information.

If you or your patients receive a suspicious call, please contact our Fraud Hotline at (800) 392-9249.



Incorrect codes may affect hospital payments

As outlined in our hospital policies and procedures manual, the Medicare DRG Grouper is used to price inpatient claims. Diagnostic and procedure codes determine the appropriate DRG as indicated to us by the Medicare DRG Grouper. While other groupers are available, the logic is different and may result in a different DRG than what the Medicare DRG Grouper would indicate. To ensure that your claims are priced correctly, please bill claims with appropriate diagnostic and procedure codes.

BlueSaver wellness pays in-network providers at 100 percent of allowable

BlueSaver is an insurance plan that works with a health savings account (HSA). While one feature of BlueSaver is a high deductible, another feature is wellness and preventive care covered at 100 percent of the Blue Cross allowable (no deductible) when an in-network provider is used.

In-network providers should file wellness and preventive claims for BlueSaver members directly to Blue Cross for payment and should not collect a deductible up-front, as excess payments taken at the time of service must be refunded to the member. Please help us encourage all of our members to get the appropriate preventive and wellness care.

Refer to Medicare Select hospitals

While BlueChoice 65 members receive in-network benefits from any physician who accepts Medicare, there is a Medicare Select facility network. Please refer BlueChoice 65 members to Medicare Select network hospitals to ensure that high-level benefits are paid. Non-emergent services often are not covered when rendered in non-Select facilities. A BlueChoice 65 hospital directory is available on the Provider Finder page at www.bcbsla.com.

Combination vaccines can benefit practice and patients

A 2005 study published in the *Journal of the American Medical Association* reported that 74 percent of children experienced delays in receiving at least one vaccine.

The use of combination vaccines, which provide protection against multiple diseases with fewer injections, may aid in the timely administration of vaccines. And—when it comes to parents reluctant to subject their children to the pain associated with multiple injections—combination vaccines may reduce the likelihood of missed vaccinations.

To minimize the number of injections children receive, the American Academy of Pediatrics, the American Academy of Family Physicians and the Advisory Committee on Immunization Practices state a preference for combination vaccines if licensed and indicated for the patient's age, instead of separate injections of their equivalent component vaccines.

Blue Cross agrees that the use of combination pediatric vaccines can have a positive effect, and we hope physicians will recognize the benefit of using combination vaccines to reduce the number of injections given to a child, keep parents happier, raise immunization coverage rates and provide more timely protection against vaccine-preventable diseases. ■

New B.R. rep



Sue Condon is one of Blue Cross' newest Network Development Representatives and is responsible for provider contracting and network management in Baton Rouge and surrounding parishes. Condon works with providers and their office staff to ensure that they understand their Blue Cross and/or HMOLA contract(s) and also helps providers with contracting issues when they add providers or locations to their practice.

She has more than 14 years of health industry experience and has developed long-lasting relationships with the area's providers and their office staff. Condon comes to Blue Cross from United Healthcare, where she was a network account manager, responsible for managing physician relationships and working with hospitals on reimbursement rates, financial analysis and network adequacy. She has also held positions at Amcare Health Plans and Foundation Health Systems, Inc. in Baton Rouge. Condon, who is a member of the Louisiana Association of Health Plans, studied business communications/office systems at Louisiana State University in Baton Rouge.

If you are a provider in the Baton Rouge area* with questions related to contracts, you may contact Condon at (225) 295-2437. If you have questions

regarding claims status or a member's benefits, eligibility or coverage, check online at *iLinkBLUE Provider Suite* or please call the *BlueLine* at (800) 392-4076.

* The Baton Rouge area includes the following parishes: Ascension, Assumption, East Baton Rouge, East Feliciana, Iberville, Livingston, Point Coupee, St. Helena, Tangipahoa, West Baton Rouge and West Feliciana.

Processing secondary claims

Remember! When billing claims to Blue Cross as the secondary payor, it is important to include a copy of the primary carrier's explanation of benefits (EOB). With Facets, our new claims processing system, all information on Medicare and other carrier EOBs must be entered to process secondary claims. By filing your secondary claims with all documentation, you are helping prevent delays in processing your claims.

It is equally important to include a copy of the primary carrier's EOB when making refunds to Blue Cross on overpaid secondary claims. This allows us to appropriately apply overpaid amounts to claims. ■

Recognizing different Blue members

① Medicare Advantage members

Medicare Advantage is the new program alternative to standard Medicare Part A and Part B fee-for-service coverage and offers Medicare beneficiaries product options including HMO, PPO, point of service (POS) and private fee-for-service (PFFS) plans. Though not available through Blue Cross and Blue Shield of Louisiana (BCBSLA) at this time, Medicare Advantage is available through other Blue Plans.

Medicare Advantage HMO plans typically require members to obtain health care services from in-network providers, except in urgent or emergency care situations. By contrast, Medicare Advantage PPO and POS plans offer added flexibility by allowing members to select out-of-network providers at additional member cost. While POS plans may limit available out-of-network benefits to those services specified by the plan, PPO plans must offer all covered services through both in- and out-of-network providers. Because there are many benefit options, coverage for out-of-network claims may vary depending on the Medicare Advantage product type and plan selected by the member. Please confirm the level of coverage for all Medicare Advantage members prior to providing services.

Medicare Advantage members are easy to recognize by the logo on their ID cards.

MEDICARE
ADVANTAGE

HMO

MEDICARE
ADVANTAGE

PPO

MEDICARE
ADVANTAGE

POS

MEDICARE
ADVANTAGE

PFFS

② International Blue plan members

Occasionally, you may see identification (ID) cards from Blue members from a foreign country. These ID cards will also contain three-character alpha prefixes. Please treat Blue international members the same as domestic Blue Plan members. Eligibility, claims filing, appeals, problem resolution and payment are the same as with BlueCard® members. Please follow the same payment collection practice as you do for the domestic members and be sure to collect payment for non-covered services. These members may not have coverage for non-emergency outpatient or physician services. In these instances, you should collect payment for non-covered services only from the members.

Benefits, claims, payment and problem resolution

Verifying eligibility and benefits for the types of members described above is the same as with other BlueCard members. Providers may send an electronic eligibility request (270 transaction) to BCBSLA or call the BlueCard Eligibility® line at (800) 676-BLUE (2573). Be sure to provide the three-character alpha prefix.

File claims directly to BCBSLA, and we will transmit claims to the Blue Plan that owns the policy. Do not bill Medicare directly for any services rendered to a Medicare Advantage member or the international Blue Plan for services rendered to an international Blue member. BCBSLA is your focal point for claims inquiries, payments and problem resolution. Reimbursement is made directly by a Blue Plan, and providers may call the *BlueLine* at (800) 392-4076 for claims inquiries.

For up-to-date Blue Cross news you can use, visit us online at www.bcbsla.com!

Steps to avoid the appeals process

Claims are often denied or paid at low level because the member was referred to an out-of-network provider or an authorization was not obtained. Generally, we do not reverse our decision on appeals if the provider failed to do these two things. The result—claims unnecessarily go through the appeals process. To get your Blue Cross claims paid correctly, you should remember to always refer to in-network providers, including laboratories. It is also important to obtain authorization prior to rendering services, when applicable, which can prevent the member from receiving low-level payments or any benefits.

You can easily locate network physicians, facilities and laboratories with our online directories at www.bcbsla.com, and benefits and eligibility are available anytime at iLinkBLUE for both Blue Cross and BlueCard® members or you may call the *BlueLine* at (800) 392-4076. ■

Eligible for Coverage with Criteria

Blue Cross medical policies outline the medical criteria used to determine if claims are covered, investigational and non-covered services, but what exactly does Blue Cross mean when we say “**eligible for coverage with criteria**”? It means that claims will be processed according to the guidelines in effect at the time the services are rendered. Our claims processing system is programmed to recognize claims that need medical policy review to make adequate determinations of coverage. If the service is a covered benefit under the member’s policy and all medical policy requirements are met, then we consider the service eligible for coverage.

Sometimes you may receive payment for services that are not covered, but were inadvertently paid. This is because claims may not always pend for review due to system and/or resource limitations. Blue Cross performs retrospective reviews and will recoup inappropriate claim payments. Updates to our claims processing system are made all the time. There are instances where we may not have all codes programmed to pay/deny appropriately at the time the policy goes into effect. Even when this happens, claims are still governed by the medical policy and will process accordingly once all system changes are made.

One such example is our breast brachytherapy medical policy, which was outlined in our January 2007 newsletter as eligible for coverage when criteria met. Claims processed on and after December 1, 2006, for CPT codes 19296-19298 are pending for medical review prior to payment and properly processed. Unfortunately codes 77750-77799 were not initially included in our system logic and may have paid incorrectly. Our goal is to process claims correctly the first time and we are always working to ensure our claims system is programmed to do this.

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Disparities in New Orleans since Katrina

On May 10, 2007, The Henry J. Kaiser Family Foundation released the findings of a survey conducted in the New Orleans area between September and November 2006. Researchers found that since Hurricane Katrina, New Orleanians face a serious problem in at least one of seven key aspects of their lives, of which 52 percent claimed to face problems with two or more of the following:

1. lacking access to health care coverage
2. lacking access to physicians
3. having physical health challenges
4. having mental health challenges
5. lacking a job
6. having inadequate wages
7. having a child who is troubled, ill or not getting needed care

According to those surveyed, progress is being made in Orleans Parish, including “getting medical facilities up and running.” Most surveyed would like to see more hospitals reopened and more physicians and other health care professionals return to the New Orleans area. They also reported wanting more availability of emergency care services and community clinics. The Kaiser Family Foundation plans to conduct additional surveys to further track disparity changes for the New Orleans area—in 18 months and again in 36 months from the first survey. For more information on this survey, visit www.kaisernetwork.org.

Major house-to-house survey finds New Orleans area residents hit hard by Katrina and struggling with serious life challenges, May 10, 2007, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=44830



medical policies update

Blue Cross continuously 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. Please see the following updated medical policies, all of which can be found on iLinkBLUE at www.bcbsla.com/ilinkblue.

New Medical Policies

There are no new medical policies to report at this time.

Changes to Coverage Eligibility of Recently Reviewed Medical Policies

Effective Date	Medical Policy Coverage Guideline	Coverage Eligibility
03/21/2007	Continuous Glucose Monitoring in the Interstitial Fluid	The use of this device for the continuous monitoring of glucose levels in the interstitial fluid, including real-time monitoring, as a technique of diabetic monitoring remains investigational. Policy expanded to include real-time monitoring as a diabetic monitoring technique.
04/18/2007	Biventricular Pacemakers for the Treatment of Congestive Heart Failure	Updated Biventricular Pacemakers and Biventricular Pacemakers with Automatic Implantable Cardioverter Defibrillators for Treatment of Congestive Heart Failure with new title at left. No other changes to policy.
04/18/2007	Cochlear Implant	Added bilateral cochlear implants as now eligible for coverage with criteria.
04/18/2007	Nonmyeloablative Allogeneic Stem Cell Support for the Treatment of Malignancies	Investigational policy statement expanded to include multiple myeloma, renal cell carcinoma, other solid tumors, or autoimmune diseases.
04/18/2007	Small Bowel Transplant, Small Bowel/Liver Transplant and Multivisceral Transplant	Policy criteria expanded to include the patient's adequate cardiopulmonary status; and absence of infection; and no history of malignancy within 5 years of transplantation, excluding nonmelanomatous skin cancers; and documentation of patient compliance with medical treatment.
04/18/2007	Vertebral Fracture Assessment with Bone Density	Updated Screening for Vertebral Fracture with Dual X-ray Absorptiometry (DEXA) title to reflect changes in technology. No other changes to policy.
09/01/2007	Tilt Table Testing	Patient selection criteria revised to indicate that recurrent or single syncopal event in a high risk setting is covered.

Policy Update: Dynamic Spinal Visualization

We have changed the name of our Digital Motion X-ray medical policy to **Dynamic Spinal Visualization**. Effective July 1, 2007, Blue Cross considers dynamic spinal visualization including digital motion X-ray of the spine, and cineradiography/videofluoroscopy when used to visualize movement of the back or spine to be investigational for all indications.

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 or call the BlueLine at (800) 392-4076.**

Case of the missing NPIs

Blue Cross has received NPIs from over 80 percent of our providers, which means we are nearly there, but still missing NPIs. May 23, 2007, was the deadline for providers to give Blue Cross their NPI number(s). Soon, the NPI will be required for all transactions with Blue Cross and its subsidiaries, regardless of network participation. Though providers may continue to file claims at this time with their Blue Cross number; we encourage all providers to begin **today** filing all claims with **both** their Blue Cross number and NPI. This will help us test our system to ensure that we can accept and correctly process claims filed with NPI only.

Once the NPI is mandatory for filing claims, Blue Cross will no longer process claims using your Blue Cross provider number. If you are among the 20 percent who still have not reported their NPI(s) to Blue Cross, please do it today.



Notifying Blue Cross of your NPI

When you get your NPI, notify Blue Cross using our interactive online Provider Update Form available on the forms section of the Provider page of our website at www.bcbsla.com, or by mail using the Individual NPI Update Form or the Facility NPI Update Form also available online. The NPI may be included on your Louisiana Standardized Credentialing Application (LSCA), Health Delivery Organization (HDO) Application or Blue Cross Recredentialing Application. Blue Cross will **not** accept notification of your NPI on claim forms.

For more information on NPIs, visit the NPI section of our website at www.bcbsla.com.



Get in step and do the 2!

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iLinkBLUE News

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Are you using iLinkBLUE for claim status and eligibility?
 You have access to claims information without waiting to speak to a customer service representative—it's free, easy to use and the fastest and most reliable way to get this information! Sign up for iLinkBLUE today. Applications are available at www.bcbsla.com.

Know your allowables

In 2006 Blue Cross enhanced iLinkBLUE *Provider Suite* so that providers can easily access their allowables by date of service. Once logged on at iLinkBLUE, click on "Fee Schedule" on the main menu. You will then be prompted to enter a date of service. This is important because providers can search current allowables, as well as allowables for past and future (when available) dates of service.

Once you've entered a date of service, you must then enter the appropriate network and CPT code. Entering modifiers and site of service codes is optional. Once you've entered your information, press submit to obtain your allowable charge for the desired date of service and CPT code. Please note that if you have a pop-up blocker, you will need to turn it off for this function. If you would prefer multiple allowables, enter only the first few numbers followed by an asterisk (*).

Examples:

- 99214 - only shows the allowable for 99214
- 992* - generates a list of all codes starting with 992
- 99* - generates a list of all codes starting with 99
- 9* - generates a list of all codes starting with 9

Need a member ID?

As you may know, Blue Cross now uses a unique identifier called a member identification (ID) number in place of using the member's Social Security number. This change was to prevent identity theft and protect member privacy.

While Blue Cross requires the member ID number for eligibility/benefits verification and claims processing, we also understand that, at times, the member may not have their ID card available. For this reason, there is a contract number search function available in iLinkBLUE where providers may search for the member's ID number using the Social Security number.

What's  NEW! in **iLinkBLUE**

Dental fees now online!

Blue Cross has great news for dentists! You can now get your Key allowable charges electronically at our iLinkBLUE *Provider Suite*. Now, instead of spending valuable time requesting allowable charges over the phone, you can access them anytime, online. Use the instructions listed at left for looking up allowables. Dentists should choose the Key Dentist Network in the network drop-down box.

BlueCard® eligibility enhancement

Does your patient have different levels of benefits for in-network versus out-of-network for outpatient ambulatory surgical services? Are you a chiropractor in need of eligibility and visit limitations for your patient?

On March 31, 2007, we added the "Type of Service" option to the existing BlueCard® Eligibility Request application, which is available in iLinkBLUE. This application was enhanced to provide you with the capability of requesting specific types of service when verifying benefits.

Want faster payments from Blue Cross?
 With electronic funds transfer (EFT), payments go directly in your bank account, and your payment register can be viewed at iLinkBLUE *Provider Suite*. Blue Cross requires that all providers have EFT and iLinkBLUE. Beginning September 1, 2007, providers who have not signed up for these services will still receive their payments, but will no longer receive hardcopy payment registers. EFT and iLinkBLUE applications are available on line at www.bcbsla.com or call the LinkLine at (800) 216-2583 for more information.