

provider
networknews

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Blue Cross adds PPO to FACETS

On October 15, 2005, Blue Cross and Blue Shield of Louisiana began the process of replacing our central operating system with an updated system, Facets, that will offer our members and providers better, quicker service. The transition is expected to take three years. The phased approach helps us to ensure that the process goes as smoothly as possible and enables us to resolve problems as they occur.

It is now time for the second wave of business to move to our new operating system. This phase includes individuals and groups that uses our network of Preferred Care PPO providers. Over the next year, Blue Cross members will be moved to the new system on their policy renewal date.

You may remember that the first wave of business to move to the new system was for HMO Louisiana, Inc. (HMOLA) individuals and groups. We are happy to report that the transition of HMOLA members to Facets had minimal impact to our members and providers. We expect an equally successful transition for our Preferred Care PPO block of business.

The conversion to Facets will continue over the next two years. During this period, we will operate the old and new systems simultaneously to

ensure we can process claims timely in the event there are any system malfunctions.

This newsletter details changes you may notice as we continue to implement Facets. Some of these changes will apply only to members who have been moved to the new system, while other changes will apply to both Facets members and to members who are still on our old operating system (Legacy).

Throughout this newsletter, changes that apply only to members on the new system will be indicated by a ⚙ and will begin on February 1, 2007, as policies are renewed.

We appreciate your patience as we work through this process.

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NOTE: Throughout this newsletter, we refer to “Facets members” and “Legacy members.” Facets and Legacy are not products; they are our terms for distinguishing between members whose claims are processed in the new system — Facets — and members whose claims are processed in the old system — Legacy.

Please share this newsletter with all staff who work with Blue Cross.

special edition



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross
and Blue Shield Association.

★ **A new product exclusive to Facets:**

PremierBlue

Blue Cross and Blue Shield of Louisiana is pleased to announce a new product, *Premier Blue*, available February 1, 2007. All *Premier Blue* claims will be processed by the Facets claims processing system. *Premier Blue* is a comprehensive group health plan with benefits resembling both a point-of-service and a PPO plan. It features copayment and deductible/coinsurance benefits.

Members will have access to network benefits when services are rendered by Blue Cross providers who participate in our Preferred Care PPO network.

Participating providers should not bill *Premier Blue* members for the difference between the actual billed charge and the Blue Cross allowable charge.

Members may access our online provider directories at www.bcbsla.com, or contact Customer Service at (800) 599-2583 to find a network provider.

For more information on this product, look for our *Premier Blue* speed guide, which will soon be available the Provider page of our website at www.bcbsla.com.

How Facets affects reimbursement processes

Charge roll-up changes

For professional services, when a service is denied as incidental, the billed charge for the incidental service will no longer carry over to the charge for the primary service (see example below). This does not affect reimbursement very often and only when the charge is less than the fee on the primary procedure.

Old Method

Code	Charge	BCBSLA Fee	Allowed
00001	\$1,000	–	Rejected incidental
00002	\$1,500	\$2,000	
Charges summed	\$2,500	\$2,000	\$2,000 paid

New Method

Code	Charge	BCBSLA Fee	Allowed
00001	\$1,000	–	Rejected incidental
00002	\$1,500	\$2,000	\$2,000
Paid			\$1,500*

*In this example, we applied our “lesser of” policy and paid \$1,500.

facets change *for* facilities

★ **Non-covered charges will not be deducted from allowable charge**

In our Legacy system, we subtract the member’s deductible amount, coinsurance and/or copayment and non-covered services from the reimbursement amount and then calculate our payment amount to facility providers. The reimbursement amount for services paid in Facets is calculated by subtracting the member’s deductible amount, coinsurance and/or copayment and then calculating our payment (see example at right). This change does **not** apply to members on our Legacy system.

The member is responsible for paying the non-covered charges.

example

Total per diem = \$5,500 (\$1,100 x 5 days)
 Billed charges = \$6,250
 Non-covered charges (NC) = \$50
 Subscriber deductible & coinsurance = \$1,260

Payment is based on the lesser of billed charges or total per diem.

\$5,500
 (\$1,260)
 \$4,240 Blue Cross’ payment

How Facets affects reimbursement processes - Part 2

★\$0 charge for outpatient claims no longer acceptable

Outpatient claims processed in Facets must have an actual dollar amount charged for each line item. In Legacy, providers can bill \$0 for a line item and the allowed amount for each line item of the outpatient claim is used to determine payment. However, **in Facets**, outpatient line items with \$0 **will not be included** in the total allowed amount, resulting in potentially lower payment (see examples below).

examples

Facets with \$0 Billed

Code	Charge	BCBSLA Fee	Allowed
61750	\$0	\$2,000	
61742	\$4,000	\$2,000	
Total		\$4,000	\$2000

Facets with Dollar Amount Billed

Code	Charge	BCBSLA Fee	Allowed
61750	\$2,000	\$2,000	
61742	\$4,000	\$2,000	
Total	\$6,000	\$4,000	\$4,000

★No payment for ZERO CDT codes

It is important to file dental claims with current American Dental Association (ADA) CDT codes. In Legacy, Blue Cross has always processed dental claims filed with deleted CDT codes that begin with a zero. In Facets, deleted codes cannot be processed and claims filed with deleted CDT codes beginning with a zero will be returned to the provider for the correct dental code(s).

Dental codes now start with a “D” instead of “0” (e.g. 00120 was deleted and replaced by D0120).

Note: While our Legacy system can still handle the deleted codes beginning with zero, it is required by HIPAA that you submit all dental claims with valid CDT codes.

★Rounding differences occur between Facets and Legacy systems

Providers may notice that some allowable charges round up or down differently between the Facets and Legacy system. As a result, some Facets payments may be a few pennies different from Legacy payments.

★E & M visit code edits

Historically, we have allowed E/M visit codes to be billed with same day surgery codes whose sum was less than \$100. The Facets system bundles E/M visit codes to the surgery codes unless the visit is a distinctly separate service and is appended with Modifier -25. This change is consistent with other E/M visit code editing at BCBSLA, and is in accordance with CPT coding guidelines.

Filing dental claims with proper tooth, surface and quadrant numbers

Consistent with the American Dental Association (ADA) CDT coding guidelines, there are tooth, surface and quadrant numbers and letters that are compatible only with certain CDT codes. Follow the guidelines below when filing tooth-, surface- and quadrant-level CDT codes:

Tooth-Level CDT Codes:

- Include a valid tooth number or letter that corresponds with each CDT code listed.
- Report each CDT code and tooth number/letter on a separate claim line, even when the CDT code is the same for multiple teeth.

Surface-Level CDT Codes:

- Include a valid surface code that corresponds with each CDT code listed.

Quadrant-Level CDT Codes:

- Include either the area of oral cavity, **or**
- Include a valid tooth number or letter that corresponds with each CDT code code listed.

Improperly filed claims will be returned to the provider for correction.

★ New operating system brings changes to payment register

As part of the Facets implementation, the Weekly Provider Payment Register is receiving a slight makeover. You will receive the new payment register when you file claims/receive payment for members who have moved to the Facets operating system. The following notes the major differences between the Legacy register and the Facets register:

● New column order

The first time you receive one of the new payment registers, you'll probably notice immediately that the columns are in a different order. The columns dedicated to payment information have been grouped together: Total Charges, Above Allowable Amount, Contract Benefits, Not Covered-Ded-Coin-Inel and Amount Paid.

● Status/reject codes

Your Facets payment register will use different status/reject codes than your Legacy register. We will continue to print the definitions for the status/reject codes at the end of the register (see sample register).

You also may notice that there is no longer a STAT CD column. In the Facets register, the status/reject codes are placed in the column to which they apply.

● Credits and Adjustments

Credits and adjustments in your Facets register are marked by parentheses and consecutive claim numbers, i.e. 30000 followed by 30001.

● Interest penalty indicator changes

Late payment penalties will be indicated by an asterisk in the Facets register. Currently, in Legacy registers, the late payment penalty can be recognized by the status code, "ST."

Although the indicator is changing for the late payment penalty, we have not changed the formula that we use to calculate the late payment penalty.

If you have any questions about your Facets register, please call the *BlueLine* at 1-800-392-4076.

sample Facets payment register

Weekly Provider Payment Register

Patient Name	Contract Number	Patient Acct	Performing Provider	Days/ Units	Admit Dis Dt	Claim Number	CPT4 Rev	Sch Drg	COB OC Pay	Total Charges	Above Allow Amt	MD CD	Contract Benefits	Not Covered Ded-Coin-Inel	Amount Paid
PUBLIC, J. Q.	XUH098765432	12345	1234567890 Deaux, John	1	09/15/2005 09/15/2005	1000000	00000		\$0.00	\$155.00 \$155.00 HCC-CO	\$155.00		\$0.00	\$0.00	\$0.00
PUBLIC, SU	XUH123456789	12346	1234567890 Deaux, John	1	09/22/2005 09/22/2005	2000000	00000		\$0.00	\$125.00	\$5.08 \$5.08 PXN-CO		\$99.92	\$20.00 \$20.00 CPY-PR	\$99.92
SMITH, JOHN	XUH345678901	12348	1234567890 Deaux, John	1	09/22/2005 09/22/2005	3000000	00000		\$0.00	(\$80.00)	(\$32.48)		(\$47.52)	\$0.00	(\$47.52)
SMITH, JOHN	XUH345678901	12348	1234567890 Deaux, John	1	09/22/2005 09/22/2005	3000001	00000		\$0.00	\$80.00	\$25.36 \$25.36 PMP-CO		\$54.64	\$0.00	54.64
SMITH, JANE	XUH456789012	INTEREST PENALTY	1234567890 Deaux, John	1	09/05/2005 09/05/2005	4000000	00000		\$0.00	\$828.00	\$190.44 \$190.44 PDC-CO		\$201.29	\$436.27 \$350.00 DED-PR \$86.27 COI-PR	\$201.29
SMITH, JANE	XUH456789012	INTEREST PENALTY	1234567890 Deaux, John	1	09/05/2005 09/05/2005	4000001	00000		\$0.00	\$2.02	\$0.00		\$2.02	\$0.00	\$2.02*
TOTAL				3					\$0.00	\$1110.02	\$343.40		\$310.35	\$456.27	\$310.35

HCC – The Provider did not obtain Preservice Authorization for this service.
 Member Copay/Coinsurance is payment in full. No other member liability.
 CO – This amount is determined by Blue Cross to be the responsibility of the provider.
 PXN – Network Std Fee Schedule
 PR – This is the amount determined by Blue Cross to be the responsibility of the patient.
 PMP – The charge exceeds the allowed amount for this service.
 PDC – The charge has been reduced based on a discount arrangement with the provider of service.
 *ST – Statutory Adjustment

All dollar amounts and medical codes are examples.

Exceptional Customer Experience

BCBSLA is committed to offering an exceptional customer experience to our members and providers. That's one of the reasons we're implementing a new operating system.

Facets offers many positive changes for providers when they call customer service. One of the most

positive changes will be that customer service representatives will be able to assist with certain coordination of benefits (COB) information. As members move to the new operating system, customer service representatives may update the member's COB information if he/she does not have other coverage. Since approximately 75 percent of our membership does not have other coverage, this means that customer service can quickly update member files, and claims can be processed faster.

We are working hard to ensure a seamless transition between the two systems; however, you may notice a slight slowdown in customer service as the representatives will be moving between the new system and the Legacy system. We appreciate your patience as we make this transition.

If you have any questions about the changes resulting from the implementation of Facets, please call the *BlueLine* at 1-800-392-4076.

news & notes

★ Claims to deny, not pend for more information

In Facets, claims that require more information, e.g. medical records, are denied with a request for additional information to be filed with the claim. In our Legacy system, claims pend while we contact the provider for more information.

★ Members to receive new ID cards

As members move to our new operating system, they will receive new ID cards. The new card will have a new contract number. To ensure that you always have the most current member ID, please make a copy of the member's ID card each time they visit your office. Member ID numbers will continue to begin with the three-character alpha prefix. Always include the alpha prefix to avoid delays in claim processing.

You'll also notice that the ID card will no longer list the member's primary care physician (PCP). Members may continue to choose a PCP, but they are not required to choose one and the information will not appear on their ID cards.

iLinkBLUE changes

Stay tuned to the **iLinkBLUE** message board for detailed information regarding **iLinkBLUE** changes caused by the implementation of the new operating system. We will post all information and documentation on the message board, and it is imperative that you read all messages on a regular basis.

★ How Facets handles maternity copayments

For members with a maternity copayment, Facets applies the maternity copayment to the claim for the delivery.

If you have any questions about a member's benefits, eligibility or claims status, you can check iLinkBLUE or call the *BlueLine* at (800) 392-4076.

Check website for Facets updates

Be sure to visit the Provider page at www.bcbsla.com. We'll have updates regarding the Facets implementation, and you can continue to view office manuals, speed guides and much more!

★ denotes changes that apply only to Facets members

★ Breaking up is hard to do: How claims will and won't split in the new system

In our current claims system, each line item of a claim is processed and paid separately. That means that line items of a single claim could pay on multiple Weekly Provider Payment Registers. In the new operating system, most claims pend until each line item is processed, and then it appears on a single Weekly Provider Payment Register.

Select types of claims are split **automatically** by our system, and may be paid on different payment registers. Claims that split include:

Claims with multiple providers

Our new system allows for only one performing provider per claim. All claims filed with more than one performing provider are automatically split into multiple claims.

Claims with dates of service covering multiple calendar months/years

If a professional or outpatient claim is submitted that spans over two months or multiple years, Facets automatically splits the claim.

Claims for members with delinquent premium payments

If a member's claim spans a time period in which the member is delinquent in premium payment, the claim splits automatically. The portion of the claim that was rendered during the month in which the premium was current is processed according to the members benefits, and the portion of the claim that was rendered during the month in which the premium was delinquent is denied.

Claims that span a change in the member's benefit plan

When the member's benefit plan changes during the span of the claim, the claim splits automatically.

Claims with multiple patient account numbers

Our new system allows for only one patient account number per claim. Professional and outpatient claims filed with more than one patient account number automatically split into multiple claims.

If you have any questions about when or why a claim is split, please call the *BlueLine* at 1-800-392-4076.

Important information – please share with insurance staff

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