

# provider networknews

providing health guidance and affordable access to quality care

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## New Style of Member ID Cards Being Issued Beginning November 2008

Blue Cross and Blue Shield of Louisiana and our wholly owned subsidiary, HMO Louisiana, Inc., are pleased to introduce for our members, a more durable style of member identification (ID) card. The new system of creating and distributing ID cards will be more cost-effective, will improve the quality of the cards and will reduce the number of errors with the cards.

Beginning in November 2008, all new group and individual member policies are being issued the new style of ID card. Existing members will receive a new card upon renewal of their policy only if they have benefit changes that affect the information to be shown on their ID cards. It will take up to two years for all members to receive an upgraded card.

During the initial stages of the transition period, you should continue to accept the old style (laminated and folded) member ID cards. By the end of 2009, you should start to see more of the new style ID cards. When a member presents your office with the new member ID card, it could be an indicator that the member has a change in benefits such as copay or deductible, as this information is printed on the card. Still, member receipt of the new ID cards does not necessarily mean that the member's coverage has changed. Other changes may include contact information, member ID number, etc. For this reason, it is always important to ask for a copy of the member's ID card and to verify benefits at each visit.

If your patient has lost or misplaced his or her member Blue Cross ID card, he or she may request a replacement card using AccessBlue through our website at [www.bcbsla.com](http://www.bcbsla.com). Members may also use our automated voice response system by calling (800) 495-BLUE (2583) to order a new card.



Sample Front View



Sample Back View

## No Prior-Auth Results in Penalties Beginning January 1, 2009

**Outpatient Authorization Penalty For PPO and HMOLA/POS Providers:** A 30 percent penalty will be imposed on Preferred Care and HMO network providers for failing to obtain authorization prior to performing **outpatient services** that require authorization. This penalty will be applied to the provider's benefit payment of the allowable charge. The network provider is responsible for the penalty amount. The member is responsible for any applicable copayment, deductible, coinsurance percentage and/or non-covered services.

**Inpatient Authorization Penalty for HMOLA/POS Facilities:** A \$1,000 penalty will be imposed on the allowable charge of the HMOLA/POS network facility's reimbursement for failure to obtain an authorization on **inpatient stays**. No penalty will be applied to professional services related to the inpatient stay. The hospital is responsible for the penalty and may not bill the member or professional providers for the penalty.

For new group HMOLA/POS plans with deductibles, the \$1,000 penalty will be applied to the Blue Cross payment based on the member's deductible/co-insurance benefit.

Seasons Greetings



## Your Provider Contact Information Is Still Getting Top Scores

Blue Cross and Blue Shield of Louisiana has again been 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 2008. This ensures that our members—your patients—are able to locate you when healthcare needs arise. Quickly notifying us with changes in your contact information has paid off!

Help us stay on top again for 2009! **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](http://www.bcbsla.com). If you have questions about updating your provider contact information, e-mail us at [network.administration@bcbsla.com](mailto:network.administration@bcbsla.com) or contact Provider Network Administration at (800) 716-2299, option 3.



## Maintaining Your NPPES Information

You've now gone through the process of obtaining your national provider identifier (NPI) from the National Plan and Provider Enumeration System (NPPES). The Centers for Medicare & Medicaid Services (CMS) recommends that healthcare providers know and maintain their NPPES user IDs and passwords.

They also recommend that you reset your NPPES password at least once a year and that you periodically review your NPPES records to ensure that the information is current and correct. This practice promotes the safety of your unique provider information and ensures accessibility to that information.

## Viewing NPPES Information

You can view the information you've submitted to NPPES in one of two ways:

1. By accessing the NPPES record at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and following the NPI hyperlink and selecting Login. You will be prompted to enter your User ID and password.
2. By accessing the NPI Registry at <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>. The NPI Registry gives healthcare providers an online view of Freedom of Information Act (FOIA)-disclosable NPPES data. You can search for information by name or NPI.

## Updating Your NPPES Information

You can also correct, add or delete information on your NPPES records by accessing your NPPES record at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and following the NPI hyperlink and selecting Login. You will then be prompted to enter your User ID and password. Note: Required information cannot be deleted from an NPPES record, but can be updated.

## Still Need Your NPI?

Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or call the NPI enumerator at (800) 465-3203 to request a paper application.

## Credentialing & Accreditation Changes for Freestanding Diagnostic Imaging Providers

Beginning January 1, 2010, we are implementing a new credentialing and accreditation requirement that affects all freestanding diagnostic imaging providers who participate in our networks. As a condition for network participation, we will require that all freestanding diagnostic facilities be accredited by either the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC) for the following modalities: magnetic resonance imaging (MRI), computed tomography (CT), positron-emission tomography (PET) or nuclear cardiology. If a provider performs these services and is NOT accredited or fails to remain accredited, they will be removed from all Blue Cross networks in which they participate. The only exception would be that the freestanding diagnostic imaging provider no longer performs a modality that requires accreditation or performs another modality that does not require accreditation. Blue Cross reviews each provider's accreditation status during the provider's regularly scheduled recredentialing cycle, which is every three years in accordance with URAC standards.

Effective October 2008, Blue Cross began requiring accreditation as a condition of participation for freestanding diagnostic imaging providers. Credentialing information is available online at [www.bcbsla.com](http://www.bcbsla.com) > Provider > Credentialing, or by calling Network Administration at (800) 716-2299, option 2.

In order to remain in our network(s), existing participating, freestanding diagnostic imaging providers must be accredited by December 31, 2009, for all of the above modalities they perform. Please send your proof of accreditation by e-mail to [network.administration@bcbsla.com](mailto:network.administration@bcbsla.com) or fax to (225) 297-2750 before December 31, 2009, to avoid network interruption.

Look for additional reminders about our new requirements throughout 2009.

## Billing and Coding

### Provide Medical Record Copies at No Charge to Blue Cross

Periodically, it is necessary for Blue Cross to review and/or request copies of the medical records of our members. As a participating provider in our networks, you have agreed not to charge Blue Cross (or our members) for copies or the inspection of our members' medical records. The following provisions of the Key Physician and HMO Louisiana, Inc., (HMOLA) agreements highlight your commitment to provide copies of Blue Cross and HMOLA member medical records at no charge to Blue Cross and/or HMOLA.

#### Key Physician Agreement

*(based on May 2008 contract language)*

"Provide PLAN, upon request and without charge to PLAN or Subscriber, information including medical records of a Subscriber reasonably required by PLAN to determine Benefits and verify services related to PHYSICIAN's attendance, examination, and/or treatment and allow PLAN on-site audit of such records."

#### HMOLA Physician Agreement

*(based on May 2008 contract language)*

"Such inspection, audit and duplication shall be allowed upon reasonable notice during PHYSICIAN's regular business hours, and duplication of such data and records shall be provided, without cost, to HMOLA, its designee or Members."

If you have any questions about these provisions, please call Network Administration at (800) 716-2299, option 1.



### Updated Manuals and Speed Guides Available Online

One of our goals is to always keep you informed with up-to-date information. To that end, we've made updates to our provider manuals and speed guides, which include updated lists of services that require authorization.

Look under the "Manuals & Speed Guides" section of our Provider page at [www.bcbsla.com](http://www.bcbsla.com). Our provider manuals are also available under the "Manuals" section of iLinkBLUE.

### Filing Claims with Blue Cross

Participating Blue Cross providers agree to submit claims for Blue Cross and Blue Shield members on either the CMS-1500 or UB-04 Health Insurance Claim Form. All applicable information should be completed in full, including CPT®, HCPCS and/or DRG codes as well as ICD-9-CM diagnosis codes to ensure payment is made accurately and without delay.

#### Who Should File the CMS-1500 Form

The CMS-1500 Health Insurance Claim Form is the standard claim form for use by non-institutional or "professional" providers and suppliers who bill for their services independently of any related facility, clinic or institutional charges. These providers include, but are not limited to, medical doctors, durable medical equipment suppliers and professional staff who perform billable services

within a facility (outpatient and/or inpatient).

Blue Cross processes professional, outpatient surgery and outpatient diagnostic and therapeutic claims using CPT, a systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. By using these procedure codes, you can enhance the speed and accuracy of claims payments. Always include the appropriate CPT code(s) when filing these types of claims.

#### Who Should File the UB-04 Form

The UB-04 is the standard claim form for use by institutional providers such as hospitals, skilled nursing facilities, hospices and other outpatient facilities. Charges billed by institutional providers on a UB-04 form are strictly for facility billable charges and not for any related professional charges.

#### Stay Updated

Because medical nomenclature and procedural coding is a rapidly changing field, certain codes may be added, modified or deleted each year. Please ensure that you are using the current edition of the code book reflective of the date of service of the claim. The applicable code books include, but are not limited to, ICD-9-CM Volumes 1, 2, and 3; CPT and HCPCS.

## Billing and Coding

### Biannual Review of Drug & Drug Administration Code Allowable Charges

As part of our routine biannual review of drug and drug administration code allowable charges, we consider the current pricing methods for Medicare, Average Wholesale Price, Specialty Pharmacy pricing and generic drug availability. We also consider the impact the allowable charge change may have on our network providers' practices.

As a result of our review, we have updated the reimbursement schedule for drug codes for professional providers, which will be effective for claims with dates of service on and after March 1, 2009.

To help providers understand the impact of these changes, you may access the allowable charges for drug and drug administration codes on our iLinkBLUE *Provider Suite* under the Provider Manuals section. Or, you may access them through our allowable charge application under the "Allowable

Charges" section of iLinkBLUE and enter the necessary information. Providers with access to iLinkBLUE can easily access the drug and drug administration code allowable charges list at any time.

**Not an iLinkBLUE user?** Providers without access to iLinkBLUE may call Network Administration at (800) 716-2299, option 3 or (225) 297-2758 to obtain a copy of the new drug reimbursement schedule. You may also request a copy of the new allowable charges schedule by e-mailing [network.administration@bcbsla.com](mailto:network.administration@bcbsla.com). Please use "allowable charges" in the subject line and provide your contact information including phone and fax numbers, provider name and NPI number within the e-mail.

To register for iLinkBLUE, more information is available on our website, [www.bcbsla.com](http://www.bcbsla.com), under "iLinkBLUE."

### No Payment for Unapproved Extended Inpatient Stays

Effective for admissions beginning February 1, 2009, Blue Cross will no longer pay admitting physician charges for days a patient spends in the hospital beyond the approved number of days determined to be medically necessary. This applies to extended stays denied due to insufficient medical, investigational and medical necessity reasons.

Because non-admitting physicians may not direct the continued stay or discharge of the patient, we will continue to pay for their services rendered in the hospital according to the member's benefit plan during any extended inpatient hospital days that are not approved.

This policy will apply to both partial and full inpatient denials.

All admitting physicians and facilities will be notified of the member's approved number of inpatient days and will be made aware that no payment will be made to the admitting physician for any days beyond the approved number.

This change affects all Blue Cross and Blue Shield of Louisiana and Federal Employee Program (FEP) members.

### Correct Taxonomy Codes Essential

Facilities must file claims with the correct taxonomy codes as well as NPI. An incorrect taxonomy code could result in claims being either paid with the wrong reimbursement or will be sent back to the facility to re-file correctly, causing delays in claims processing.

### Preparing for ICD-10

On August 22, 2008, the proposed rule for "Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS" was issued. The plans are to replace the ICD-9-CM (for all morbidity and mortality classifications) and the ICD-9 (for procedure classifications) with ICD-10-PCS in acute care. October 1, 2011 is the proposed effective date for the ICD-10 switch.

Most agree that the new system is necessary to keep up with new medical developments constantly emerging every year—ICD-10 will have nearly 10 times as many codes as are currently used with ICD-9. Centers for Medicare and Medicaid Services (CMS) says the new system will allow providers to include more details on patient records. The coding changes will also make it easier to track new disease outbreaks.

Because of the time and expense involved in converting to ICD-10, many providers and health plans have requested that the deadline be extended at least five years. The transition is also expected to bring an increase in billing errors and delays, ultimately affecting consumers. More time before the system takes effect may be needed to avoid or reduce the affect of these issues.

Because ICD-10 may overlap the transition to version 5010 of the HIPAA electronic transaction standards causing more difficulty with either transition, the Blue Cross Plans have proposed a five-year schedule outlining actions necessary for a successful transition to ICD-10 without overlapping the two new system transitions. The proposed plan recommends that CMS adopt a timely process in advance of the October 2011 compliance date to respond to the industry's questions regarding all aspects of the implementation. The Blue Cross Plans will continue to work to extend the deadline.

## Electronic Services

### Avoid Untimely Claim Denials When Submitting Through Clearinghouse



Providers are filing unnecessary appeals for claims that reject for untimely filing, creating additional work for both them and Blue Cross. We have researched some of the appeals and found that in many instances, the timely filing could have been met if the billing office had procedures in place to perform daily reconciliation of their electronic claims submitted to Blue Cross.

**The Process:** When claims are received by a clearinghouse, they perform a basic set of editing on claims, and most provide the sender with a list of the claims that were forwarded to the payer and a list of the claims that contained errors (were not sent to the payer). In most instances, clearinghouses send this report to their providers. Claims rejected on this report must be corrected and resubmitted.

When the clearinghouse sends the claims to Blue Cross, we also subject the claims to editing. Claims that do not contain errors are listed on the Accepted Report. These are the claims that actually enter the Blue Cross system for processing. Claims that contain errors are listed on the Not Accepted Report, and an error message is displayed indicating what was wrong with the claim. Some clearinghouse locations do not return this report to their providers.

#### To Ensure Your Claims Are Transmitted, You Should:

(1) Develop an electronic balancing process using the daily Accepted and Not Accepted reports issued by your clearinghouse.

(2) If you do not get reports from your clearinghouse, ask them for the report or use the iLinkBLUE system to confirm your claim submissions. iLinkBLUE contains applications that can be used to ensure your claims are received for processing. Below are the details:

**For Facets Claims:** Use of the “Confirmation Reports” feature will allow you to view Accepted (Facets) and Not Accepted (Facets) claims. All claims found on the Not Accepted Report cannot be processed by Blue Cross; therefore, you must correct them and then resubmit the claim(s).

**For Legacy Claims:** All electronic claims that are not accepted for processing are returned via letter to the provider. This letter will identify the patient and date of service and will indicate if the entire claim or service line (line item) contained an error and has been deleted from our system. It is very important that you make the correction indicated on the letter and resubmit that claim or service line.

To confirm that claims are accepted by Blue Cross, use the iLinkBLUE “Claim Status” feature or a sampling of the claim(s) that did not appear on the Facets Accepted or Not Accepted reports found on the “Claim Confirmation” feature.

In order for us to process your claims, the corrected claim must be resubmitted to us no later than 15 months from the date of service.

For more information on electronic/clearinghouse claim submissions to Blue Cross, you may e-mail [edich@bcbsla.com](mailto:edich@bcbsla.com) or call (225) 291-4334.

**! Did you know that it typically takes three to four days after you submit a claim to your clearinghouse before it first appears on iLinkBLUE?**

### More Groups Move to Facets

On January 1, 2009, the groups listed below are moving to Facets, our new operating system. Providers should notice little impact to claims processes with this move. However, please be aware that you may receive more than one type of payment register during this transition.

Group Name	Group No. <i>(shown on member's ID card)</i>
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Diocese of Baton Rouge	76304
East Carroll Parish Schools	75709
Estate of William G. Helis	47776
Georgia Pacific Corp.	76673
Iberia Parish Schools	77547
LAHSIC (Blue Cross Blue Shield of LA)	46210
Whitney National Bank	75914



These members will be issued the new style of ID card mentioned on the front page of this newsletter.

### Are You Using iLinkBLUE to View Allowables?

If you're not already using iLinkBLUE to look up your allowable charges, now is the time. With iLinkBLUE, you can look up allowable charges by network, date of service and even code range.

Go to [www.bcbsla.com/ilinkblue/](http://www.bcbsla.com/ilinkblue/) and look for “Allowable Charges” on the menu bar.

If you're not an iLinkBLUE user, visit the iLinkBLUE section of our Provider page at [www.bcbsla.com](http://www.bcbsla.com) for more information.

## Member Benefits

# 2009

## Blue Cross and Blue Shield of Louisiana Product Enhancements

Effective as group and individual policies are renewed beginning January 1, 2009

### ● Outpatient Authorization Penalty for PPO and HMO/POS Providers

A 30 percent penalty will be imposed on Preferred Care and HMO network providers for failing to obtain authorization prior to performing outpatient services that require authorization. This penalty will be applied to the provider's benefit payment of the allowable charge. The network provider is responsible for the penalty amount. The member is responsible for any applicable copayment, deductible, coinsurance percentage and/or non-covered services.

### ● Authorization Penalty for HMOLA Point of Service Policies

A \$1,000 penalty will be imposed on the allowable charge of the HMOLA/POS network facility's reimbursement for failure to obtain an authorization on inpatient stays. No penalty will be applied to professional services related to the inpatient stay. The hospital is responsible for the penalty and may not bill the member or professional providers for the penalty.

### ● Dietician Visits

A new benefit of \$250 per calendar year is available for outpatient dietician services when rendered by registered dietitians. The member is responsible for amounts in excess of the benefit maximum. Dietician visits for diabetics may be available under a separate benefit for diabetes self-treatment training and education.

### ● Self-Administered Drugs

Blue Cross will no longer reimburse providers for certain self-administered medications even when obtained from an infusion therapy provider (unless prescribed in conjunction with another drug that must be administered by an intravenous infusion). Self-injected medications will continue to be a benefit for our members when purchased at a retail pharmacy, or in some cases, through our specialty pharmacy network.

*A complete list of non-payable J-codes is available at [http://www.bcbsla.com/web/reddotcm/html/13\\_557.asp](http://www.bcbsla.com/web/reddotcm/html/13_557.asp), or you may call Provider Services at (800) 922-8866 to request a copy of this list.*

### ● Periodic Oral Examinations & Dental Prophylaxis (Cleanings)

These services have always been limited to two per covered year. Benefits will be updated to clarify the number of allowances per covered year, stating: twice yearly, six (6) months apart.

### ● Pharmacy Coinsurance

Some members have deductible and coinsurance as part of their pharmacy benefits instead of copayments. Participating pharmacies may collect one hundred percent (100%) of the discounted cost of the drug at the point of sale if the member's deductible has not been met. If the member has met the deductible, the pharmacy should only collect the coinsurance amount and should also electronically submit the claim for the member.

### ● Autism as a Medical Benefit

Blue Cross and HMOLA group policies will cover the diagnosis and treatment of autism as a medical benefit (*this change does not apply for Federal Employee Program (FEP) or individual policies and may vary for self-insured groups and BlueCard® members*). Applied Behavior Analysis is eligible for coverage when services are rendered by a board-certified Behavior Analyst. Authorization is required for all Applied Behavioral Analysis services.

The benefit maximum for members under the age of 17 is \$36,000 per calendar year and \$10,000 per calendar year for members 17 and older. The lifetime maximum for all autism benefits is \$144,000. Coverage for members 17 and older may not include Applied Behavioral Analysis.

### ● Limb Prosthetics and Prosthetic Services for Limbs

New benefits are now available for Limb Prosthetics and Prosthetic Services for Limbs for Blue Value and Blue Select policies with a benefit maximum of \$50,000. The maximum limitation for all Blue Cross policies including HMOLA and Premier Blue will increase to \$50,000 for Limb Prosthetics and Prosthetic Services.

Authorization is required and repair or replacement is covered only within a reasonable time period. Deluxe appliances are covered when documented to be medically necessary. Prosthetic appliances and devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification on Orthotics, Prosthetic and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

### ● Combined Durable Medical Equipment Maximum (DME)

All Blue Cross policies including HMOLA and Premier Blue will have a combined maximum limitation of \$15,000 per calendar year for DME, orthotics and non-limb prosthetics.

# Federal Employee Program

## 2009 Prior Approval Requirements

Please call the number listed on the member's ID card to obtain authorization for these services.

### For Mental Health/Substance Abuse

In 2009, Standard Option members must obtain prior approval before receiving any outpatient Mental Health/Substance Abuse services. A treatment plan will no longer be required from providers prior to the member's ninth outpatient Mental Health/Substance Abuse visit. When members call for prior approval, they will be provided with the names and phone numbers of several Preferred providers and advised on how many visits are being initially approved. Members may then choose which of those providers they would like to see.

### Outpatient Surgeries

In 2009, prior approval will be required for outpatient surgery for morbid obesity, outpatient surgical correction of congenital anomalies and outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth for Standard and Basic Option members. Previously, these types of services did not require prior approval. This requirement applies to both the physician services and the facility services, regardless of network participation (applies to network and non-network providers alike).

## Medical Management



### Specialty Pharmacy Program

Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. have established a Specialty Pharmacy Network offering prescription fulfillment and support services for covered members being treated with specialty medications. Specialty drugs are biotechnology medications or other drug products that often require special ordering, handling, patient education and/or customer service.

Beginning on January 1, 2009, Blue Cross members with specialty pharmacy provisions in their benefits will need to access our Specialty Pharmacy Network (see below) to receive in-network pricing for specialty drugs.

If these members choose not to fill specialty prescriptions at one of our network specialty pharmacies, they will be required to pay the full cost of the medication at the point of sale and submit a paper claim for reimbursement. They will then be reimbursed the specialty pharmacy network price, less any applicable deductible, copayment or coinsurance amount.

Physicians are not required to use our Specialty Pharmacy Network and may continue to buy and bill for the infused medications they administer in their offices.

### Who is in the Specialty Pharmacy Network?

At present, there are two specialty pharmacies included in our Specialty Pharmacy Network:

CVS/Caremark (formerly PharmaCare)  
600 Penn Center Boulevard  
Pittsburgh, PA 15225

(800) 238-7828

CuraScript  
6272 Lee Vista Boulevard  
Orlando, FL 32822

(866) 848-9871

View our complete list of specialty medications that are included in the Specialty Pharmacy Program, available on our website, [www.bcbsla.com](http://www.bcbsla.com). Go to Health Tools>Covered Drugs.

## Medical Management

### Formulary Updates for 2009



Each year, branded and generic drugs are introduced into the marketplace and new and updated clinical information is published. To ensure that we offer our members a responsible and cost-effective drug benefit, Blue Cross and HMO Louisiana, Inc., update our preferred medication list or “formulary” each year.

Effective January 1, 2009, the following medications will be moving from a Tier 3 (higher) to a Tier 2 (middle) copayment level, which means they will be more cost-effective for members:

Gleevec®	Intelence™	ISENTRESS®
Kuvan™	Lipitor®	Nexavar®

The medications listed in the left column below are moving to a Tier 3 (higher) copayment level on January 1, 2009. Also listed below (middle and right columns) are the lower-cost alternatives for each Tier 3 medication. We offer this information to our members and encourage them to discuss options with their physician(s).

Tier 3 Medication (Higher Copayment)	Tier 2 Alternatives (Middle Copayment)	Tier 1 Alternatives (Lowest Copayment)
Avodart®		finasteride
Betoptic®		betaxolol, brimonidine, carteolol, levobunolol, metipranolol, timolol
Vytorin®	Crestor®, Lipitor®	lovastatin, pravastatin, simvastatin

*Copayment Tiers in table effective January 1, 2009*

### Find the Latest Drug Copayment Information

The latest preferred medication list is always available to read or download on our website at [www.bcbsla.com/pharmacy](http://www.bcbsla.com/pharmacy). Blue Cross members may call the Express Scripts customer service department toll-free at (866) 781-7533, which is also printed on their member ID card, to request a printed copy by mail.

### Why Some FDA-Approved Devices are Considered Investigational

The U.S. Food and Drug Administration (FDA) is responsible for ensuring the safety and effectiveness of medical devices in the United States. Approximately 90 percent of the devices submitted to the FDA for approval are classified as Class I or Class II and require fewer resources than Class III devices. They are approved through a 510(k) application process that does not require a clinical trial period. Class I and II devices consist mostly of non-invasive, non-life-threatening devices based on ones already on the market. Only about 10 percent of devices submitted to the FDA are Class III and required to undergo a premarket evaluation phase. Class III consists of devices that usually sustain or support life, are implantable or present potential, unreasonable risk of illness or injury.

The FDA has the challenge of keeping the “product-to-market” time for Class III devices short enough to be patient-beneficial in a timely manner and still cost-effective for the manufacturer. Often Class III devices are released onto the market in two years or less.

Blue Cross takes many factors into consideration when determining if a medical device should be considered investigational. One key factor is whether the device has received FDA approval. Even with devices that have FDA approval, we may require further studies or clinical trials to determine the maximum tolerated toxicity, safety or effectiveness as compared with the standard means of treatment or diagnosis, according to the consensus of opinion among experts as shown by reliable evidence. This is partly because the vast majority of FDA-approved devices are Class I and II, which do not require clinical trials.

In making such determinations, we use a variety of references including, but not limited to: the Blue Cross and Blue Shield Association (BCBSA) Technology Evaluation Center (TEC), BCBS Medical Policy Reference Manuals, Hayes Medical Technology Directory and peer-reviewed published literature.

Coverage determination for medical devices, treatments, procedures, drugs and biological products are available in our medical policies, under the medical policy section of iLinkBLUE at [www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue).

## Medical Management



### 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

Policy No.	Policy Name	Effective Date
00231	Sacroiliac Joint Arthrography and Injection	April 1, 2009

#### Recent Medical Policy Updates...

##### September 2008

- Genetic Testing for Congenital Long QT Syndrome - 00208
- Human Growth Hormone - 00188
- Immune Prophylaxis or Respiratory Syncytial Virus - 00177
- Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel - 00137

##### October 2008

- Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia - 00053
- Recombinant Human Erythropoietin Epoetin (Epogen® and Procrit®) and Darbepoetin (Aranesp®) - 00210

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 Provider Services at (800) 922-8866.



#### Medical Policy Highlights

##### Sacroiliac Joint Arthrography

This new policy is effective for claims with a date of service on and after April 1, 2009. Arthrography of the sacroiliac joint as well as injections into the sacroiliac joint for diagnostic or therapeutic purposes are considered to be investigational. This policy parallels the Blue Cross and Blue Shield Association's medical policy.

##### Genetic Testing for Congenital Long QT Syndrome

This test was considered investigational in the past, but as of September 2008, the services are eligible for coverage.

##### Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia

Effective March 1, 2009, autologous stem-cell transplantation as a treatment of chronic myelogenous leukemia (CML) will be considered investigational.

## Blue Cross Welcomes New Medical Director of Medical Policy



Blue Cross has appointed Dr. Thomas Kim as medical director of medical policy.

Dr. Kim previously served as vice president and chief medical officer for a large primary care clinic in California, where he provided medical leadership and oversight for five medical directors and more than 90 providers who delivered services to the underserved population.

Dr. Kim received his medical degree from Drexel University's Hahnemann Medical College in Philadelphia. In addition, he has earned a master's degree in business administration from Northwestern University in Evanston, Ill., and a master's degree in public health from the University of Illinois' School of Public Health in Chicago. Dr. Kim is currently certified with the American Board of Internal Medicine. His clinical practice of more than 20 years was in critical care medicine as medical director of a large community hospital in the Chicago metropolitan area.

## BlueCard® Program

### 2009 Medicare Advantage PPO Network Sharing

Recent government rule changes effective in 2009 enable health plans to enroll and cover some retiree group members in Medicare Advantage (MA) HMO or PPO products, even in areas where a formal provider network is not available. This rule change makes these MA products available to more accounts and their members, often offering enhanced benefits, lower premiums and improved care management.

“Non-network members,” those enrolled in areas without a provider network, receive the same benefits as members enrolled in areas where network providers are available. Non-network members’ benefits will be paid at the in-network benefit level. They may receive care from any Medicare eligible provider, including all Medicare participating providers.

**How do Medicare Advantage policies affect Louisiana Blue Cross Providers?** Providers are currently not required to render services to non-network members, although, they are encouraged to do so. You should continue to verify eligibility and bill for services as you currently do for any out-of-state Blue Plan member you agree to treat.

Claims are to be submitted directly to Blue Cross and Blue Shield of Louisiana. Providers will be paid the “Medicare Allowed Amount” unless a different reimbursement rate has been agreed upon with Blue Cross. Benefits will be paid under the member’s out-of-network benefits unless for urgent or emergency care.

### Blue Coverage for Jamaica Members Terminates January 1st

Effective January 1, 2009, Blue health insurance coverage for international Blue members of Blue Cross of Jamaica will be terminated. These members will carry ID cards with alpha prefix JAM.

Remember, to ensure eligibility and benefits, always verify patient coverage prior to rendering services by using one of your electronic technologies, or by calling (800) 676-BLUE.

Please note the following:

- You should not accept ID cards with alpha prefix JAM after December 31, 2008. Claims for services rendered after this date will not be reimbursed through the BlueCard Program.
- For services rendered prior to or on December 31, 2008, submit all claims to Blue Cross and Blue Shield of Louisiana by May 1, 2009.
- Original claims and adjustments submitted after May 1, 2009, for services provided prior to or on December 31, 2008, will not be reimbursed through BlueCard.

### TRICARE Bid is In

Blue Cross is eagerly awaiting the Department of Defense’s decision on who will be awarded the TRICARE contract for the South Region. While the official contract award will not be effective until June 2009, and the delivery of healthcare for the next contract period will not begin until early 2010, we anticipate some notification of the government’s intent in the near future.

When we hear more from the Department of Defense, we will let providers know. In the meantime, thanks to all providers who signed letters of intent with Blue Cross.



### Value of Blue Distinction Centers

Blue Distinction is a designation awarded by Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare.

To date, the Blue Cross and Blue Shield Association has designated nearly 800 Blue Distinction Centers across 43 states in the areas of Bariatric Surgery, Cardiac Care, Transplants and Complex and Rare Cancers.

The value of Blue Distinction is being incorporated into benefit design or member incentives by Plans and Accounts around the nation. These changes may currently affect some out-of-state members’ coverage of certain services performed. Always verify members’ eligibility/coverage prior to rendering services.

For more information concerning the Blue Distinction program, contact Kim S. Gassie, Network Initiatives Administrator at (225) 297-2685 or [kim.gassie@bcbsla.com](mailto:kim.gassie@bcbsla.com).

### Are Your Patients “Doing the 2?”



[www.Louisiana2Step.com](http://www.Louisiana2Step.com) has online tools such as food and activity logs, healthy recipes and a current calendar of health and fitness events in communities across Louisiana.



[www.2Step4Kids.com](http://www.2Step4Kids.com) is aimed at children ages 5-12 and includes a resource area for both parents and teachers, with careful attention paid to safeguarding children who come to the website.

## Company News

### Blue Cross to Celebrate 75th Anniversary in 2009

The year 1934 was a notable time in Louisiana history: Huey P. Long served in the U.S. Senate, Tulane won the Sugar Bowl, Bonnie and Clyde were ambushed near Shreveport ... and Blue Cross opened its doors in New Orleans with two employees to serve our customers. A lot has changed since 1934, but our commitment to Louisiana has never wavered.

Today, Blue Cross and Blue Shield of Louisiana employs more than 1,600 residents across the state. And the once-small, one-room company now makes a \$3.5 billion impact on the state's economy.

Throughout 2009, we'll celebrate our diamond jubilee in a number of ways. Blue Cross is proud of the fact that we can count nearly 9 out of every 10 Louisiana doctors in our networks, as well as every full-service acute care hospital in the state. Our four straight No. 1 rankings for provider satisfaction help to show our commitment to serving you as well as your patients ... our mutual customers.

We've served those customers since 1934 through good times and bad... in sickness and in health. We're proud of our 75 years of commitment to the health of all Louisianians. Join us as we look forward with a vision for a healthier Louisiana to come.



### 2008 Angel Award Winners Selected

For their outstanding volunteer service on behalf of Louisiana's children, eight men and women from across the state have been named the 2008 winners of the Angel Award presented by Blue Cross and Blue Shield of Louisiana.

A committee of past recipients of the Angel Award, now in its 14th year, considered more than 50 nominations from throughout the state before selecting Chris Broussard of Minden, Raymond Hicks of Shreveport, Cherry Seal of Glenmora, Ellen "Deedee" Suthon of Covington, and Baton Rouge residents Carolyn Carnahan, Shirley Porter, Dee Robinson and Ella Rein Wheeler.

You can read more about all of the winners on Blue Cross' website at [www.bcbsla.com](http://www.bcbsla.com). Just click on Community to find a searchable database of all past nominees, finalists and winners, as well as nomination criteria and an online nomination form.

The 2008 Angel Award winners were announced by Supriya Jindal at a presentation ceremony on October 27th in Baton Rouge. They joined more than 100 men and women from all walks of life and all corners of the state who have been recognized since the program's inception in 1995. Grants to the charitable causes chosen by honorees over the years now total more than \$880,000. Each honoree receives a \$20,000 grant from the Blue Cross and Blue Shield of Louisiana Foundation\* to be donated to a charity that benefits children.



(left to right) Carolyn Carnahan, Volunteers In Public Schools, Baton Rouge; Cherry Seal, Glenmora School-Based Health Center, Glenmora; Ella Rein Wheeler, Buchanan Elementary School, Baton Rouge; Shirley Porter, The Sunshine Foundation, Baton Rouge; Supriya Jindal, First Lady of Louisiana, Mistress of Ceremonies; Deedee Suthon, Safe Harbor, Covington; Dee Robinson, Brave Heart Children in Need, Baton Rouge; Raymond Hicks, Alliance for Community Development, Shreveport; and Chris Broussard, Cultural Crossroads of Minden, Minden

\*The Blue Cross and Blue Shield of Louisiana Foundation is an independent licensee of the Blue Cross and Blue Shield Association.

# What's New on the Web

## www.bcbsla.com

- External Review of Billing Disputes: After exhausting our internal dispute resolution processes, providers may submit an external billing dispute resolution request online. Available under the "Forms for Providers" section of the Provider page.
- Traveling: Blue Members now have local access to network providers nationwide. Available on the Customer page.

## www.bcbsla.com/ilinkblue

- March 2009 Standard Drug, DME Drug and Infusion Therapy Drug code allowable charges now available.
- Updated manuals, including the Member Provider Policies and Procedures Manual and the Professional Provider Office Manual.

## Have an Idea?

NetworkNews is your newsletter, provided to serve you, our valued providers. The views of our readership are important to us. If you have ideas for articles or suggestions about how we can improve this newsletter, please e-mail us at [provider.communications@bcbsla.com](mailto:provider.communications@bcbsla.com).

# 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.

If you would like to receive this newsletter by e-mail, please contact us at [provider.communications@bcbsla.com](mailto:provider.communications@bcbsla.com).

View the newsletter online at

[www.bcbsla.com](http://www.bcbsla.com) > Provider > Provider News.

## Important Contact Information

### Network Administration

(800) 716-2299

[network.administration@bcbsla.com](mailto:network.administration@bcbsla.com)

### Provider Services Call Center

(800) 922-8866

### iLinkBLUE & EFT

(800) 216-BLUE(2583)

[iLinkBLUE.ProviderInfo@bcbsla.com](mailto:iLinkBLUE.ProviderInfo@bcbsla.com)

### EDI Clearinghouse

(225) 291-4334

[EDICH@bcbsla.com](mailto:EDICH@bcbsla.com)

### Fraud & Abuse

(800) 392-9249

[fraud@bcbsla.com](mailto:fraud@bcbsla.com)

### Authorization

See member's ID card

### Claims Filing

P.O. Box 98029

Baton Rouge, LA 70898

### BlueCard® Eligibility

(800) 676-BLUE(2583)

### FEP

(800) 272-3029

### TRICARE

(800) 363-9150

Please share this newsletter with your insurance and billing staff!



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