Medicare Advantage PPO Quick Guide
for Blue Cross and Blue Shield of Louisiana Providers

Recent government rule changes 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. Blue Cross and Blue Shield of Louisiana does not maintain a provider network for MA at this time; although, our providers may be asked to service a MA member while they are in our service area. MA members who are enrolled in areas without a provider network (in this case, Louisiana), are “non-network members,” and may receive care from any Medicare eligible provider, including all Original Medicare participating providers.

BCBSLA network providers, who are Original Medicare-eligible providers, are currently encouraged, but not required, to render services to non-network members. Should you decide to provide services to a MA member, you will be reimbursed for Medicare covered services at the “Medicare Allowed Amount” based on where the services were rendered and under the member’s out-of-network benefits. Providers should continue to verify eligibility and bill for services for any out-of-state Blue Plan member they agree to treat. Claims are to be submitted directly to BCBSLA.

1 Identify MA Members
All MA cards will have the Medicare Advantage PPO/suitcase-type logo. Some employer groups may offer both MA and non-MA benefit plans. The identification cards for both will look the same, except those members who have the MA option will have the MA PPO/suitcase logo.

2 Verify MA Member Eligibility & Authorizations
Providers should verify MA PPO member eligibility or obtain authorizations through one of the following methods:
• Online through our iLinkBLUE Provider Suite under BlueCard/Out-of-State, Coverage Information Request,
• Calling the number on the member’s ID card or
• Calling the BlueCard Eligibility Line® at 1.800.676.BLUE (2583).
Be prepared to provide the member’s alpha prefix located on their ID card.

3 Servicing Confirmation Form
You must complete a Member Servicing Confirmation Form for every MA member that you treat. By completing this form, you agree to provide services to that particular MA member for the period of time indicated on the form at the Medicare Allowed Amount. Find the form at www.bcbsla.com under Out-of-State; click on the Servicing Medicare Advantage button. Submit the form by e-mail to Network.Administration@bcbsla.com or fax to 225.297.2750.

Medicare Advantage Quick Facts

• MA PPO members from other Blue Plans may obtain in-network benefits when traveling or living in the service area of another Medicare Advantage Blue Plan as long as the member sees a contracted MA PPO provider.
• Benefits will be based on the Medicare allowed amount for Medicare covered services based on where services are rendered and paid under the member’s out-of-network benefits. Services for urgent or emergency care are paid based on in-network benefits.
• All out-of-network MA claims go through the same process as the BlueCard® Program.
• You should continue to verify eligibility and bill for services as you currently do for any out-of-area Blue Medicare Advantage member you agree to treat.
• Providers should refer to Original Medicare policies and procedures when billing for MA PPO members.
**Medicare Providers**

In order to see MA members, you must be an Original Medicare eligible provider and follow all Original Medicare requirements. Because BCBSLA does not maintain a provider network for MA at this time, providers should follow the policies and procedures of the member’s home plan or Medicare. Contact the number on the member’s ID card for more information or go to [www.cms.hhs.gov/home/medicare.asp](http://www.cms.hhs.gov/home/medicare.asp) to view Medicare’s policies.

**Filing Claims**

Providers should submit claims directly to BCBSLA just as you would a BlueCard or any other out-of-state claim. Once we receive the claim, we will electronically route the claim to the member’s Home Blue Plan. That plan then processes the claim and approves payment, enabling us to reimburse you.

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<th><strong>Hard Copy Claims</strong></th>
<th><strong>Electronic Claims</strong></th>
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<td>BCBSLA, Claims Department</td>
<td>Blue Cross Approved Clearing Houses or iLinkBLUE at <a href="http://www.bcbsla.com/ilinkblue">www.bcbsla.com/ilinkblue</a></td>
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<td>P O Box 98029</td>
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<td>Baton Rouge, LA 70898-9029</td>
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MA non-network members’ claims will be adjudicated according to the benefits that their health plan provides. The claims will be paid according to Centers for Medicare and Medicaid Services’ guidelines. At a minimum, eligible claims will be reimbursed at the Medicare Allowed Amount based on where the services were rendered and under the member’s out-of-network benefits.

The Medicare Allowed Amount is the fee schedule reimbursement that Medicare would pay to a provider who accepts assignment of benefits for services rendered to a member for covered benefits.

Urgent or emergency care is paid at the Medicare Allowed Amount based on where services were rendered.

Providers should refer to the member ID card for instructions on how to access terms and conditions. Louisiana providers will receive reimbursement directly from BCBSLA the same as other BlueCard claims.

**Please note:** Original Medicare Primary claims, with Blue Cross as secondary or supplemental, follow a different process. For more on Original Medicare Primary claims, see the BlueCard Program Provider Manual on [www.bcbsla.com](http://www.bcbsla.com) under the Manuals & Speed Guides section of the Provider page.

**Allowable Charges**

Medicare fee schedules may be found at the following website: [www.cms.hhs.gov/FeeScheduleGenInfo/](http://www.cms.hhs.gov/FeeScheduleGenInfo/)

**Ancillary/Allied Health Providers**

The following provider types should consult the member’s home plan for coverage and claims filing information:

- Behavioral Health
- Complementary/Alternative Medicine
- DME/HME
- Hearing
- Lab
- Routine Vision
- Routine Dental
- Self-Administered Pharmacy
- Specialty Pharmacy

**More Information**

Providers may find more information on Medicare Advantage PPO and Medicare Advantage Private Fee For Service online at [www.bcbsla.com](http://www.bcbsla.com) under Provider, BlueCard/Out-of-State. Click on the Servicing Medicare Advantage button. This information and more on servicing Medicare Advantage members may be found in BCBSLA’s BlueCard Program Provider Manual, and Professional Provider Office Manual. Information is also available in our Member Provider Policies and Procedures (Facility) Manual, which is available on iLinkBLUE under Manuals.

**Contact Information**

- **BCBSLA Provider Services**
  1.800.922.8866, option 3
- **BCBSLA Provider Relations Representative**
  To find your representative, see our interactive map at [www.bcbsla.com](http://www.bcbsla.com) under Provider Tools.
- **Member ID Cards**
  Please refer to the number(s) on the member’s ID card.

The information included in this guide only applies to the Medicare Advantage PPO product.
Hospital, Cancer Centers, Federally Qualified Health Centers, Rural Health Clinic Claims

**Interim Payment Rate Letters**
Home Plans must pay certain types of institutional providers on a reasonable cost basis according to interim payment rate letters. When the Home Plans don’t receive the interim payment rate letter, they cannot correctly calculate the payment owed the provider. Providers paid by Original Medicare on a reasonable cost basis should write the member’s ID number and date of service on a copy of their most current interim payment rate letter then send it with the claim when billing for a Medicare Advantage (MA) PPO claim. BCBSLA will then send a copy of the letter via BlueSquare General Inquiry when we process the claim. Certain Medicare providers are paid based on a reasonable cost basis (based on interim payment rate letters) instead of the Medicare Prospective Payment System. These providers include:

- Critical Access Hospitals (CAH)
- Cancer Centers
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)

**Admitting Diagnosis Code for Inpatient Claims**
Home Plans will need the admitting diagnosis code for the submission of Medicare Risk Adjustment (MRA) Data. We require the admitting diagnosis code for all MA PPO inpatient claims.
- **UB04 Form**: Block 69.
- **837I Form**: 2300 Loop, HI segment, with “BJ” qualifier.

Institutional Claims

**Taxonomy Code**
Home Plans need the taxonomy code for MRA data validation. We require that all institutional providers with more than one subpart to bill with a taxonomy code for MA PPO claims.
- **UB04 Form**: Block 57, “other” field.
- **837I Form**: 2000A Loop, with the “ZZ” qualifier.

**The Source of Referral for Admission**
Home Plans require the one-digit source of referral for admission for institutional claims (this indicates a transfer or readmission). We require that providers include the one-digit source of referral for home health claims with revenue code 0023.
- **UB04 Form**: Block 15.
- **837I Form**: 2300 Loop, CL segment.

Professional Claims (Physician, Lab and Radiology)

**Service Location Zip Code**
Home Plans need the service location zip code in order to price professional claims based on the services that were rendered. We require that professional providers bill with the zip code of where the services were rendered on physician, lab and radiology MA PPO claims.
- **CMS 1500 Form**: Block 32.
- **837P Form**: 2310D Loop.

**Facility Zip Code**
Home Plans need the facility zip code to price professional services incurred in a facility. Pricing is based on where the services were rendered. We require that professional providers bill with the service location facility zip code when services are incurred in an institutional facility for MA PPO claims.
- **CMS 1500 Form**: Block 32.
- **837P Form**: 2310D Loop (same as service location zip code).

- Over -
Medicare Advantage PPO Network Sharing Claim Tips

Ambulance Claims

Pick Up Zip Code
Home Plans need the zip code of the location where the member was picked up on any professional ambulance claim. We require providers to include the pick up zip code for all professional ambulance claims.
- CMS 1500 Form: Block 32.

Medicare Advantage Home Health, Skilled Nursing Facility and Inpatient Rehab Facility

HIPPS Code
Home Plans require a five-digit Health Insurance Prospective Payment System (HIPPS) code to process MA PPO Home Health, Skilled Nursing Facility and Inpatient Rehab Facility claims that are submitted with revenue codes 0022, 0023 and 0024. We require that providers file the five-digit HIPPS code for Home Health, Skilled Nursing Facility and Inpatient Rehab Facility Medicare Advantage claim when revenue codes 0022, 0023 and 0024 are submitted.
- UB04 Form: Block 44.
- 837I Form: Loop 2400.

Home Health

Treatment Authorization Code
Home Plans require an 18-digit alpha/numeric code for home health claims for MA PPO. The code represents the start date, date assessment was completed, reason for assessment, and clinical and functional severity points. The payment owed the provider will vary based on the treatment authorization code submitted on the claim. We are requiring that providers file the 18-digit treatment authorization code for Home Health MA PPO claims with revenue code 0023.
- UB04 Form: Block 63.
- 837I Form: Loop 2300.

Core Based Statistical Area (CBSA)
Home Plans require this five-digit code for all home health and dialysis claims. Because home health and dialysis claims are often incurred in a home setting, the provider's zip code would not indicate where the services were rendered. The home plan needs the CBSA to calculate the provider payment for where a home health or dialysis claim was incurred. We require providers to include the five-digit CBSA with a value code 61 for all home health and dialysis MA PPO claims that include revenue code 0023.
- UB04 Form: Block 39, 40 or 41.
- 837I Form: Loop 2300.

Value Codes A8 and A9 - Dialysis Claims only
These codes represent the height and weight of a patient receiving dialysis treatment and Home Plans require this for end stage renal disease (ESRD) MA PPO claims. We require the value codes A8 and A9 with the height and weight codes for ESRD MA PPO claims that include revenue codes 821, 831, 741, 851, 880 or 881.
- UB04 Form: Block 39, 40 or 41.
- 837I Form: Loop 2300.

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