Professional Provider Office Manual
Blue Cross and Blue Shield of Louisiana
PROFESSIONAL PROVIDER OFFICE MANUAL

This manual is designed to provide information you will need as a participant in the Blue Cross and Blue Shield of Louisiana Professional Provider Network—it is an extension of your Professional Provider Agreement.

To use your manual, first familiarize yourself with the Network Overview and Definitions sections. From that point on, the Table of Contents should direct you to the information you need.

Periodically, we send newsletters and informational notices to providers. Please keep this information and a copy of your respective provider agreement(s) along with your manual for your reference. Updated office manuals and provider newsletters may be found on the Provider page of our website at www.bcbsla.com/providers.

If you have questions about the information in your manual or your participation as a network provider, please call Network Administration at 1-800-716-2299, option 1 or (225) 297-2758.

Please Note:
This manual contains a general description of Benefits that are available subject to the terms of a Member’s contract and our corporate medical policies. The Member Contract/Certificate contains information on Benefits, limitations and exclusions and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed. This manual is provided for informational purposes and is an extension of your Professional Provider Agreement. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the Professional Provider Office Manual as needed. The Professional Provider Office Manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

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IMPORTANT ADDRESSES AND PHONE NUMBERS

Provider Services
Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. offer an enhanced Interactive Voice Response (IVR) system that lets you and your office staff take care of many routine services by phone 24 hours a day, seven days a week. Call the customer service phone number on the back of your patient’s Blue Cross ID card and enter your NPI number and the patient’s member number when prompted and select one of the following options:

- Benefits
  - Voice back of benefits
  - Fax back of benefits
- Claims
  - Voice back of claims status
  - Fax back of claims status
- Medical Management*
  - Status of authorization
  - Request new authorization

*Medical Management requests are handled by transfer; not currently by self-service.

Provider Network Administration
network.administration@bcbsla.com
Participation/Contracting/Credentialing/Provider Relations Questions: 1-800-716-2299 or (225) 297-2758.

Claims Addresses
All completed claim forms should be forwarded to the following addresses for processing:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

FEP claims should be mailed to:
  Blue Cross and Blue Shield of Louisiana - FEP Claims
  P.O. Box 98028
  Baton Rouge, LA 70809-9029

Electronic Services
www.bcbsla.com
www.bcbsla.com/ilinkblue
iLinkBLUE.ProviderInfo@bcbsla.com
1-800-216-BLUE (1-800-216-2583)

EDI Clearinghouse
EDICH@bcbsla.com
(225) 291-4334

BlueCard® Eligibility Line
1-800-676-BLUE (1-800-676-2583)

Member Benefits
Call the number on the member’s ID card.

Fraud & Abuse Hotline
1-800-392-9249

Appeals and Grievances/Provider Dispute Resolution
Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Department
P.O. Box 98045
Baton Rouge, LA 70898-9045
1-800-376-7741 or (225) 293-0625
Section 1

NETWORK PARTICIPATION

Participating providers are those physicians and allied health providers who have entered into a provider agreement with Blue Cross and Blue Shield of Louisiana (herein referred to as Blue Cross or Plan). As a participating provider in our networks, you join other providers linked together through a business relationship with Blue Cross.

Our networks emphasize the primary roles of the participating provider and Blue Cross and Blue Shield. They are designed to create a more effective business relationship among providers, consumers and Blue Cross and Blue Shield. Our participating provider networks:

• Facilitate providers and Blue Cross working together to voluntarily respond to public concern over costs
• Continue to give Blue Cross and Blue Shield members freedom to choose their own providers
• Demonstrate providers’ support of realistic cost-containment initiatives
• Limit out-of-pocket expenses for patients to predictable levels and reduce their anxiety over the cost of medical treatment

As applicable, providers are encouraged to comply with Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the HITECH Act.

As applicable, provider agrees to maintain a notice of HIPAA privacy practices, as required by HIPAA, at the point where a Plan Member would enter provider’s website or web portal.

Participating Provider Agreements

Your responsibilities and agreements as a participating provider are defined in your provider agreement(s). You should always refer to your agreement when you have a question about your network participation. As a participating provider, you also have the following responsibilities to our members—your patients:

• Submitting claims for Blue Cross and Blue Shield members.

  This includes claims for inpatient, outpatient and office services. To ensure prompt and accurate payment, it is important that you provide all patient information on the CMS-1500 claim form (or the UB-04 claim form for certain allied providers) including appropriate Physicians’ Current Procedural Terminology (CPT®) codes and ICD-10-CM diagnosis codes. National Provider Identifiers (NPIs) are required on all claims (Blue Cross-assigned provider numbers are no longer used). The Claims Submission section of this manual gives specific information about completing the claim form as well as CPT and ICD-10-CM coding information. The Allied Health Providers section gives specific information about completing the CMS-1500 and UB-04 claim forms.
• **Accepting Blue Cross’ payment plus the member’s deductible, coinsurance and/or copayment, if applicable, as payment in full for covered services.**

Blue Cross’ payment for covered services is based on your charge not to exceed Blue Cross’ allowable charge. You may bill the member for any deductible, coinsurance, copayment and/or noncovered service. However, you agree not to collect from the member any amount over Blue Cross’ allowable charge.

The Provider Payment Register/Remittance Advice summarizes each claim and itemizes patient liability, the amount above the allowable charge and other payment information. Additional information concerning the Payment Register/Remittance Advice is included in the Reimbursement section of this manual.

• **Cooperating in Blue Cross’ cost-containment programs where specified in the Member Contract/Certificate and not billing the member or Plan for any services determined to be not Medically Necessary or Investigational, unless the provider has notified the member in advance in writing that certain not Medically Necessary or Investigational services will be the member’s responsibility.** Generic or all-encompassing notifications to member will not meet the specific notification requirement mentioned here.

Certain Plan Member Contracts/Certificates include cost-containment programs such as prior authorization, concurrent review and case management. The member’s identification card will contain telephone numbers for prior authorization. Also, the member should inform you if his/her benefit program includes cost-containment provisions or incentives.

• **Informing Blue Cross of your possible involvement in a concierge or membership program.**

Such involvement must be communicated in writing to your Network Representative before our members are contacted about this new process. Blue Cross will discuss with you your intentions and plans for the concierge or membership program and how it will impact our members.

**Amendments to Provider Agreements**

Blue Cross has the right to amend provider agreements by making a good faith effort to notify the provider at least sixty days prior to the effective date of the change.

**Allied Health Providers**

Allied health providers are licensed and/or certified healthcare providers other than a physician, or hospital, and may include a clinical laboratory, urgent care center, managed mental healthcare provider, optometrist, chiropractor, podiatrist, psychologist, therapist, durable medical equipment supplier, ambulatory surgical center, diagnostic center and any other healthcare provider, organization, institution or such other arrangement as recognized by Blue Cross.

A separate provider contract should be signed for allied health providers to participate in our networks.
**Locum Tenens**
A locum tenens is a physician who is hired to temporarily replace another physician. The usual physician may be absent for reasons such as illness, pregnancy, vacation or continuing medical education. The usual physician identifies the reported services as locum tenens physician services by entering code Modifier Q6 (service furnished by a locum tenens physician) after the procedure code on the CMS-1500 claim form. Blue Cross follows the CMS locum tenens billing requirements, which can be found at [www.cms.gov](http://www.cms.gov).

**Non-participating Providers**
Non-participating providers do not have a contract with Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. network, or any other Blue Cross and Blue Shield plan. These providers are not in our networks. We have no fee arrangements with them. We establish an allowable charge for covered services rendered by non-participating providers. We use this allowable charge to determine what to pay for a member’s covered services when a member receives care from a non-participating provider. The member will receive a lower level of benefit because he did not receive care from a network provider. Additionally, a 30 percent penalty may apply when the non-participating provider is a hospital.

Members usually pay significant costs when using non-participating providers. This is because the amounts that providers charge for covered services are usually higher than the fees that are accepted by participating and HMO Louisiana providers. In addition, participating and HMO Louisiana providers waive the difference between the actual billed charge for covered services and the allowable charge, while non-participating providers do not. The member will pay the amounts shown in the “Non-Network” column on their schedule of benefits, and the provider may balance bill the member for all amounts not paid by Blue Cross or HMO Louisiana.

**Please note:** The member’s policy is an agreement between the member and Blue Cross or HMO Louisiana only. Providers cannot waive the member’s cost sharing obligations, such as deductibles, coinsurance (including out-of-network coinsurance differentials), penalties or the balance of the bill. A claim that is filed that includes any amounts the provider waives may be a fraudulent claim because it includes amounts that the member is not being charged, and will be reduced by the total amount waived.

**PPO and HMO Point of Service Members**
When a member receives covered services from a non-participating hospital, the benefits that Blue Cross will pay under the member’s benefit plan will be reduced by 30 percent. This penalty is the member’s responsibility.

The member may also be responsible for higher copayments, coinsurances and deductibles when receiving services from non-participating providers.
HMO Louisiana, Inc. Members
HMO Louisiana members enrolled in an HMO product have no benefits for services provided by non-participating providers without obtaining prior approval. Our authorization department will (1) determine if the services are medically necessary, and (2) approve a member to receive the medically necessary covered services from a non-participating provider, benefits will be at the highest level possible to limit the member’s out-of-pocket expenses. There are no guarantee of benefits.

HMO (HMO and HMO POS) members do not have to obtain prior authorization to receive emergency medical services. A member should seek emergency care at the nearest facility.

Credentialing Program
Participating providers are expected to cooperate with quality-of-care policies and procedures. An integral component of quality of care is the credentialing of participating providers. This process consists of two parts: credentialing and recredentialing.

Credentialing Process
Credentialing consists of an initial full review of a provider’s credentials at the time of application to our networks.

1. If a provider applies for participation in any of our networks, credentialing is required before being approved for participation. A Louisiana Standardized Credentialing Application (LSCA) and provider agreement are forwarded to the provider upon receipt of the request for participation in our networks. This form can be found on our website at www.bcbsla.com/providers >Forms for Providers or Credentialing.

2. The form and agreement are completed by the provider and submitted to Blue Cross for approval.

3. Upon receipt of the completed LSCA, credentialing staff verify the provider’s credentials including, but not limited to, state license, professional malpractice liability insurance, State CDS Certificate, etc., according to the Plan’s policies and procedures and Utilization Review Accreditation Committee (URAC) standards.

4. Blue Cross staff and the Credentialing Committee, review the provider’s credentials to ascertain compliance with the following credentials criteria. All participating providers must maintain this criteria on an ongoing basis:
   • Unrestricted license to practice medicine in Louisiana as required by state law
   • Agreement to participate in the Blue Cross networks
   • Professional liability insurance that meets required amounts
   • Malpractice claims history that is not suggestive of a significant quality of care problem
   • Appropriate coverage/access provided when unavailable on holidays, nights, weekends and other off hours
   • Absence of patterns of behavior to suggest quality of care concerns
• Utilization review pattern consistent with peers and congruent with needs of managed care
• No sanctions by either Medicaid or Medicare
• No disciplinary actions
• No convictions of a felony or instances where a provider committed acts of moral turpitude
• No current drug or alcohol abuse

5. Based upon compliance with the criteria, Blue Cross staff will recommend to the Credentialing Committee that a provider be approved or denied participation in our networks.

6. The Credentialing Committee, comprised of network practitioners, will make a final recommendation of approval or denial of a provider’s application.

Recredentialing
After a provider has completed the initial credentialing process, he/she will undergo recredentialing at least every three years thereafter from the date of the last approval. The recredentialing process is conducted in the same manner as outlined in the Credentialing section above. The provider is considered to be approved by the Credentialing Committee and recredentialed for another three-year cycle unless otherwise notified.

If a provider’s network participation has been terminated, that provider may be required to reapply and complete the initial credentialing process above before being reinstated as a participating provider in our networks.

Important Note: All providers, regardless of network participation, must include their NPI(s) on their application.

Status Changes
A provider is required to report changes to credentialing criteria to Blue Cross within 30 days from the date of occurrence. Failure to do so may result in immediate termination.

CLIA Certification Required
If you perform laboratory testing procedures in your office, we require a copy of your Clinical Laboratory Improvement Act (CLIA) certification to be mailed or faxed with your LSCA when applying for credentialing or recredentialing:

    BCBSLA - Network Operations
    P.O. Box 98029
    Baton Rouge, LA  70898-9029
    Fax: (225) 297-2750 • Attn: Network Operations
Credentialing Process and Network Provider Directory
As a network provider, you may only participate in the Blue Cross networks and be listed in the network provider directory as the specialty you actually practice. For example, providers may not participate in our networks as one of the following specialties of general practice, family practice, internal medicine or pediatrics unless they practice in a full primary care provider (PCP) capacity. For more information on our credentialing process, visit www.bcbsla.com/providers > Credentialing.

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Access Standard</th>
<th>Examples</th>
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| **Emergency**   | Immediate access, 24 hours a day, 7 days a week | • Loss of consciousness  
• Seizures  
• Chest pain  
• Severe bleeding  
• Trauma |
| **Urgent**      | 30 hours or less                         | • Severe or acute pain  
• High fever in relation to age and condition |
| **Routine Primary Care** | 5 to 14 days | • Backache  
• Suspicious mole |
| **Preventive Care** | 6 weeks or less | • Routine physical  
• Well baby exam  
• Annual Pap smear |

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

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

**Provider Directories**
As a participating provider, your name is included in the Blue Cross product-specific provider directories featured on our website, www.bcbsla.com. Participating providers are listed in the directories by parish in alphabetical order under their specialty(ies).

Thousands of healthcare professionals and facilities across the state are in our networks. You can find the one you need quickly with our easily searchable directories online. Listings are updated daily.

We make every effort to ensure the information in our provider directories is current and accurate. **Please notify Provider Network Administration in writing, if you have one of the following changes occur:**

- have a change in contact information
- obtain a new tax ID number
- you close or merge a practice
- new providers join your practice
- providers in your clinic retire or move
- new or updated email address contact

A Provider Update Request Form is provided in this manual and can be used to notify us of changes or additions to provider directories. You may also complete the update form online at www.bcbsla.com/providers >Forms for Providers. Select the “Provider Update Form” form from the list and fill in the blanks.

You may notify us of a change by contacting us through the following ways as well:

1-800-716-2299, option 3
provider.update@bcbsla.com
(225) 297-2750 (fax)

**Please note:** Blue Cross cannot guarantee the continuing participation of providers listed in the online directories. Providers with multiple locations may not participate at all locations. Facility-based physicians may not be contracted healthcare providers.
Provider Directory Information
A part of our commitment to serving our members is to provide them with current comprehensive information about our network providers.

Provider directory information includes demographic information such as medical schools(s) attended and graduation year, gender, race/ethnic background (voluntarily reported), languages spoken and whether a physician’s office is accepting new patients. Other information like providers' specialties, board certifications, hospitals where they admit and certain accreditation information is also available.

Refer Members to Network Providers
As a participating provider in our networks, you agree to assist us in our efforts to keep our members’ costs down. One way to do that is to refer our members—your patients—to other participating providers.

Referring to participating providers is important because members may pay significant costs when using a non-participating provider. The amounts that some non-participating providers charge for their services are higher than the negotiated fees participating providers have agreed to accept. When seeing a non-participating provider, the member may be responsible for the difference between the allowed amount and the billed charge.

In the interest of affordable, quality care for your patients, it is important that you refer your Blue Cross patients to participating providers. To confirm if a provider is participating, please consult our online directories at www.bcbsla.com.
Section 2
NETWORK OVERVIEW

For 75 years, Blue Cross has worked to develop business relationships with doctors, hospitals and other healthcare providers throughout Louisiana. These relationships have allowed us to develop some of the largest, most comprehensive provider networks in the state.

With the number of insurance companies and network programs available, it can be quite challenging for providers to navigate the various administrative requirements of these programs. To help you better understand the Blue Cross networks in which you may participate, we are providing an overview of our provider network programs. You will also see examples of ID cards associated with the various networks. If you have questions about our networks please call Provider Services at 1-800-922-8866.

Preferred Care PPO

Our Preferred Care PPO network includes hospitals, physicians and allied providers. Members with PPO benefit plans receive the highest level of benefits when they receive services from PPO providers.

A special Preferred Care logo distinguishes Preferred Care PPO members from our other members. This logo is located at the top right corner of the ID card as shown. The “PPO” in a suitcase logo identifies the nationwide BlueCard® Program. For more information, view the Preferred Care PPO Provider Speed Guide, available online at www.bcbsla.com/providers >Education on Demand >Speed Guides.

Preferred Care PPO ID cards are issued to each member on the policy. ID cards are used for both medical and dental coverage when a dental network is indicated.
HMO Louisiana

HMO Louisiana is a wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana. The HMO Louisiana provider network is a select group of physicians, hospitals and allied health providers who provide services to individuals and employer groups seeking managed care benefit plans. In January 2016, our HMO Louisiana service expanded to be a statewide network.

HMO Louisiana allows members to choose from both HMO and Point of Service (POS) benefit plans. Members pay a lower copayment when they receive services from primary care physicians (PCPs). HMO Louisiana members carry a member ID card similar to the one shown here.

Please note: HMO Louisiana providers should follow the guidelines set forth in this manual. Differences and additional guidelines are included in the HMO Louisiana Provider Office Manual, which is a supplement to this office manual and is located on our website at www.bcblsa.com/providers > Education on Demand > Provider Office Manuals.

HMO member ID cards are issued for each covered member and separate ID cards are issued for each covered dental member. The ID number is the same for both ID cards.
Blue Connect

Blue Connect is an HMO Point of Service product available to groups and individuals in (Lafayette Area) - Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes and (New Orleans Area) Jefferson, Orleans and St. Tammany parishes. Members with Blue Connect may choose each time they need care—at the point of service—whether to use a network provider or go out-of-network. Members receive the highest level of benefits when using network providers and with proper authorization when required. Members receive a lower level of benefits when using providers who are not in the Blue Connect network. The Blue Connect logo on the ID card identifies a member participating in this network.

Please note: While the Blue Connect product is offered only in the Lafayette and New Orleans areas, Blue Connect members may still access Blue Connect network providers located in other parishes.

Community Blue

Community Blue is an HMO Point of Service product available to groups and individuals in the Baton Rouge Area: Ascension, East Baton Rouge and West Baton Rouge parishes; and Shreveport Area: Bossier and Caddo parishes only. Members may choose each time they need care—at the point of service—whether to use a network provider or go out-of-network. Members receive the highest level of benefits when using network providers and with proper authorization when required. Members receive a lower level of benefits when using providers who are not in the Community Blue network. The Community Blue logo on the ID card identifies a member participating in this network.
Federal Employee Program

The Federal Employee Program (FEP) provides benefits to federal employees and their dependents. These members access the Preferred Care PPO Network.

FEP members have two benefit plans from which they may choose: Standard Option or Basic Option. Under Standard Option, members receive the highest level of benefits when they receive care from in-network providers and reduced benefits when they receive care from out-of-network providers. Members with Basic Option receive no benefits when they receive care from out-of-network providers except for select situations such as emergency care.

For more information on FEP benefits, please see the Benefit Information section of this manual.
Office of Group Benefits Benefit Plans

Blue Cross and Blue Shield of Louisiana administers benefits for the Office of Group Benefits’ (OGB’s) state of Louisiana employees, retirees and dependents. Effective March 1, 2015, five new benefit plans are available: Pelican HRA 1000, Pelican HSA 775, Magnolia Local, Magnolia Local Plus and Magnolia Open Access. These products are self-insured plans that utilize our networks of doctors, hospitals and other medical care providers as well as Blue Providers nationwide.

Pelican HRA 1000 (Active employees & retirees with and without Medicare) This benefit is a consumer-driven benefit plan (CDHP) paired with a health reimbursement arrangement (HRA). This benefit plan utilizes the OGB Preferred Care network, which is Blue Cross’ Preferred Care PPO network of doctors and hospitals.

Pelican HSA 775 (Active employees only) This benefit plan is a consumer-driven benefit plan that is paired with a health savings account (HSA) option. The Pelican HSA 775 benefit plan utilizes the OGB Preferred Care Network, which is Blue Cross’ Preferred Care PPO network of doctors and hospitals.

Magnolia Local (Active employees & retirees with and without Medicare) This benefit plan utilizes our Blue Connect or Community Blue provider networks. Magnolia Local is an HMO Point of Service product that allows members to choose each time they need care—at the point of service—whether to use a Primary Care Physician (PCP) or a specialist without a referral. This benefit plan is only available as follows: Blue Connect network (Lafayette Area) - Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes; (New Orleans Area) - Jefferson, Orleans and St. Tammany parishes; Community Blue network (Baton Rouge & Shreveport Areas) - Ascension, Bossier, Caddo, East Baton Rouge and West Baton Rouge parishes. Magnolia Local members in Jefferson, Orleans and St. Tammany parishes do not have coverage if they choose to see Community Blue, providers just as Magnolia Local members in the Community Blue parishes do not have coverage if they choose to see Blue Connect providers. With this benefit plan, there is no coverage for services performed by non-network providers. Please refer your patients to providers within their network to ensure they receive the highest level of benefits available.
Magnolia Local Plus (Active employees & retirees with and without Medicare) This benefit plan has an HMO benefit design but through a PPO network. Members with this benefit plan are not limited to a local-area only network. Members who choose the Magnolia Local Plus benefit plan will instead have access to the OGB Preferred Care network, which is Blue Cross’ statewide Preferred Care PPO network of doctors and hospitals. With this benefit plan, there is no coverage for services performed by non-network providers.

Magnolia Open Access (Active Employees & Retirees with and without Medicare) This benefit plan is OGB’s PPO benefit plan. Members with this benefit plan have access to the OGB Preferred Care PPO network of doctors and hospitals.

BlueChoice 65

BlueChoice 65 is a series of Medicare supplement plans. It is designed to pay for many of the expenses Medicare does not pay. Some of the options in this series include:

- Part A deductible coverage
- Part B deductible coverage, coinsurance and excess charges
- Skilled nursing coinsurance

BlueChoice 65 Select plans feature lower premiums and a select network of hospitals that have agreed to waive the Part A deductible and coinsurance.

Please note: BlueChoice 65 refers to certain contracts and is not connected with or endorsed by the U.S. government or the federal Medicare program.
**BlueCard® Program**

The BlueCard® Program links participating providers and the independent Blue Cross and Blue Shield (BCBS) Plans across the country and abroad with a single electronic network for professional, outpatient and inpatient claims processing and reimbursement. The program allows BCBS participating providers in every state to submit claims for members who are enrolled through another Blues Plan to their local BCBS Plan.

You should submit claims for BCBS members (including Blue Cross only and Blue Shield only) visiting you from other areas directly to Blue Cross and Blue Shield of Louisiana. Blue Cross and Blue Shield of Louisiana is your sole contact for all BCBS claims submissions, payments, adjustments, services and inquiries.

*Please note*: Providers should follow the guidelines set forth in this manual and those that are included in the *BlueCard Program Provider Manual*, which is a supplement to this office manual and is located on our website at [www.bcbsla.com/providers > Education on Demand](http://www.bcbsla.com/providers > Education on Demand).

**How to Identify BlueCard Members**

When out-of-area BCBS members arrive at your facility, be sure to ask them for their current membership ID card. The two main identifiers for BlueCard members are the alpha prefix and a “suitcase” logo.

**Alpha Prefix**

The three-character alpha prefix of the member’s identification number is the key element used to identify and correctly route out-of-area claims. The alpha prefix identifies the Blue Plan or the national account to which the member belongs.

There are three types of alpha prefixes: plan-specific, account-specific and international:

1. **Plan-specific** alpha prefixes are assigned to every BCBS Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.

2. **Account-specific** prefixes are assigned to centrally-processed national accounts. National accounts are employer groups with offices or branches in more than one area, but offer uniform coverage benefits to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

3. Occasionally, you may see ID cards from foreign BCBS members. These ID cards will also contain three-character alpha prefixes. For example, “JIS” indicates a Blue Cross and Blue Shield of Israel member. The BlueCard claims process for international members is the same as that for domestic BCBS members.
**ID cards with no Alpha Prefix**

Some ID cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member’s ID card for information on how to file these claims. If that information is not available, call Provider Services at 1-800-922-8866.

**“Suitcase” Logo**

BlueCard PPO offers members traveling or living outside of their Blue Plan’s area the PPO level of benefits when they obtain services from a provider or hospital designated as a BlueCard PPO provider. Members are identified by the “PPO in a suitcase” logo on their ID card.

Providers should verify benefits for HMO members. The empty suitcase logo does not guarantee that the HMO member has benefits if they see a participating provider in that state. Most HMO members must get an authorization to see a provider outside of their service area. To ensure claims are paid timely and accurately, please use iLinkBLUE or call Provider Services at 1-800-922-8866.

**HMO patients serviced through the BlueCard® Program**

In some cases, you may see BCBS HMO members affiliated with other BCBS Plans seeking care at your facility. You should handle claims for these members the same way you handle claims for Blue Cross and Blue Shield of Louisiana members and BCBS PPO patients from other Blue Plans — by submitting them through the BlueCard Program. Members are identified by the “empty suitcase” logo on their ID card.

BlueCard members throughout the country have access to information about participating providers through BlueCard Access, a nationwide toll-free number 1-800-810-BLUE (1-800-810-2583) that allows us to direct patients to providers in their area. Members call this number to find out about BlueCard providers in another Blue Plan’s service area. You can also use this number to get information on participating providers in another Blue Plan’s service area.

**How the Program Works**

1. You may verify the patient’s coverage on iLinkBLUE at [www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue) under BlueCard-Out of Area, then Coverage Information Request or by calling BlueCard Eligibility® Line at 1-800-676-BLUE (1-800-676-2583). An operator will ask you for the alpha prefix on the member’s ID card and will connect you to the appropriate membership and coverage unit at the member’s plan. If you are unable to locate an alpha prefix on the member’s ID card, check for a phone number on the back of the ID card, and if that’s not available, call Provider Services at 1-800-922-8866.

2. After you render services to a BCBS member, you should file the claim (according to your contractual arrangements) with Blue Cross and Blue Shield of Louisiana. **Reminder: The claim must be filed using the three-character alpha prefix and identification number located on the patient’s ID card.**
3. Once the claim is received, Blue Cross and Blue Shield of Louisiana electronically routes it to the member’s own independent BCBS Plan.

4. The member’s plan applies benefits, adjudicates the claim and transmits it to Blue Cross and Blue Shield of Louisiana, either approving or denying payment. The processing time of the claim may take longer than most Blue Cross processes.

5. Blue Cross and Blue Shield of Louisiana reconciles payment and forwards it to you according to your payment cycle.

6. The member’s local Blue Plan sends a detailed Explanation of Benefits (EOB) report to the member.

**Types of claims filed through the program**

All professional claims as well as facility inpatient and outpatient claims for BCBS out-of-state members should be filed to Blue Cross and Blue Shield of Louisiana. Medicare Primary could be paid differently by each Blue plan. Blue Cross and Blue Shield of Louisiana pays according to the member’s participation with us and their participation with Medicare. If the member is of Medicare age and does not indicate that Medicare is primary, we will pay as if Blue Cross is primary.

The Federal Employee Program (FEP) and other Blue Cross plans will pay according to the member’s contract language. However, if it is determined that the member should have been set up initially with Medicare as primary, the provider will be asked to return any reimbursement and the claim will have to be reprocessed with Medicare as primary.

**BlueCard Claims Submission**

**Hardcopy Claims**

BCBSLA -Claims Department

P.O. Box 98029

Baton Rouge, LA  70898-9029

**Electronic Claims**

Please submit electronic claims through Blue Cross Approved Clearinghouse locations. For more information about filing claims through approved Blue Cross Clearinghouse locations, please contact our EDI Clearinghouse Support unit at (225) 291-4334 or email EDICH@bcbsla.com.

Electronic claims also may be submitted through iLinkBlue, our free online provider tool. For more information about filing claims through iLinkBLUE, please call 1-800-216-BLUE (1-800-216-2583) or email iLinkBlue.ProviderInfo@bcbsla.com.
Ancillary Claims Filing Instructions for BlueCard Claims

Ancillary claims for Independent Clinical Laboratory, Durable/Home Medical Equipment and Supply, and Specialty Pharmacy are filed to the Local Plan in whose service area the ancillary services were rendered—if these services were performed in Louisiana, the Local Plan is Blue Cross and Blue Shield of Louisiana.

- Lab Local Plan is the Plan in whose service area the specimen was drawn.
- DME Local Plan is the Plan in whose service area the equipment was shipped or purchased at a retail store.
- Specialty Pharmacy Local Plan is the Plan in whose service area the ordering physician is located.

Consumer-Directed Health Care

Consumer-directed health care (CDHC) is a movement in the healthcare industry designed to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make informed and appropriate healthcare decisions through the use of member support tools, provider and network information, and financial incentives. CDHC includes many different benefit plans and services including consumer-directed health plans (CDHP), high deductible health plans and the option to use debit cards for payment. In conjunction with these plans, members may have a health reimbursement account (HRA), health savings account (HSA) or flexible spending-account (FSA).

When the consumer is paying more of the bill, you may need to devote resources to conducting pre-service work with patients. Consumers on a high deductible health plan may require more specialized service work due to the questions on cost and options.

<table>
<thead>
<tr>
<th>When the Consumer Is Paying More of the Bill</th>
<th>Sales/ Marketing Fulfillment</th>
<th>Pre-Service</th>
<th>At Point of Service</th>
<th>Post-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Seeks education about choices</td>
<td>• Seeks information</td>
<td>• Knows what they owe</td>
<td>• Seeks help with next steps of treatment plan</td>
<td></td>
</tr>
<tr>
<td>• Selects health plan</td>
<td>• Estimates costs to compare providers and treatment options</td>
<td>• Can apply payment from a variety of sources, including access to credit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Selects network/providers</td>
<td>• Seeks quality information about providers</td>
<td></td>
<td>- Health information/ coaching</td>
<td></td>
</tr>
<tr>
<td>• Promotion to consumers</td>
<td>• Determines member eligibility and benefits</td>
<td>• Determines eligibility, benefits and specific member responsibility</td>
<td>• Provides feedback on performance</td>
<td></td>
</tr>
<tr>
<td>• Performance information for consumers</td>
<td>• May estimate member responsibility for upcoming service</td>
<td>• Collects correct amount from the source selected by the member</td>
<td>- Administrative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• May inform member of estimate in advance</td>
<td></td>
<td>- Clinical</td>
<td></td>
</tr>
</tbody>
</table>
Consumer Directed Health Plans

High-deductible health plans (HDHPs) partnered with member personal savings accounts (PSAs), such as an HSA, an HRA, or a FSA, form a CDHP. The type of account used in these arrangements has strong implications to the administration of the CDHP, as the IRS regulations governing these tax-favored PSAs vary significantly.

Once members have met their deductible, covered expenses are paid based on the member’s benefit plan. As a participating provider, you should treat these members just as you would any other Blue Cross member:

- You should accept the Blue Cross reimbursement amount/allowable charge (up to the member’s deductible amount) and any co-insurance amount, if applicable, as payment in full.
- If you collect billed charges up front, you must refund the member the difference between your charge and the Blue Cross reimbursement amount/allowable charge within 30 days.

### Examples of what to collect from members:

<table>
<thead>
<tr>
<th>Example</th>
<th>Member’s Total Deductible</th>
<th>Member’s Deductible Applied</th>
<th>Allowable Charge</th>
<th>Amount to be collected from member</th>
<th>Blue Cross Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>$2000</td>
<td>$2000</td>
<td>$100</td>
<td>$0</td>
<td>$100</td>
</tr>
<tr>
<td>2)</td>
<td>$2000</td>
<td>$1000</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>3)</td>
<td>$2000</td>
<td>$2000</td>
<td>$100</td>
<td>$20</td>
<td>$80</td>
</tr>
</tbody>
</table>

BlueCard members whose plan includes a debit card can pay for out-of-pocket expenses by swiping the card through any debit card swipe terminal. These cards are used just like any other debit card. The funds will be deducted automatically from the member’s appropriate HRA, HSA or FSA account. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to accept any other signature debit card.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their debit cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.
BlueSaver Claims Filing Tips
Below are some helpful tips that will guide you when processing claims for and payments from Blue members with a consumer directed health plan like BlueSaver:

• Commit to pre-service work with patients. Contact to confirm appointment and ask them to bring a copy of their current member card. Offer to discuss out of pocket expenses prior to their visit.

• Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.

• Verify the member’s eligibility or benefits through iLinkBLUE or by calling BlueCard Eligibility® Line at 1-800-676-BLUE (1-800-676-2583) and provide the alpha prefix, or use electronic capabilities.

• Carefully determine the member’s financial responsibility before processing payment.

• If the member presents an HSA or HRA debit card or debit/ID card, be sure to verify the member’s cost sharing or out-of-pockets amount before processing payment.

• Please do not use the card to process full payment up front.

• File Claims for all members with CDHPs (including those with BlueCard) to Blue Cross.

If you have any questions about the healthcare debit card processing instructions or payment issues, please contact the debit card administrator’s toll-free number on the back of the card.

Members with Consumer Directed Health Plans Like BlueSaver
Many consumer directed healthcare (CDHC) members carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Some cards are “stand-alone” debit cards that cover out-of-pocket costs, while others also serve as a member identification card and include the member’s identification number. The combined card will have a nationally recognized Blue logo, along with the logo from a major debit card company such as MasterCard® or Visa®.

Members can use their cards to pay outstanding balances on billing statements. If your facility currently accepts credit card payments, there is no additional equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit cards.
If the member presents a debit card (stand-alone or combined), be sure to verify the member’s cost sharing amount before processing payment. Do not use the card to process full payment up front. For more information, see the Consumer Directed Health Plans section of this manual.

**Please Note:** If you have questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator’s number on the back of the card.

**HMO of Louisiana Inc.’s Blue Advantage (HMO) Plan**

Blue Advantage (HMO) is our new Medicare Advantage member benefit plans and provider network. For information to aid you in servicing members with BCBSLA Blue Advantage healthcare benefits, please refer to the Blue Advantage Provider Administrative Manual. It is located on the Blue Advantage Provider Portal, available through iLinkBlue at [www.bcbsla.com/mlinkblue >Blue Advantage](http://www.bcbsla.com/mlinkblue).

**Medicare Advantage Members From Other Blue Plans**

For information to aid you in servicing Medicare Advantage members from other Blue plans, please refer to the our BlueCard® Program Provider Manual, available at [www.bcbsla.com/providers >Education on Demand](http://www.bcbsla.com/providers).

Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. HMO Louisiana is a subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.
Section 3
MEMBER ENGAGEMENT TOOLS

Overview
Our member engagement initiative is designed to give our members the tools they need to become more active in managing their own healthcare. Our plan is to work hand-in-hand with our network providers to get our members clear, understandable and easily accessible information to make smarter healthcare choices. Two of these tools are the Estimated Treatment Cost Tool and Member Reviews. Additional tools will be launched in the future.

Estimated Treatment Cost Tool
With this tool, Preferred Care PPO members may view PPO cost displayed on the national Blue Cross Blue Shield Association (BCBSA) Hospital & Doctor Finder website. The Tool features the costs and volumes associated with 1,638 elective/planned procedures. Total cost of care estimates display bundled service and facility charges that are typically a standard part of a procedure or treatment.

Cost Estimates
Cost estimates are developed from our historical claims with updates, as needed, to reflect current arrangements and combined data that enables members to understand the total cost for a service without complications. These estimates are created in four ways:

- For inpatient procedures primary DRG codes(s) related to each treatment category should reflect the professional, diagnostic and other related costs for the category per line and the total displayed.
- For outpatient procedures primary CPT code(s) identify each treatment category and all costs for that member that day are summed to create the estimate.
- For diagnostic services both the technical and professional component are combined.
- For professional office visits, primary CPT code(s) identify each treatment category. For chiropractic and physical therapy, all costs for the visit are summed to create the estimate. For other categories, weighted average costs per CPT codes(s) created the estimate.

Viewing Cost Estimates
A report of cost estimates is available to providers on iLinkBlue. Log into your existing login ID and click the new menu item named “Estimated Treatment Costs.” You must have access to iLinkBlue in order to view your cost data, as this information will not be mailed. The report contains the cost ranges calculated for the facility or practicing location, as well as, an overview of the methodology used to develop these cost ranges. Providers who log into iLinkBlue to view PPO cost data should be aware that no data will be displayed for providers with:

Applicable for facility procedures
- less than three episodes
- episodes less than $100
- episodes that do not contain facility charges

Applicable for office procedures
- less than three episodes
Figures displayed are a total PPO cost and includes all facility and professional charges. Individual physician costs will not be displayed as they are lumped together with the facility costs. The member will see the approximate cost range for the selected treatment category with all fees associated for the service. In addition, the member will be able to view the name, address and phone number of the provider. The member will be able to see the cost broken out by the facility and physician to help in managing their healthcare.

**Reconsideration Process**

Providers have 30 days from the date of notice that the data is available to review the cost data and determine if they want to request a reconsideration. To access the interactive Estimated Treatment Cost Reconsideration Form, provider’s will log onto iLinkBlue and click on Estimated Treatment Cost > Reconsideration Form. Follow the instructions on the screen to complete the form. Prior to submitting the form, you will have the option to print a copy for your records. All required fields must be completed and forms must be submitted electronically. Faxed or mailed forms will not be accepted. The Electronic Reconsideration Form will only be available to providers during the reconsideration period prior to each cost data submission. During times outside this window, the link to the form will be inactive. Resource documents are available on iLinkBlue. Click on the Estimated Treatment Cost menu to see the following:

- Estimated Treatment Cost Methodology
- Frequently Asked Questions
- Treatments Codes Listing

**Member Reviews**

Patient reviews are seen as a quality and transparency domain in proposed healthcare reform measures. The market demand for member review is growing, fueled by the new and expanding individual retail health insurance market. Approximately 85 to 90 percent of patient reviews are positive. Encouraging all of your Blue patients to add to these reviews will help assure an overall positive score. Key Components of Patient Reviews are:

- Members must first log in to their online account on www.bcbsla.com.
- Members are then authenticated during log-in before being able to submit reviews.
- Members must access a specific claim on file to comment on an encounter with the physician.
- Members then respond to a core set of member review questions.
- Member-written comments are checked for appropriateness before posting to our website.
- The review is then displayed in the comments section on our online directory for the physician.
- Physicians are able to give one response to each patient review.

In most instances, this can be a good marketing tool for your practice given that there is such positive feedback.
Section 4
CLAIMS SUBMISSION

Filing Claims
As a participating provider, you agree to submit claims for Blue Cross and Blue Shield members on the CMS-1500 Health Insurance Claim Form. All applicable information should be completed in full, including CPT codes, ICD-10-CM diagnosis codes and applicable medical records to support the use of modifiers or unlisted codes with a charge greater than $500 to ensure payment is made to you accurately and without delay.

Claims should include all services rendered during the visit, using a place of service designation, such as "11" or "19" for office. Our reimbursement allowable for the Evaluation and Management (E&M) service includes the components for physician work, practice expense and malpractice insurance. No additional room usage charge should be billed by any party, since the practice expense component includes overhead expenses, and is an integral part in the E&M or procedure allowable charge. This methodology applies to hospital owned and physician owned practices, and helps ensure that contractual benefits for our members are correctly applied to claims.

An example of a claim form and instructions on completing the CMS-1500 claim form are provided in this manual.

All completed claim forms should be submitted electronically. If you must mail claims hardcopy, please send to the following addresses for processing:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

FEP claims should be mailed to:

Blue Cross and Blue Shield of Louisiana – FEP Claims
P.O. Box 98028
Baton Rouge, LA 70898-9028

OGB claims should be submitted electronically or by mail to Blue Cross directly.

Timely Filing
Please note: Not all Member Contracts/Certificates follow the 15-month claims filing limit.

Blue Cross claims must be filed within 15 months, or length of time stated in the member’s contract, of the date of service. Claims received after 15 months, or length of time stated in the member’s contract, will be denied, and the member and Blue Cross should be held harmless for these amounts.

FEP claims must be filed by December 31 of the year after the year the service was rendered.
Medicare claims must be filed within one (1) calendar year after the date of service. Self-insured plans and plans from other states may have different timely filing guidelines. Please call Provider Services at 1-800-922-8866 to determine what the claims filing limits are for your patients.

Blue Cross claims for OGB members must be filed within 12 months of the date of service. Claims received after 12 months will be denied for timely filing and the OGB member and Blue Cross should be held harmless. Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim. OGB claims are not subject to late payment interest penalties.

**Refunds Process**

There may be times when Blue Cross must request refunds of payments previously made to providers. When refunds are necessary, Blue Cross notifies the provider of the claim in question 30 days prior to any adjustment. The notification letter explains that Blue Cross will deduct the amount owed from future Payment Registers/Remittance Advices unless the provider contacts us in writing within 30 days. Recoveries and payments for omissions and underpayments shall be initiated within 15 months of the claim’s last date of payment or adjustment. Blue Cross and the participating provider agree to hold each other and the member harmless for underpayments or overpayments discovered after 15 months from the date of payment.

If Blue Cross returns a claim or part of a claim for additional information, providers must resubmit it within 90 days or before the timely filing period expires, whichever is later.

If Blue Cross has made any omissions or underpayments, the Plan will make payment for such errors as soon as they are discovered or within 30 days of written notice from the participating provider regarding the error.

We make every effort to pay claims in a timely manner; however, when a clean claim is not paid on time, we follow the late payment penalty guidelines outlined in House Bill 2052/Regulation 74. Providers automatically receive penalty payment for claims that are not processed in the time frames set forth by House Bill 2052/Regulation 74. The additional payment will almost always appear on the same Payment Register/Remittance Advice as the claims payment and can be identified by the status code “ST, Statutory Adjustment.”

**Please note:** House Bill 2052/Regulation 74 does not apply to FEP, self insured plans, insured ERISA plans, worker’s compensation plans or state employee group benefit programs. Also, the late payment penalty does not apply if the claim is delayed through the fault of the claimant.

**Procedure and Diagnosis Codes and Guidelines**

processing. Blue Cross follows these coding guidelines unless otherwise identified in our policies. Because medical nomenclature and procedural coding is a rapidly changing field, certain codes may be added, modified or deleted each year. Please ensure that your office is 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-10-CM Volumes 1, 2 and 3; CPT and HCPCS.

New CPT codes will be accepted by Blue Cross as they become effective.

**Helpful Hints for Diagnosis Coding**

- Always report the primary diagnosis code on the claim form. Principal Diagnosis – “Reason for service or procedure”
- Report up to 12 (four per line) diagnosis codes when services for multiple diagnoses are filed on the same claim form
- Report all digits of the appropriate ICD-10-CM code(s)
- Report the date of accident if the ICD-10-CM code is for an accident diagnosis
- HIPAA regulations require valid ICD-10-CM diagnosis codes

**Diagnosis Code Specificity**

Blue Cross requires diagnosis code specificity when filing claims. It is important to file “ALL” applicable diagnosis codes to the highest degree of specificity. Use the following specificity rules for filing claims:

- Always report the most specific diagnosis codes. Example: Only use 3-digit ICD-10 codes when 4-digit codes are not available and 4-digit codes when 5-digit codes are not available in a particular category. Always report the most specific codes.
- Always include ALL related diagnoses, including chronic conditions you are treating the member for.
- Always include an additional code when required to provide a more complete picture. For example, in etiology/manifestation coding, the underlying condition is coded first followed by the manifestation.
- Medical records must support ALL diagnosis codes on claims.
- Filing claims with NOS (not otherwise specified) and NEC (not elsewhere classified) diagnosis codes is not preferred. Filing claims with NOS and NEC codes delays claim processing and may result in Blue Cross requesting medical records. It may also result in delayed payment and possible payment reductions.
- Reporting a header code on a claim is considered to be an incomplete code and the claim will be returned to the provider as “incomplete.”

**Example of specific ICD-10 coding:**

<table>
<thead>
<tr>
<th>Not Billable</th>
<th>Preferred</th>
<th>Not Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>M86.44 Chronic osteomyelitis with draining sinus, hand</td>
<td>M86.441 Chronic osteomyelitis with draining sinus, right hand</td>
<td>M86.449 Chronic osteomyelitis with draining sinus, unspecified hand</td>
</tr>
<tr>
<td>Header</td>
<td>Specified</td>
<td>Unspecified</td>
</tr>
</tbody>
</table>
Commercial Risk Adjustment
Blue Cross is using the Commercial Risk Adjustment (CRA) model that the Affordable Care Act (ACA) has adopted to predict healthcare costs based on enrollees in risk-adjustment-covered plans. The model incorporates organized diagnosis codes also known as HCCs (hierarchical condition categories) that correlate or link to corresponding diagnosis categories. It is critical that Blue Cross receive complete and accurately coded claims to properly indicate our members’ health status.

Claims Resubmission (or Refiling)
When a claim is refiled for any reason, all services should be placed on the claim. For example, it is inappropriate to refile a claim with only one procedure when more than one procedure was placed on the initial claim. Splitting the claim may cause adjustments to be performed.

Adjustment and Void Claim Submissions
Adjustment and Void claims can be submitted on any claim that has completed the processing cycle and appears on your BCBS Remittance Advice. The claim number assigned on the remittance will be needed to submit an adjustment or void claim.

Void Claim - The submission of a void claim is requesting that the entire claim be removed and any payments or rejections be retracted from the member and provider’s records.

Adjustment Claim - The submission of an adjustment claim requests that a previously processed claim be changed (information or charges added to, taken away or changed).

Electronic (837I & 837P) Adjustment and Void Claims
Adjustments and Void claims can be submitted for all changes except for changes to the member ID or pay-to-provider number. If these fields require change, you must submit the claim on paper, clearly indicating the old information and new information (pay-provider number and/or member ID).

To submit these claims, you first obtain the claim number found on the Remittance Advice. This claim number will be used in the ICN (internal control number) field.

Ensure the accurate electronic (837I or 837P) submission by following the instructions below:

Adjustment Claim
• Enter the frequency code “7” in Loop 2300 Segment CLM05-03.
• Enter the 10-character ICN of the original claim (assigned on the processed claim) in Loop 2300 in an REF segment and use F8 as the qualifier.
Note: The Adjusted claim should include all charges (not just the difference between the original claim and the adjustment).

**Void the Claim**
- Use frequency code “8” in Loop 2300 Segment CLM05-03.
- Use the 10-character ICN of the original claim (assigned on the processed claim) in Loop 2300 in an REF segment and use F8 as the qualifier.

**iLinkBlue Facility UB04 Adjustment and Void Claims**
- Field 4 Institutional Claim type of bill 3rd position (frequency) is required:
  - 7 - Adjustment
  - 8 - Void
- Field 64 Internal Control Number (ICN Number) – The ICN Number is the claim number from the BCBSLA Remittance Advice (Provider Payment Register).

**iLinkBlue Professional 1500 Adjustment and Void Claims**
- Field 19a Professional Claim Adjustment/Void Indicator is required:
  - A - Adjust original claim
  - V - Void original claim
- Field 19b Internal Control Number (ICN Number) – The ICN Number is the claim number from the BCBSLA Remittance Advice (Provider Payment Register).

**Overpayments**
In the event that Blue Cross has overpaid on a claim and we have not sent a request for the overpayment, please return it to us at the following address:

Blue Cross and Blue Shield of Louisiana
Special Claims Review
P.O. Box 98029
Baton Rouge, LA 70898-9029

Please include the following information:
- Contract number
- Patient name
- Date of service
- Patient account number
- Reason for the overpayment
- Copy of remittance
Please Note: Facilities should actively work credit balances due to Blue Cross and return overpayments to Blue Cross. Refunds greater than $10,000 should be identified back to Blue Cross within 120 days from the occurrence date. This should be done even when credit balance recovery vendors are assisting with this process. Failure to do so will result in the facility being responsible for the fees incurred for the recovery.

National Provider Identifier (NPI)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard unique identifier for healthcare providers. The Centers for Medicare and Medicaid Services (CMS) has assigned national provider identifiers (NPIs) to comply with this requirement. NPIs are issued by the National Plan and Provider Enumeration System (NPPES). This one unique number is to be used when filing claims with Blue Cross as well as with federal and state agencies, thus eliminating the need for you to use different identification numbers for each agency or health plan.

To comply with the legislation mentioned above, all covered entities must use their NPI and corresponding taxonomy code, where applicable, when filing claims. All providers who are being credentialed or who are undergoing recredentialing, regardless of network participation, must include their NPI(s) on their application. Claims processing cannot be guaranteed unless you notify Blue Cross of your NPI(s) prior to filing claims using your NPI(s).

Notifying Blue Cross of your NPI
Once you have been assigned an NPI, please notify us as soon as possible. To do so, you may use one of the following ways:

1. Include it on your Louisiana Standardized Credentialing Application (LSCA), Health Delivery Organization (HDO) Application or Blue Cross recredentialing application.
2. Include it on the online Provider Update Form at www.bcbsla.com/providers >Forms for Providers.
3. Submit it along with your name and tax-ID or social security number printed on your office letterhead by fax to (225) 297-2750 or by mail to Blue Cross and Blue Shield of Louisiana; Attn. Network Administration; P.O. Box 98029; Baton Rouge, LA 70898-9029.

Filing Claims with NPIs
Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your tax identification number (TIN). To appropriately indicate your NPI and TIN on UB-04 and CMS 1500 claim forms, follow the corresponding instructions for each form included in this manual. Remember, claims processing cannot be guaranteed if you have not notified Blue Cross of your NPI, by using one of the methods above, prior to filing claims. See the first part of this section for more details on how to submit claims to Blue Cross.

For more information, including whom should apply for an NPI and how to obtain your NPI, visit our website or CMS’ site at www.cms.hhs.gov/NationalProvIdentStand. If you have any questions about the NPI relating to your Blue Cross participation, please contact us at 1-800-716-2299, option 3.
**Referring Physician NPIs**

Referring physician NPIs are required on all applicable claims filed with Blue Cross and HMO Louisiana. Place the NPI in the indicated blocks of the referenced claim forms:

- CMS -1500: Block 17a
- UB-04: Block 78
- 837P: 2310A loop, using the NM1 segment ad the qualifier of DN in the NM101 element
- 837I: 2310D loop, segment NM1 with the qualifier of DN in the NM101 element

For more information on NPIs, visit [www.bcbsla.com/providers >NPI](http://www.bcbsla.com/providers >NPI).

**Modifiers**

A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

To ensure you receive the most accurate payment for services you render, Blue Cross recommends using modifiers when you file claims. For Blue Cross claims filing, modifiers, when applicable, always should be used by placing the valid CPT or HCPCS modifier(s) in Block 24D of the CMS-1500 claim form. A complete list of valid modifiers is listed in the most current CPT or HCPCS code book. Please ensure that your office is using the current edition of the code book reflective of the date of service of the claim. If necessary, please submit medical records with your claim to support the use of a modifier.

Please use the following tips to avoid the possibility of rejected claims:

- Use valid modifiers. Blue Cross considers only CPT and HCPCS modifiers that appear in the current CPT and HCPCS books as valid.
- Indicate the valid modifier in Block 24D of the CMS-1500. We collect up to four modifiers per CPT and/or HCPCS code.
- Do not use other descriptions in this section of the claim form. In some cases, our system may read the description as a set of modifiers and this could result in lower payment for you.
- Avoid excessive spaces between each modifier.
- Do not use dashes, periods, commas, semicolons or any other punctuation in the modifier portion of Block 24D.

![Modifier Example](image-url)
Modifier Guidelines

The table on the next page lists some of the modifiers that Blue Cross accepts and their reimbursement schedule (Blue Cross does not recognize all modifiers, CPT or HCPCS modifiers).

If you have any questions about billing with modifiers, please call Provider Network Administration at 1-800-716-2299, option 4 or (225) 297-2758.

<table>
<thead>
<tr>
<th>CPT/HCPCS Modifiers</th>
<th>Description</th>
<th>Blue Cross Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Unusual procedural service</td>
<td>A 15 to 20 percent additional payment will be considered for minor additional circumstances; 25 percent additional payment will be considered for very unusual additional circumstances. Additional documentation required with claim.</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated evaluation and management service by the same physician during a postoperative session</td>
<td>Pays separate allowable charge. Supportive documentation required in medical record.</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service</td>
<td>Pays separate allowable charge. Supportive documentation required in medical record.</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
<td>Pays professional component of the allowable charge.</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
<td>Payment based on 150 percent of allowable charge for applicable codes for primary bilateral procedures; secondary bilateral procedures are reimbursed at 75 percent of the allowable charge.</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedures</td>
<td>Generally pays primary or highest allowable procedure at 100 percent of allowable charge and rest at 50 percent of allowable charge.</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
<td>Allowable charge will be reduced by 20 percent.</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued procedure</td>
<td>Pays 50 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
<td>Pays 80 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>55</td>
<td>Post-operative management only</td>
<td>Pays 20 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>56</td>
<td>Pre-operative management only</td>
<td>Pays 10 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
<td>Pays separate allowable charge.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Details</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td>Pays separately except for BCBSLA edits (see: iLinkBlue, Providers, Medical Code Editing, Modifier 59).</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons</td>
<td>If allowed, pays 120 percent of allowable charge divided between both surgeons.</td>
</tr>
<tr>
<td>78</td>
<td>Returns to the operating room for a related procedure during the post-operative period</td>
<td>Pays 80 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
<td>Pays 20 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>81</td>
<td>Minimum assistant surgeon</td>
<td>Pays 20 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
<td>Pays 20 percent of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>AS</td>
<td>Physician assistant or clinical nurse specialist for assistant at surgery</td>
<td>Pays at 85 percent of assistant surgeon allowable charge for applicable codes.</td>
</tr>
<tr>
<td>MS</td>
<td>Six-month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty</td>
<td>Pay rental amount once every six months after purchase price reached for applicable codes.</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
<td>Payment based on purchase allowable charge.</td>
</tr>
<tr>
<td>RR</td>
<td>Rental</td>
<td>Payment based on rental allowable charge up to purchase allowable charge.</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
<td>Pays at 85 percent of the allowable charge.</td>
</tr>
<tr>
<td>SB</td>
<td>Nurse midwife</td>
<td>Pays at 85 percent of the allowable charge.</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
<td>Pays technical component of the allowable charge.</td>
</tr>
</tbody>
</table>

**Modifier 22**

When using Modifier 22 (unusual procedural services), please attach to the claim form a medical or operative report and an explanation of why the modifier is being submitted or copies of applicable medical records. Without this information, the modifier will not be recognized and the standard allowable charge will be applied without review or consideration of the modifier. It is not appropriate to bill Modifier 22 for an office visit, X-ray, lab or evaluation and management services.

**Modifier 25**

Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Pays separate allowable charge. Supportive documentation required in medical record.
Modifier 33
Providers can append Modifier 33 to indicate that the screening colonoscopy (45378) was converted to a polypectomy (45383). In this scenario Modifier 33 is appended to 45383 will ensure that the claim is paid correctly. **Modifier 33 will impact how the claim is paid only for colonoscopy procedures.** Modifier 33 should not be applied to nonpreventive colonoscopies (done to evaluate signs, symptoms, follow-up or existing conditions).

Modifier 59
The primary purpose of Modifier 59 is to report two or more procedures that are being performed at different anatomic sites or for different patient encounters by the same provider on the same date of service. This modifier should not be used to bypass an edit unless the proper criteria for its use are met and documentation in the patient's medical record clearly supports this criteria and the use of Modifier 59. Modifier 59 should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same date, see Modifier 25.

CMS has established four new HCPCS modifiers to define specific subsets for Modifier 59. For professional claims, Blue Cross will allow the same incidental and mutually exclusive edit overrides for the new 2015 modifiers XE, XP, XS and XU as it does for Modifier 59.

- XE - Separate Encounter - A service that is distinct because it occurred during a separate encounter
- XP - Separate Practitioner - A service that is distinct because it was performed by a different practitioner
- XS - Separate Structure - A service that is distinct because it was performed on a separate organ structure
- XU - Unusual Non-Overlapping Service - The use of a service that is distinct because it does not overlap usual components of the main service

Modifiers 73 and 74 - Discontinued Services *(postponing surgery after patient is prepped)*

- **Modifier 73** is used when a procedure is discontinued and anesthesia WAS NOT administered. A 50 percent reduction is applied to the allowable charge.
- **Modifier 74** is used when a procedure is discontinued and anesthesia WAS administered. Blue Cross applies the full allowed amount (no reduction is applied).

Modifiers TA and T1-T9
When billing toe or toenail surgeries, Modifiers TA and T1-T9 are necessary to ensure services are processed and paid correctly.

HCPCS Level II toe Modifiers TA and T1-T9 are anatomical modifiers that describe procedures performed on the right and left foot digits. It is incorrect to additionally append Modifiers LT and/or RT. It is also incorrect to use modifier 59 and/or modifier 59 subset “X modifiers” (XE, XS, XP, XU).
Failure to use these modifiers appropriately may result in claims denial. Additionally, post audits will be performed and will result in recoupments if documentation reviewed supports unbundling by incorrect use of modifiers 59, XE, XS, XP, XU, LT and RT.

Multiple Births
Blue Cross and HMO Louisiana physicians may receive additional reimbursement of $300 (subject to applicable network discounts) when filing for multiple births. The additional reimbursement applies to both vaginal deliveries and cesarean sections. To be eligible for the additional reimbursement, claims should be filed with the following CPT codes and Modifier 76:

- 59400 59510 59610 59618
- 59409 59514 59612 59620
- 59410 59515 59614 59622

Multiple Surgical Procedures
Multiple surgical procedures are procedures performed during the same operative session. Bilateral procedures are considered multiple procedures.

When multiple procedures are performed, the primary or major procedure is considered to be the procedure with the greatest value based on the allowable charge and may be reimbursed up to the allowable charge. The modifier used to report multiple procedures is 51. The modifier to report single and multiple bilateral procedures is 50, see below for more information on Modifier 50.

If a service includes a combination of procedures, one code should be used rather than reporting each procedure separately. If procedures are coded separately, Blue Cross may bundle the procedures and apply the appropriate allowable charge.

Secondary covered procedures are reimbursed up to 50 percent of the allowable charge.

Modifier 50 - Billing Single Bilateral Procedures

- Single Bilateral (Modifier 50) procedures can anatomically be done bilaterally only once per session.
- Multiple Bilateral (Modifier 50) procedures can anatomically be done bilaterally multiple times per session.

Correct submission of a bilateral procedure is the code on one line with Modifier 50 and “1” in the units field.

For all professional and facility claims, bilateral procedures are reimbursed as follows:

1. The primary bilateral procedures are reimbursed at 150 percent of the allowable charge.
2. The secondary bilateral procedures are reimbursed at 75 percent of the allowable charge.

Proper billing of bilateral procedures ensures correct reimbursement and eliminates the need for refund requests and payment adjustments.
**Modifier RT and LT Clarification:**

- Modifiers RT and LT are informational modifiers only and should not be used when Modifier 50 applies.
- Modifier 50 should be used to report bilateral procedures that are performed on both sides at the same operative session as a single line item.

**Radiology, Pathology and Laboratory**

Modifiers are used to report both the professional and technical components for radiology, pathology and laboratory services. Professional component only or technical component only codes do not require Modifier 26 or TC.

Modifier rules are as follows:

- Use Modifier 26 when billing separately for the **professional** component of a service.
- Use Modifier TC when billing separately for the **technical** component of a service.
- Total component (global) billing does not require a modifier.
- To ensure prompt and correct payment for your services, always use the appropriate modifier.

When billing for diagnostic and therapeutic hospital-based physician services, you should only bill the professional component and such billing should be submitted on the CMS-1500 claim form. Blue Cross will not separately reimburse technical components associated with hospital inpatient and outpatient services. Reimbursement for these services are included in the hospital’s payment.

The technical and/or professional components for all radiology and other imaging services may be billed by the PHYSICIAN only if he/she actually renders the service. The PHYSICIAN may not bill Blue Cross for the technical and/or professional component of any diagnostic test or procedure, including but not limited to, X-rays, ultrasound, or other imaging services, computerized axial tomography or magnetic resonance imaging by utilizing another entity’s NPI. The referring provider may not receive compensation, directly or indirectly, from the provider who rendered the service.

**Billing for Surgical Assistant Services**

The following provider types may be reimbursed for procedures approved to have an assistant at surgery:

- Certified registered nurse first assistants (CRNFA)
- Physician’s assistants
- Registered nurse first assistants (RNFA)

FEP contracts will pay for registered nurse surgical assistant services for those procedures approved to have an assistant at surgery.

The aforementioned provider types may file claims using their NPI or the supervising physician’s NPI and they should use Modifier AS when billing for surgical assistant services. They should not use Modifiers 80, 81 or 82. These modifiers should be used by physicians only. Reimbursement will be 85 percent of the assistant surgeon allowable charge.
Reporting National Drug Code (NDC) on Claims

We require all clinician administered drugs billed on professional and outpatient hospital claims to be processed through the member’s medical benefits, and to include the NDCs for the drugs. Providers are required to report NDCs on claims with any associated HCPCS or CPT codes, including immunizations. (HCPCS codes beginning with the letter “A” are excluded from this requirement). Failure to report an NDC on these claims will result in automatic rejections.

Providers should use the following billing guidelines to report NDCs on professional CMS-1500 claims:

- NDC code editing will apply to any clinician administer drug billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter “A”).
- Each clinician administered drug must be billed on a separate line item.
- Claims that do not meet the requirements will be rejected and returned on your “Not Accepted” report. Units indicated would be “1” or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs.
- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim.
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format. If the NDC is not submitted in the correct format, the claim will be denied.

For Hardcopy Claims

- On the CMS-1500 claim form, report the NDC in the shaded area of Box 24A. We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g. N49999999999. The drug quantity and measurement/qualifier should be included.
- On the UB-04 claim form, report the NDC and the quantity in Box 43 (description field). We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g. N49999999999. The drug quantity and measurement/qualifier should be included.

For Electronic Claims

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.
For iLinkBlue Claims (Professional Only)
Select 24K to expand the claim line to report the NDC, Quantity, and Measurement.

- NDC Code Field: Enter the 11 digit NDC code. No alpha characters, spaces or hyphens can be present.
- Quantity: Numeric value of quantity
- Measurement: Select the appropriate measurement from the drop down menu
  - F2 – International Unit
  - GR- Gram
  - ME- Milligram
  - ML – Milliliter
  - UN- Unit

Equipment, Devices and Supplies
Blue Cross will not reimburse non-hospital providers for equipment, devices or supplies used in conjunction with hospital inpatient or outpatient services. Reimbursement for these services is included in the hospital’s payment.

Code Editing: Billing Practices Subject to Reduction
Unbundling occurs when two or more CPT or HCPCS codes are used to describe a procedure performed when a single, more comprehensive code exists that accurately describes the entire procedure. The unbundled procedures will be rebundled for assignment of the proper comprehensive code as determined by Blue Cross. The allowable charge includes the rebundled procedure or service. Blue Cross will provide benefits according to the proper comprehensive code for the rebundled procedure or service, as determined by Blue Cross.

Reductions in payment for multiple, bilateral and combined procedures are considered above allowable amounts and appear on the Payment Register/Remittance Advice in the above allowable amount column. These amounts are not collectable from the Blue Cross member.

Co-surgery is defined as two surgeons of different specialties operating together to perform a single surgery, usually expressed under one CPT code. For co-surgeries, Blue Cross allows 120 percent of the allowable charge and divides that amount equally between the two surgeons. Additional assistants are not covered, since contract benefits have already been paid.

Incidental covered procedures, such as the removal of appendix at the time of other intra-abdominal surgery with no pathology, are not reimbursed separately. The incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the more extensive procedure. The allowable charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.
Mutually exclusive procedures are two or more procedures that usually are not performed at the same session on the same patient on the same date of service. Mutually exclusive procedures also may include different procedure codes and descriptions for the same type of procedures in which the physician should be submitting only one of the codes.

Evaluation and Management (E&M) rules apply to the E&M services included in the following codes and code ranges:

- 99201-99499
- 99024 (Miscellaneous Services)
- 92002-92004 & 92012-92014 (Ophthalmology)

The separate billing of an E&M service will not be allowed when a substantial diagnostic or therapeutic procedure has been performed on the same date of service by the same provider.

**Multiple Service Reduction for Diagnostic Imaging Services**

Blue Cross is adding multiple service reduction logic to diagnostic imaging radiology services performed for the same patient encounter.

The applicable radiology services are identified by Medicare’s diagnostic imaging family groupings as published in the CMS National Physician Fee Schedule Relative Value File. Blue Cross will review and update the list of services following Medicare’s annual release of the CMS National Physician Fee Schedule.

**For Professional Providers**

The multiple service reduction applies to the technical component of diagnostic imaging radiology services for dates of service on and after December 1, 2016.

When more than one radiology service from Medicare’s diagnostic imaging family grouping is performed for the same patient encounter:

- The technical component allowable charge for the primary radiology service will be paid at 100 percent of the allowable charge.
- The technical component for second and subsequent services will be reduced by 50 percent.
- The primary radiology service will be identified as the code with the highest technical component allowable charge.

**For Facility Providers**

The multiple service reduction applies to outpatient diagnostic imaging radiology services for dates of service on and after January 1, 2017.

When more than one radiology service from Medicare’s diagnostic imaging family grouping is performed for the same patient encounter:

- The allowable charge for the primary radiology service will be paid at 100 percent of the allowable charge.
• Second and subsequent services will be reduced by 50 percent.
• The primary service will be identified as the code with the highest allowable charge.

**Provider Access to Medical Code Editing Section on iLinkBlue**

From the Home Page of iLinkBlue, click on “Medical Code Editing” section on the menu on the left.

• The **Clear Claim Connection** link connects to a disclaimer page, then to Clear Claim Connection (C3), a Web-based code auditing reference tool designed to audit and evaluate code combinations. C3 is a self-service inquiry tool to help reduce manual inquiries and time consuming appeals. C3 also indicates whether or not a CPT, modifier or CPT/modifier combination is valid for the date of service entered on the inquiry.

**CMS-1500 Claims Filing Guidelines**

Blue Cross scans all paper claims to eliminate the need to manually enter the claims data into our system. Please follow the guidelines below to ensure that your claims are scanned properly, which will allow you to benefit from faster, more accurate claims processing:

• Blue Cross does not accept black and white hardcopy claim forms. Do not submit black and white copies, as data recognition can be affected and may delay the processing of claim payments. Black and white claims are less legible after they are scanned.
• Laser printed claims produce the best scanning results. If you use a dot-matrix printer, please use a standard 10 or 12 font ribbon when the type begins to fade.
• Use CMS-1500 forms that are printed on good quality paper. When the paper is too thin, the claim cannot be scanned properly.
• Type or computer print all information within the appropriate blocks on the CMS-1500 claim form. Information should not overlap from one block into another.
• Type or computer print Block 14. This information cannot be handwritten because only typed information can be scanned and converted to text file for our system to process.
• If there is a signature in Block 31, it should not overlap into Block 25 (Federal Tax ID number) because the Tax ID number cannot be read.
• Do not use any stamps or stickers on your claim forms. The scanning equipment has a lamp that distorts stamps with black ink and completely removes any information with red ink. Therefore, stamps with pertinent information in red ink, such as “Benefits Assigned” or “Corrected Copy,” will be lost if the claim is scanned.
Blue Cross only accepts CMS-1500 "version 02/12." No black and white copies or faxed claims are accepted.

Example

**CMS-1500 CLAIM FORM**

Blue Cross and Blue Shield of Louisiana
Professional Provider Office Manual

December 2016

Blue Cross only accepts CMS-1500 "version 02/12." No black and white copies or faxed claims are accepted.
Health Insurance Claim Form (CMS-1500 Version 02-12) Explanation

<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td>Type(s) of Health Insurance - Indicate coverage applicable to this claim by checking the appropriate block(s).</td>
</tr>
<tr>
<td>Block 1A</td>
<td>Insured's I.D. Number - Enter the member’s Blue Cross and Blue Shield identification number, including their three-character alpha prefix, exactly as it appears on the identification card.</td>
</tr>
<tr>
<td>Block 2</td>
<td>Patient’s Name - Enter the full name of the individual treated.</td>
</tr>
<tr>
<td>Block 3</td>
<td>Patient’s Birth Date - Indicate the month, day and year. Sex - Place an X in the appropriate block.</td>
</tr>
<tr>
<td>Block 4</td>
<td>Insured’s Name - Enter the name from the identification card except when the insured and the patient are the same; then the word “same” may be entered.</td>
</tr>
<tr>
<td>Block 5</td>
<td>Patient’s Address - Enter the patient’s complete, current mailing address and phone number.</td>
</tr>
<tr>
<td>Block 6</td>
<td>Patient’s Relationship to Insured - Place an X in the appropriate block. Self - Patient is the member. Spouse - Patient is the member’s spouse. Child - Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes stepchildren). Other - Patient is the member’s grandchild, adult-sponsored dependent or of a relationship not covered previously.</td>
</tr>
<tr>
<td>Block 7</td>
<td>Insured’s Address - Enter the complete address; street, city, state and zip code of the policyholder. If the patient’s address and the insured’s address are the same, enter “same” in this field.</td>
</tr>
<tr>
<td>Block 8</td>
<td>Reserved for NUCC USE - This section is reserved for NUCC use. Deleted “Patient Status” and content of field.</td>
</tr>
<tr>
<td>Block 9</td>
<td>Other Insured’s Name - If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).</td>
</tr>
<tr>
<td>Block 10</td>
<td>Is patient’s condition related to: a. Employment (current or previous)?: b. Auto Accident?: c. Other Accident?. Check appropriate block if applicable.</td>
</tr>
<tr>
<td>Block 10D</td>
<td>When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or</td>
</tr>
</tbody>
</table>
private payer regarding the need to report claim codes. When required by payers to provide
the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this
field. The Condition Codes approved for use on the CMS-1500 Claim Form are available
at [www.nucc.org](http://www.nucc.org) under Code Sets. When reporting more than one code, enter three blank
spaces and then the next code.

**Block 11**

Not required.

**Block 11D**

When appropriate, enter an X in the correct box. If marked "YES," complete 9, 9A, and 9D.
Only mark one box.

**Block 12**

Patient’s or Authorized Person’s Signature - Appropriate signature in this section authorizes
the release of any medical or other information necessary to process the claim. Signature or
"Signature on File" and date required. "Signature on File" indicates that the signature of the
patient is contained in the provider’s records.

**Block 13**

Insured’s or Authorized Person’s Signature - Payment for covered services is made directly
to participating providers. However, you have the option of collecting for office services
from members who do not have a copayment benefit and having the payments sent to
the patients. To receive payment for office services when the copayment benefit is not
applicable, Block 13 must be completed. Acceptable language is:

a. Signature in block  
   b. Signature on file  
   c. On file  
   d. Benefits assigned  
   e. Assigned  
   f. Pay provider

**Please Note:** Assignment language in other areas of the CMS-1500 claim form or on any
attachment is not recognized. If this block is left blank, payment for office services will be sent
to the patient. Completion of this block is not necessary for other places of treatment.

**Block 14**

Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the present illness, injury or
pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.
Enter the applicable qualifier to identify which date is being reported.

**Block 15**

Enter another date related to the patient’s condition or treatment. Enter the date in the date
in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format. Enter the applicable qualifier
to identify which date is being reported.

**Block 16**

Dates Patient Unable to Work in Current Occupation - Enter dates, if applicable.

**Block 17**

Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the
professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple
providers are involved, enter one provider using the following priority order:
1. Referring Provider
2. Ordering Provider
3. Supervising Provider
Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported to the left of the vertical, dotted line.

| Block 17A | Other ID#. The non-NPI ID number of the referring physician, when listed in Block 17. |
| Block 17B | **NPI – Required.** Enter the national provider identifier (NPI) for the referring physician, when listed in Block 17. |
| Block 18 | For Services Related to Hospitalization - Enter dates of admission to and discharge from hospital. |
| Block 19 | Additional Claim information to be completed by NUCC. |
| Block 20 | Laboratory Work Performed Outside Your Office - Enter, if applicable. |
| Block 21 | **Diagnosis or Nature of Illness or Injury** - Enter the applicable ICD indicator to identify which version of ICD codes is being reported: "0" for ICD-10-CM codes- Note: All transactions, electronic or paper-based, for services on and after October 1, 2015, must contain ICD-10 codes or they will be rejected. Blue Cross will not accept ICD-9 codes with dates of services on or after October 1, 2015. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient’s diagnosis and/or condition. Use the most specific diagnosis codes when reporting codes. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. |
| Block 23 | Prior Authorization Number - Enter the authorization number obtained from Blue Cross HMO Louisiana, if applicable. |
| Block 24A | Date(s) of Service - Enter the “from” and “to” date(s) for service(s) rendered. Report the NDC in the shaded area. |

**We follow CMS billing requirements for CMS-1500 claims when billing the NDC codes:**

(CMS Claims Processing Manual, chapter 26, section 10.4) states the following:

Item 24 - The six service lines in section 24 have been divided horizontally to
accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N49999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g., UN2 or F2999999).

Block 24B  
Place of Service - Enter the appropriate place of service code. Common place of service codes are:
  - Inpatient - 21  
  - Outpatient - 22  
  - Office - 11

Block 24C  
EMG - Enter the Type of Service code that represents the services rendered.

Block 24D  
Procedures, Services, or Supplies - Enter the appropriate CPT or HCPCS code. Please ensure your office is using the most current CPT and HCPCS codes and that you update your codes annually. Append modifiers to the CPT and HCPCS codes, when appropriate.

Block 24E  
Diagnosis Pointer - Enter the diagnosis code reference letter (pointer) as shown in Block 21 to relate the date of service and procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.

Block 24F  
Charges - Enter the total charge for each service rendered. You should bill your usual charge to Blue Cross regardless of our allowable charges.

Block 24G  
Days or Units - Indicate the number of times the procedure was performed, unless the code description accounts for multiple units, or the number of visits the line item charge represents. Base units value should never be entered in the “units” field of the claim form.

Block 24J  
Rendering Provider ID# - Enter the national provider identifier (NPI) for the rendering physician for each procedure code listed when billing for multiple physicians’ services on the same claim. Laboratory, Durable Medical Equipment, Emergency Room Physicians,
Diagnostic Radiology Center, Laboratory and Diagnostic Services and Urgent Care Center providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed.

**Please note:** Rural health clinics and Federally Qualified Health Centers are required to enter the rendering provider NPI.

| Block 25 | Federal Tax I.D. Number - Enter the provider’s/clinic’s federal tax identification number to which payment should be reported to the Internal Revenue Service. |
| Block 26 | Patient’s Account Number - Enter the patient account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register/Remittance Advice only if it is indicated on the claim form. |
| Block 27 | Accept Assignment - Not applicable - Used for government claims only. |
| Block 28 | Total Charge - Total of all charges in Item F. |
| Block 29 | Amount Paid - Not required. |
| Block 30 | Not required. |
| Block 31 | Signature of Provider - Provider’s signature required, including degrees and credentials. Rubber stamp is acceptable. |
| Block 32 | Name and Address of Facility - Required, if services were provided at a facility other than the physician’s office. |
| Block 32A | NPI - Enter the NPI for the facility listed in Block 32. |
| Block 32B | Other ID. The non-NPI number of the facility refers to the payer-assigned unique identifier of the facility. |
| Block 33 | Billing Provider Info & Ph# - Enter complete name, address, telephone number for the billing provider. |
| Block 33B | Other ID#. The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional. |
| Block 33A | NPI - Enter the NPI for the billing provider listed in Block 33. |
### iLinkBlue 1500 Claim Electronic Entry Screen

<table>
<thead>
<tr>
<th>Block 1</th>
<th>Type(s) of Health Insurance - Indicate coverage applicable to this claim by checking the appropriate block(s).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1A</td>
<td>Insured’s I.D. Number - Enter the member’s Blue Cross and Blue Shield identification number, including their three-character alpha prefix, exactly as it appears on the identification card.</td>
</tr>
<tr>
<td>Block 2</td>
<td>Patient’s Name - Enter the full name of the individual treated.</td>
</tr>
<tr>
<td>Block 3</td>
<td>Patient’s Birth Date - Indicate the month, day and year. Sex - Place an X in the appropriate block.</td>
</tr>
<tr>
<td>Block 4</td>
<td>Insured’s Name - Enter the name from the identification card except when the insured and the patient are the same; then the word “same” may be entered.</td>
</tr>
<tr>
<td>Block 5</td>
<td>Patient’s Address - Enter the patient’s complete, current mailing address and phone number.</td>
</tr>
<tr>
<td>Block 6</td>
<td>Patient’s Relationship to Insured - Place an X in the appropriate block. Self - Patient is the member.</td>
</tr>
<tr>
<td>Block 6</td>
<td>Spouse - Patient is the member’s spouse. Child - Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes stepchildren). Other - Patient is the member’s grandchild, adult-sponsored dependent or of relationship not covered previously.</td>
</tr>
<tr>
<td>Block 7</td>
<td>Insured’s Address - Enter the complete address; street, city, state and zip code of the policyholder. If the patient’s address and the insured’s address are the same, enter “same” in this field.</td>
</tr>
<tr>
<td>Block 8</td>
<td>Reserved for NUCC USE - This section is reserved for NUCC use. Deleted “Patient Status” and content of field.</td>
</tr>
<tr>
<td>Block 9</td>
<td>Other Insured’s Name - If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).</td>
</tr>
<tr>
<td>Block 10</td>
<td>Is patient’s condition related to: a. Employment (current or previous)?; b. Auto Accident?; c. Other Accident?. Check appropriate block if applicable.</td>
</tr>
</tbody>
</table>
Block 11
Not required.

Block 11D
When appropriate, enter an X in the correct box. If marked “YES”, complete 9, 9A and 9D. Only one box can be marked.

Block 12
Patient’s or Authorized Person’s Signature - Appropriate signature in this section authorizes the release of any medical or other information necessary to process the claim. Signature or “Signature on File” and date required. “Signature on File” indicates that the signature of the patient is contained in the provider’s records.

Block 13
Insured’s or Authorized Person’s Signature - Payment for covered services is made directly to participating providers. However, you have the option of collecting for office services from members who do not have a copayment benefit and having the payments sent to the patients. To receive payment for office services when the copayment benefit is not applicable, Block 13 must be completed. Acceptable language is:

a. Signature in block
d. Benefits assigned
b. Signature on file
e. Assigned
c. On file
f. Pay provider

Please Note: Assignment language in other areas of the CMS-1500 claim form or on any attachment is not recognized. If this block is left blank, payment for office services will be sent to the patient. Completion of this block is not necessary for other places of treatment.

Block 14
Date of Current - Enter the first date of illness, injury or pregnancy filed on claim- Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. for pregnancy, use the date of the last menstrual period (LMP) as the first date.

Block 15
Enter another date related to the patient’s condition or treatment. Enter the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format. Enter the applicable qualifier to identify which date is being reported.

Block 16
Dates Patient Unable to Work in Current Occupation - Enter dates, if applicable.

Block 17
Name of Referring Provider or Other Source - Enter the name (First Name, Middle Initial,
Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the qualifier to the left of the vertical, dotted line.

**Block 17A**
Other ID#. The non-NPI ID number of the referring physician, when listed in Block 17.

**Block 17B**
NPI – Required. Enter the national provider identifier (NPI) for the referring physician, when listed in Block 17.

**Block 18**
For Services Related to Hospitalization - Enter dates of admission to and discharge from hospital.

**Block 19**
(Designated by NUCC) - Additional Claim information to be completed by NUCC.

**Block 20**
Laboratory Work Performed Outside Your Office - Enter, if applicable.

**Block 21**
**Diagnosis or Nature of Illness or Injury**- Enter the applicable ICD indicator to identify which version of ICD codes is being reported: "9" for- ICD-9-CM or "0" for ICD-10-CM codes- Note: All transactions, electronic or paper-based, for services on and after October, 1, 2015, must contain ICD-10 codes or they will be rejected. Blue Cross will not accept ICD-9 codes with dates of services on or after October 1, 2015. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient’s diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

**Block 23**
Prior Authorization Number- Enter the authorization number obtained from Blue Cross/ HMO Louisiana, if applicable.

**Block 24A**
Date(s) of Service - Enter the “from” and “to” date(s) for service(s) rendered.

**Block 24B**
Place of Service - Enter the appropriate place of service code. Common place of service codes are:

- Inpatient - 21
- Outpatient - 22
- Office - 11

**Block 24C**
EMG - Enter the Type of Service code that represents the services rendered.
<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24D</td>
<td>Procedures, Services, or Supplies - Enter the appropriate CPT or HCPCS code. Please ensure your office is using the most current CPT and HCPCS codes and that you update your codes annually. Append modifiers to the CPT and HCPCS codes, when appropriate.</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer - Enter the diagnosis code reference letter (pointer) as listed in Block 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.</td>
</tr>
<tr>
<td>24F</td>
<td>Charges - Enter the total charge for each service rendered. You should bill your usual charge to Blue Cross regardless of our allowable charges.</td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units - Indicate the number of times the procedure was performed, unless the code description accounts for multiple units, or the number of visits the line item charge represents. Base units value should never be entered in the “units” field of the claim form.</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider ID# - Enter the national provider identifier (NPI) for the rendering physician for each procedure code listed when billing for multiple physicians’ services on the same claim. Laboratory, Durable Medical Equipment, Emergency Room Physicians, Diagnostic Radiology Center, Laboratory and Diagnostic Services, and Urgent Care Center providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed. <strong>Please note:</strong> Rural health clinics and Federally Qualified Health Centers are required to enter the rendering provider NPI.</td>
</tr>
<tr>
<td>24K</td>
<td>Expand claim line to report NDC, Quanitity, and Measurement.</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax I.D. Number - Enter the provider’s/clinic’s federal tax identification number to which payment should be reported to the Internal Revenue Service.</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account Number - Enter the patient account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register/Remittance Advice only if it is indicated on the claim form.</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment - Not applicable - Used for government claims only.</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge - Total of all charges in Item F.</td>
</tr>
<tr>
<td>Block 29</td>
<td>Amount Paid - Not required.</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Block 30</td>
<td>Not required.</td>
</tr>
<tr>
<td>Block 31</td>
<td>Signature of Provider - Provider’s signature required, including degrees and credentials.</td>
</tr>
<tr>
<td>Block 32</td>
<td>Name and Address of Facility - Required, if services were provided at a facility other than the physician’s office.</td>
</tr>
<tr>
<td>Block 32A</td>
<td>NPI - Enter the NPI for the facility listed in Block 32.</td>
</tr>
<tr>
<td>Block 32B</td>
<td>Other ID. The non-NPI number of the facility refers to the payer-assigned unique identifier of the facility.</td>
</tr>
<tr>
<td>Block 33</td>
<td>Billing Provider Info &amp; Ph# - Enter complete name, address, telephone number for the billing provider.</td>
</tr>
<tr>
<td>Block 33A</td>
<td>NPI - Enter the NPI for the billing provider listed in Block 33.</td>
</tr>
<tr>
<td>Block 33B</td>
<td>Other ID#. The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional.</td>
</tr>
</tbody>
</table>
**Place of Service Codes**

Place of service codes are not converted. When filing a claim make sure to use the appropriate code for the services rendered. Below is a listing of the place of treatment codes and their descriptions.

<table>
<thead>
<tr>
<th>POS</th>
<th>Description</th>
<th>Norm POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy</td>
<td>Outpatient</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
<td>Outpatient</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
<td>Outpatient</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service Free-Standing Facility</td>
<td>Outpatient</td>
</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider-Based Facility</td>
<td>Inpatient</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-Standing Facility</td>
<td>Outpatient</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-Based Facility</td>
<td>Inpatient</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
<td>Outpatient</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s Home</td>
<td>Outpatient</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
<td>Outpatient</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
<td>Outpatient</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
<td>Outpatient</td>
</tr>
<tr>
<td>17</td>
<td>Retail Health Clinic</td>
<td>Outpatient</td>
</tr>
<tr>
<td>19</td>
<td>Office</td>
<td>Outpatient</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
<td>Outpatient</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>Inpatient</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
<td>Outpatient</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
<td>Outpatient</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
<td>Outpatient</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
<td>Outpatient</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
<td>Outpatient</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POS</th>
<th>Description</th>
<th>Norm POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Nursing Facility</td>
<td>Inpatient</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
<td>Inpatient</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
<td>Inpatient</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance – Land</td>
<td>Outpatient</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
<td>Outpatient</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
<td>Outpatient</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
<td>Outpatient</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
<td>Inpatient</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
<td>Outpatient</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
<td>Outpatient</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/ Mentally Retarded</td>
<td>Inpatient</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Center</td>
<td>Inpatient</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
<td>Inpatient</td>
</tr>
<tr>
<td>58</td>
<td>Addiction Facility Partial Hospitalization</td>
<td>Outpatient</td>
</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
<td>Outpatient</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
<td>Inpatient</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
<td>Outpatient</td>
</tr>
<tr>
<td>65</td>
<td>End Stage Renal Disease Treatment Facility</td>
<td>Outpatient</td>
</tr>
<tr>
<td>71</td>
<td>State or Local Public Health Clinic</td>
<td>Outpatient</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
<td>Outpatient</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
<td>Outpatient</td>
</tr>
<tr>
<td>99</td>
<td>Other Unlisted Facility</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>
Example

**UB-04 CLAIM FORM**

The following sample UB-04 claim form and instructions are given for those providers who should file claims using a UB-04 claim form, specifically acute care facilities, dialysis and home health providers.

### UB-04 CLAIM FORM

**Example**

**UB-04 CLAIM FORM**

The following sample UB-04 claim form and instructions are given for those providers who should file claims using a UB-04 claim form, specifically acute care facilities, dialysis and home health providers.

### UB-04 CLAIM FORM

**Example**

**UB-04 CLAIM FORM**

The following sample UB-04 claim form and instructions are given for those providers who should file claims using a UB-04 claim form, specifically acute care facilities, dialysis and home health providers.
## UB-04 Claim Form Explanation

<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td>Enter billing provider name and address.</td>
</tr>
<tr>
<td>Block 2</td>
<td>Enter pay-to provider name and address, if different than Block 1.</td>
</tr>
<tr>
<td>Block 3A</td>
<td>Patient Control Number: Enter the number or code that is used by your facility to retrieve or post financial records.</td>
</tr>
<tr>
<td>Block 3B</td>
<td>Medical Record Number: Enter the number or code that is used by your facility to retrieve or post medical/health records</td>
</tr>
<tr>
<td>Block 4</td>
<td>Type of Bill: This is a three-position code that indicates the type of facility, the bill classification and the frequency.</td>
</tr>
<tr>
<td>Block 5</td>
<td>Fed. Tax ID: Enter the tax identification number of the facility.</td>
</tr>
<tr>
<td>Block 6</td>
<td>Statement Covers Period: Enter the first date associated with this claim in the “From” box and enter the final date of the claim in the “Through” box.</td>
</tr>
<tr>
<td>Block 8A-8B</td>
<td>Patient Name: Enter the patient’s name with last name first, then first name and middle initial, if any. Do not use titles or nicknames.</td>
</tr>
<tr>
<td>Block 9A-9E</td>
<td>Address: Patient address must be completed.</td>
</tr>
<tr>
<td>Block 10</td>
<td>Birthdate: Enter the patient’s actual date of birth in MM-DD-YYYY format.</td>
</tr>
<tr>
<td>Block 11</td>
<td>Sex: An “M” for male or an “F” for female must be present.</td>
</tr>
<tr>
<td>Block 12</td>
<td>Admission Date: This field is required for inpatient claims and not required for outpatient claims.</td>
</tr>
<tr>
<td>Block 13</td>
<td>HR: This field is required for inpatient claims and not required for outpatient claims.</td>
</tr>
<tr>
<td>Block 14</td>
<td>Type: This field is required for inpatient claims and not required for outpatient claims.</td>
</tr>
<tr>
<td>Block 15</td>
<td>SRC: This field is required for inpatient claims and not required for outpatient claims.</td>
</tr>
<tr>
<td>Block</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>16</td>
<td>DHR: Discharge hour field is required on all final inpatient claims except for 021x. This includes claims with a Frequency Code of 1 (Admit through Discharge), 4 (Interim- Last Claim) and 7 (Replacement of Prior Claim) when the replacement is for a prior final claim.</td>
</tr>
<tr>
<td>17</td>
<td>STAT: Enter the applicable discharge status code. This field is not required for outpatient claims, but can be present.</td>
</tr>
<tr>
<td>18-28</td>
<td>Condition Codes: The condition code(s) is a two-position code that identifies conditions, if any, relating to this bill that may affect payer processing.</td>
</tr>
<tr>
<td>29</td>
<td>Two digit state abbreviation where the accident occurred.</td>
</tr>
<tr>
<td>30</td>
<td>Reserved for assignment by the National Uniform Billing Committee (NUBC).</td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence Codes and Occurrence Dates: The occurrence code is a two-position code used to determine liability, coordination of benefits and to administer subrogation clauses in the member contract/certificate. The occurrence date is the date that corresponds with the preceding occurrence code. The date must be in MM-DD-YYYY format and is required if occurrence codes are used.</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence Span Codes and Dates: These fields are used when the patient was seen as an outpatient for follow-up treatment. In the “From” field, enter the first date the patient was treated for this condition. In the “Through” field, enter the last date the patient was treated for this condition. This field is not required for inpatient claims.</td>
</tr>
<tr>
<td>37</td>
<td>Reserved for assignment by the NUBC.</td>
</tr>
<tr>
<td>38</td>
<td>The name and address of the party responsible for the bill.</td>
</tr>
<tr>
<td>39-41</td>
<td>Value Code/Amount: Value code(s) identify data necessary for processing claims. The value amount is the dollar amount or number associated with the corresponding value code. A value amount must be present for each value code. If the amount does not represent a dollar amount, two zeros should be entered following the number. Example: If the patient received three units of blood, enter 300.</td>
</tr>
<tr>
<td>42</td>
<td>Rev CD: The revenue code is the code that best identifies a particular accommodation/ancillary service that was rendered to the patient. Revenue codes can be duplicated only if the rates differ.</td>
</tr>
<tr>
<td>Block</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>43</td>
<td>Description: The provider reports the NDC code. The provider enters a narrative description or standard abbreviation for each revenue code shown. This field is not required but may be present.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rates: The rate is the actual charge for the services rendered. If rates are different, duplicate the revenue code to show the different rates. Revenue codes can only be duplicated when the rates are different. Rate multiplied by units must equal charges.</td>
</tr>
<tr>
<td>45</td>
<td>Serv. Date: Date of service for HCPCS code listed. If there are multiple dates of service for the same HCPCS code, each date must be listed on a separate line.</td>
</tr>
<tr>
<td>46</td>
<td>Service Units: Service units are the number of times a service was rendered per date of service.</td>
</tr>
<tr>
<td>47</td>
<td>Total Charge: Enter the amount charged for each of the revenue codes given. If rates and units are present, multiply these to get the total charges except when rates are zeros.</td>
</tr>
<tr>
<td>49</td>
<td>Reserved for assignment by the NUBC.</td>
</tr>
<tr>
<td>50</td>
<td>Payer Name: This field is required only on lines 50 B and 50 C when indicating other payer information.</td>
</tr>
<tr>
<td>52</td>
<td>REL INFO: The release information field must be “Y” if you are filing electronically. This indicates that you have signed written authority to release medical or billing information for purposes of claiming insurance benefits. If “N,” you must file hardcopy.</td>
</tr>
</tbody>
</table>
| 53    | ASG BEN: Enter one of the following codes to indicate who will receive payment for the claim:  
|       | Y Assignment/payment to provider | N Assignment/payment to member  
Blue Cross pays all participating providers directly unless assignment indicates to pay the member. |
<p>| 56    | NPI: Enter the appropriate national provider identifier (NPI) number in this field. |
| 57    | Other Prv ID: Enter your Blue Cross assigned five-digit or ten-digit provider number in this field. |
| Block 58 | Insured’s Name: If the patient is not the insured, enter the member’s name exactly as it appears on the Blue Cross identification card. |
| Block 59 | P REL: If the patient and insured are the same, this field is not required. If the patient is not the insured, enter one of the following codes that identifies the patient’s relationship to the contract holder: |
| | 01 Spouse 18 Self |
| | 19 Child 20 Employee |
| | 21 Unknown 39 Organ donor |
| | 40 Cadaver donor 53 Life Partner |
| | G8 Other relationship |
| Block 60 | Insured’s Unique ID: Enter the member’s identification number exactly as it appears on the ID card. |
| Block 61 | Group Name: This field is required if known. |
| Block 62 | Insurance Group No.: Enter the group number as it appears on the member’s ID card. |
| Block 63 | Treatment Authorization Codes: Enter the Blue Cross authorization number, when available. |
| Block 65 | Employer Name: Enter the patient’s employer in this field. If patient is a housewife, retired, unemployed or a student in college, enter this. Do not enter the member’s employer, unless the patient is the employer. |
| Block 66 | ICD Version Indicator: Qualifier Code “9” required on claims representing services through September 30, 2015. Qualifier Code “0” required on claims representing services on October 1, 2015, and beyond. |
| Block 67 | Principle Diagnosis Code: The principal diagnosis code must be entered in this field. You must use ICD-10-CM codebook. The first position should contain “V” or a numeric character. The second and third positions must be numeric with no punctuation. Fourth and fifth positions must be numeric or blank. |
| Blocks 67A-Q | Other Diagnosis Codes: These fields should be used when additional conditions exist at the time of admission or develop subsequently and affect the treatment received or the length of stay. Follow the coding guidelines for the principal diagnosis code. |
| Block 68 | Reserved for assignment by the NUBC. |
| Block 69 | Admit Dx: Enter the ICD-10-CM diagnosis code related to the patient's admission. |</p>
<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>The ICD-CM diagnosis code describing the patient’s reason for visit at the time of outpatient registration.</td>
</tr>
<tr>
<td>71</td>
<td>The Prospective Payment System (PPS) code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.</td>
</tr>
<tr>
<td>72</td>
<td>The ICD diagnosis code pertaining to external cause of injuries, poisoning, or adverse effect. See ICD-10-CM Guidelines for Coding and Reporting.</td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Code/Date: The principal procedure should be entered in this field. This is the procedure that was performed for treatment rather than diagnostic or exploratory purposes, or the procedure that is most related to the principal diagnosis. The procedure coding method must be ICD-10-CM. Enter the date the primary/principal procedure was performed in MM-DD-YYYY format.</td>
</tr>
<tr>
<td>74A-E</td>
<td>Other Procedure Code/Date: For outpatient billing, if a CPT code is not required, enter the ICD-10-CM procedure code. Enter the date of the additional procedure(s) in MM-DD-YYYY format.</td>
</tr>
<tr>
<td>75</td>
<td>Reserved for assignment by the NUBC.</td>
</tr>
<tr>
<td>76</td>
<td>Attending: Enter the NPI, last name and first name of the attending physician who rendered the services. This field is required.</td>
</tr>
<tr>
<td>77</td>
<td>Operating: Enter the NPI, last name and first name of the operating physician who had primary responsibility for surgical procedures. This is only required when a surgical procedure code is listed.</td>
</tr>
<tr>
<td>78-79</td>
<td>Other: <strong>Required.</strong> Enter the NPI, last name and first name of referring physician, assistant surgeon, and/or rendering physician, as applicable, but the fields are not required.</td>
</tr>
<tr>
<td>80</td>
<td>Remarks: The remarks field must be completed if the type bill is “XX5” or “XX6” or if the third digit of a revenue code is “9” or if revenue codes 920 or 940 are present.</td>
</tr>
<tr>
<td>81</td>
<td>Enter B3-qualifier and then your respective taxonomy code. All claims need to be filed with a taxonomy code to ensure timely and accurate claims processing.</td>
</tr>
<tr>
<td>Remarks</td>
<td>If the claim is for a federal employee contract and therapy revenue codes 42X, 43X or 44X are present, the actual dates of service for each revenue code must be entered in the remarks field.</td>
</tr>
</tbody>
</table>
Coordination of Benefits

Other health insurance coverage information is important in the coordination of benefits (COB) process. COB occurs when a member is covered by two or more insurance plans.

You can assist in the COB process by asking your Blue Cross patients if they have other coverage and indicating this information in Block 9 on the CMS-1500 claim form.

When COB is involved, claims should be filed with the primary insurance carrier first. When an Explanation of Benefits (EOB) is received from the primary carrier, the claim then should be filed with the secondary carrier, attaching the primary carrier EOB.

If claims are filed with the primary and secondary insurance carrier at the same time and Blue Cross is the secondary carrier, claims will be pending for applicable other coverage information from the member. If the requested information cannot be obtained from the primary carrier’s explanation of benefits or the member has not provided a response to our other coverage questionnaire, the claim will be rejected within 21 days. Once a rejection appears on the Payment Register/Remittance Advice, the patient may be billed for the total charge.

Medicare Primary Coordination of Benefits

Blue Cross coordinates with Medicare like we do with any other carrier that is the primary carrier for OGB members.

Coordination of Benefits Questionnaire

To streamline claims processing and reduce the number of denials, a COB questionnaire is available to you online at www.bcbsla.com/providers >Forms for Providers. When treating Blue Cross members and you are aware that they might have other health insurance coverage such as Medicare, give them a copy of the questionnaire during their visit. Ask them to complete the form as soon as possible and send it to the Blue Plan through which they are covered. Members will find the appropriate contact information on their ID card.

Subrogation

Subrogation is a contract provision that allows healthcare insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party. The third party’s liability insurance carrier normally makes these payments. A third party is another carrier, person or company that is legally liable for payment from the treatment of the claimant’s illness or injury.

All claims you submit to Blue Cross must indicate if work-related injuries or illnesses are involved and if the services are related to an accident.

Providers should:

• Not require the Blue Cross member or the member’s attorney to guarantee payment of the entire billed charge.
• Not require the Blue Cross member to pay the entire billed charge up front.
• Not bill the Blue Cross member for amounts above the reimbursement amount/allowable charge.
• Charge the member no more than is ordinarily charged other patients for the same or similar service.
• Bill the member only for any applicable deductible, coinsurance, co-pay and/or noncovered service.

If amounts in excess of the reimbursement amount/allowable charge were collected, you should refund that amount to the member.

In the case of OGB claims, Blue Cross pursues recovery of claims payments and Blue Cross makes payments as applicable.

**Employment-related Injuries or Illness**

There are generally three types of legal remedies available to members who sustain employment-related injuries or illnesses:

• Workers’ Compensation under state law – Workers’ Compensation under state law is a legal remedy whereby an employee who is injured within the course and scope of employment is usually entitled to certain benefits regardless of whether anyone was at fault.

• Longshore & Harbor Workers’ Compensation Act (LHWCA) - The LHWCA is a federal law that provides for the payment of medical care to employees who suffer “on the job” injuries that occur on the navigable waters of the United States or in adjoining areas used in loading, unloading, repairing or building certain vessels, regardless of whether anyone was at fault.

• Jones Act – The Jones Act is a federal law that provides protection only to “seamen” who are injured while working on a vessel.

Please understand that we do not make any coverage determinations as to which legal remedy would apply to a member’s injury.

We understand that it can be very difficult to determine which one of these legal remedies may cover a particular injury or illness; however, your patients may have medical benefits available to them under their Blue Cross contract. All claims for covered services, including those claims for which a third party may be liable, must be filed directly to Blue Cross. Please understand that services for injuries and illnesses that arise under the Jones Act, like any other covered services that do not fall under any workers’ compensation guideline, are not considered contractual exclusions, and therefore, must be filed with Blue Cross. Although services that fall under a workers’ compensation guideline are, in most circumstances, typically excluded under the terms of the member contracts/certificate of coverage, we strongly encourage our providers to file claims for these services with us. If the service is determined not to be covered by workers’ compensation or the particular contract does not exclude these types of services, you risk any future consideration by failing to meet administrative filing requirements. The current administrative claims process may deny an initial claim for employment related injuries however, please contact Customer Service so that we can work with your office to apply the appropriate member benefits.

Coordination of benefits does not apply in any of these scenarios.
**Medicare Supplemental Claims**

In order to reduce the administrative expense and time involved with manual claims submission, in most cases, Medicare supplemental claims will automatically cross over to Blue Cross and you do not need to file a claim for the Blue Cross portion to be processed.

**For out-of-state BCBS members**

Blue Plans may receive crossover claims for providers who are not within their state boundaries. All claims for out-of-state Blue Plan members will be processed by the out-of-state Blue Plan listed on the member’s ID card.

**Provider information at Medicare and Blue Cross of Louisiana**

To further ensure eligible Medicare Supplemental claims cross over from Medicare to Blue Cross successfully, please notify us immediately of the following:

- If you have a new Tax ID number, or
- If you have not previously given Blue Cross your NPI, you must do before filing claims including your NPI. For instructions, see the National Provider Identifier section of this manual.

**How to determine if the claim was crossed over from Medicare**

If a claim is crossed over, you will receive a message beneath the patient’s claim information on the Payment Register/Remittance Advice that indicates the claim was forwarded to the carrier.

*Example 1:* “Claim information forwarded to: BCBS of Louisiana-Supplemental

*Example 2:* “Claim information forwarded to: BCBS of Alabama

When a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting a claim to Blue Cross and Blue Shield of Louisiana. Claims you submit to the Medicare intermediary will be crossed over to Blue Cross only after they have been processed by Medicare. This process may take approximately 14 business days to occur. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days from the crossover for you to receive payment or instructions from Blue Cross.

If the remittance does not contain a message similar to the above, the claim was not crossed over to the payer. This claim must be filed on paper to the Plan listed on the member’s ID card.

The following claims are excluded from the crossover process for Blue Cross:

- Original Medicare claims paid at 100 percent
- 100 percent denied claims with no additional beneficiary liability
- Adjustment claims that are non-monetary/statistical
- Medicare Secondary Payer (MSP); claims for which other insurance exists for beneficiary
- National Council for Prescription Drug Programs (NCPDP) claims
What to do when the claim WAS NOT crossed over from Medicare

For Louisiana claims that did not crossover automatically (except for Statutory Exclusions), the provider should wait 31 days from the date shown on the Medicare remittance to resubmit the claim. Claims submitted before 31 days will be rejected on the Blue Cross and Blue Shield of Louisiana Not Accepted Report.

After 31 days, the claim that did not crossover can be submitted electronically in the 837 format (if sending through a clearinghouse, verify your clearinghouse allows the electronic submission of these claims) or on a paper claim form (CMS-1500 or UB-04) along with a copy of the Medicare remittance advice.

Follow-up on Crossover Claims

Blue Cross Blue Shield of Louisiana:
- Wait 21 days before conducting follow-up on iLinkBlue

Blue Cross Blue Shield out-of-state plans:
- Wait 30 days before contacting the out-of-state plan

Services Excluded or Not Covered by Medicare

When a charge is considered excluded or not covered, providers are not required to wait the 31 days to file the claim. The claim should contain a GY modifier with the specific, appropriate, HCPCS code, if available. If there is not a specific HCPCS code, a “not otherwise classified code” (NOC) must be used with the GY modifier.

These claims can be filed electronically or on paper to Blue Cross and Blue Shield of Louisiana.

Medicare Payment Rules for Consultation Services

Medicare no longer recognizes consultation CPT codes 99241-99245 and 99251-99255. This applies for both Medicare-primary and Medicare-secondary claims.

Please Note: We have current allowable charges for these codes and any changes in allowable amounts or billing policies for these codes will be communicated to our providers with a 90-day notice. At this time, we do not anticipate any changes.

Per CMS, physicians and others must bill an appropriate Evaluation and Management code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:

1. Bill the primary payer an Evaluation and Management code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same Evaluation and Management code, to Medicare for determination of whether a payment is due; or
2. Bill the primary payer using a consultation code that is appropriate for the service, and then report
the amount actually paid by the primary payer, along with an Evaluation and Management code that is appropriate for the service, to Medicare for determination of whether a payment is due. Note: The first option may be easier from a billing and claims processing perspective.


If you have any questions or require additional information on Medicare supplemental claims, please contact Provider Services at 1-800-922-8866.

**Medicare Part A Benefit Exhaust Claims Requirements**

Blue Cross requires the following when Medicare Part A benefits exhaust:

- Medicare exhaust letter, including the date Medicare benefits exhausted. Medicare Part A charges and Explanation of Benefits (EOB) must match.
- Blue Cross authorization from the date Medicare benefits exhausts.
- Medicare EOB for the entire stay.
- When Medicare has exhausted for the entire stay, one (1) claim needs to be submitted with admit date to discharge date inclusive of all Part A charges.
- When Medicare exhaust in the middle of the stay, two (2) claims should be submitted with one claim representing all services from the admit to the exhaust date and another claim listing the exhaust date to discharge date.

If you have questions, please email network.administration@bcbsla.com.
Section 4-A
ELECTRONIC CLAIMS SUBMISSION & PAYMENT

Electronic Data Interchange (EDI)
Providers can decrease paperwork and increase operating efficiency with Electronic Data Interchange (EDI). EDI is the fastest, most efficient way to exchange eligibility information, payment information and claims. Blue Cross’ experienced EDI staff is ready to assist in determining the best electronic solution for your needs.

iLinkBlue
iLinkBlue is a free provider tool that allows providers to verify members’ eligibility, coinsurance and deductible information, file claims electronically, check claims status, and more from an Internet connection. iLinkBlue features more than 30 applications and allows providers to have immediate access to Blue Cross member, claims and authorization data from any Internet-ready desktop using Internet Explorer version 8 or higher. iLinkBlue users can:

- Verify eligibility and benefit coverage.
- Verify dollar amounts remaining for deductible and out-of-pocket expenses. (This information is updated daily).
- Electronically submit CMS-1500 and UB-04 claims for Louisiana members, FEP members and out-of-state members.
- Submit and receive pre-authorizations for Imaging Authorizations.
- Submit claim inquiries electronically using our “Action Request” functionality.
- Review outstanding Medical Record Requests for out of area members.
- Obtain status of paid, rejected and pending claims and authorization verification.
- View and print current accepted/not accepted claims reports.
- View and print Payment Registers and Electronic Funds Transfer information on Monday of each week.
- View allowable charges online.
- Access various manuals, BlueCard out of area network information, and medical policy guidelines.
- Check the iLinkBlue message board often for added features, news and important notices.

**iLinkBlue is a free online service for physicians and professional providers.**

To learn more about iLinkBlue:
- Go to [www.bcbsla.com/providers](http://www.bcbsla.com/providers) > Electronic Services
- Email us at: [iLinkBlue.ProviderInfo@bcbsla.com](mailto:iLinkBlue.ProviderInfo@bcbsla.com)
- Call (225) 293-LINK (225-293-5465).
**Electronic Transaction Exchange**

Various healthcare transactions can be submitted electronically to the Blue Cross clearinghouse in a system-to-system arrangement. Blue Cross does not charge a fee for electronic transactions; however, the trading partner is responsible for its own expenses incurred for sending and/or receiving electronic communications.

You can send your transactions to Blue Cross via indirect submission through a clearinghouse or through direct submission to the Blue Cross EDI Clearinghouse.

For more information about system-to-system electronic transactions, please contact EDI at EDICH@bcbsla.com or (225) 291-4334.

**Security Administrative Representative**

Blue Cross offers many online services that require secure access. Blue Cross requires that each provider organization must register at least one security administrative representative to self-manage user access to our secure online services. These services include applications such as:

- iLinkBlue
- BCBSLA Authorizations
- Behavioral Health Authorizations
- Pre-Service Review for Out-of-Area Members (for BlueCard® members)
- and more (as we develop new services)

The role of an administrative representative is to serve as the key person at your organization who will:

- Delegate electronic access to appropriate users.
- Ensure those appropriate users adhere to our guidelines.
- Only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities.
- Promptly terminate employee access at such time as an employee changes roles or terminates employment with the organization

If your organization does not have an administrative representative, please contact our Provider Identity Management Team at ProviderIdentMgmt@bcbsla.com or 1-800-716-2299, option 5.

**Electronic Payment Register/Remittance Advice (HIPAA 835 Transaction)**

Providers, who submit their claims electronically, can receive an electronic file containing their Weekly Provider Remittance Advice/Payment Register. Once downloaded at the provider’s office, the remittance file can be uploaded into an automated posting system, thus eliminating a number of manual procedures. The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible.
ERA specifications are available from Blue Cross at no cost to vendors and providers, but they do require programming changes by your practice management billing system vendor. Traditionally, there is an up-front fee from your vendor for programming. From that point, you may receive the Blue Cross weekly Remittance Advice/Payment Register at no charge. For more information, please contact Blue Cross EDI at EDICH@bcbsla.com or (225) 291-4334.

**Electronic Funds Transfer (EFT)**

Electronic Funds Transfer (EFT) is a provider service where Blue Cross deposits your payment directly into your checking account. EFT, like iLinkBlue, is a free service to providers. With iLinkBlue, you will have access to EFT notifications and Payment Registers/Remittance Advices (that can be printed directly) through the iLinkBlue. EFT eliminates the mail time associated with the delivery of your Payment Register/Remittance Advice and check, as well as the time consuming task of making a manual deposit to your bank.

All Blue Cross providers who sign up for iLinkBlue, must also be a part of our EFT program. In the future, Blue Cross plans to implement mandatory use of the EFT program for all providers. Please see the form included in this manual to apply.

Blue Cross has created a guide for completing the EFT Application form. The guide as well as the EFT Application form are included in this manual.

For more information on obtaining EFT, please call (225) 293-LINK (225-293-5465) or email iLinkBlue.ProviderInfo@bcbsla.com.

To initiate EFT, please contact Network Operation at 1-800-716-2299, option 3 or Provider File at (225) 297-2758.
Blue Cross and Blue Shield of Louisiana requires that participating providers enroll in our electronic funds transfer (EFT) service. EFT allows providers to receive payment electronically directly into their accounts. You can download a copy of the EFT Enrollment Form at www.bcbsla.com/providers >Forms for Providers. The following information should help you complete the form.

1 CONSENT
The consent legally allows Blue Cross to electronically transfer funds to your financial account. The provision for Blue Cross to deduct funds applies when an erroneously credit occurs such as a banking error.

2 PROVIDER INFORMATION
Provider Name – Complete legal name of institution, corporate entity, practice or individual provider
Street Address – The number and street name where a person or organization can be found
City – City associated with provider address field
State/Province – The two character code associated with the State/Province/Region of the applicable country
ZIP Code/Postal Code – System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities

3 PROVIDER IDENTIFIERS INFORMATION
Provider Federal Tax Identification Number (TIN) / Employer Identification Number (EIN) – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted by HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Group NPI (if applicable) – If part of a provider group, please also report the NPI for your group.

4 PROVIDER CONTACT INFORMATION
Provider Contact Name – Name of a contact in provider office for handling ERA issues
Title – Title of the contact person
Telephone Number – Associated with the contact person
Email Address – An electronic mail address at which the health plan might contact the provider
Fax Number – A number at which the provider can be sent facsimiles

5 RETAIL PHARMACY INFORMATION (this section should be completed by pharmacies only)
Pharmacy Name – Complete name of pharmacy
NCPDP Provider ID Number – The NCPDP-assigned unique identification number
FINANCIAL INSTITUTION INFORMATION
Financial Institution Name – Official name of the provider’s financial institution
Financial Institution Routing Number – The 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited
Type of Account at Financial Institution – The type of account the provider will use to receive EFT payments (e.g. checking, savings, etc.)
Provider’s Account Number with Financial Institution – The provider’s account number at the financial institution to which EFT payments are to be deposited
Account Number Linkage to Provider Identifier – Choose then enter either the Provider TIN or NPI for the purpose of grouping (bulking) claim payments. Provider preference for grouping (bulking) claim payments must match preference for v5010 X12 835 remittance advice.

SUBMISSION INFORMATION
Reason for Submission
- New Enrollment – check to indicate applying for new EFT enrollment
Include with Enrollment Submission
- Voided Check – A voided check is attached to provide confirmation of Identification/Account Numbers. Temporary checks are not accepted.
  or
- Bank Letter – A letter on bank letterhead that formally certifies the account owners routing and account numbers
Authorized Signature – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.
Written Signature of Person Submitting Enrollment – The (usually cursive) rendering of a name unique to a particular person used as conformation of authorization and identity
Printed Name of Person Submitting Enrollment – The printed name of the person signing the form
Submission Date – The date on which the enrollment is submitted

RETURN INFORMATION
The form lists the mailing address, fax number and email address of BCBSLA’s Network Operations as three options for returning the ERA (835) Enrollment Form.

Mail to:  Attn: NAD / BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029
Fax: 1.225.297.2750
Email: network.administration@bcbsla.com
Providers should contact their financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. Shown below are the Data Elements that are necessary for re-association:

<table>
<thead>
<tr>
<th>CCD Record #</th>
<th>Field #</th>
<th>Field Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>9</td>
<td>Effective Entry Date</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Amount</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>Payment Related Information</td>
</tr>
</tbody>
</table>

**Late/Missing EFT and ERA Transactions Resolution Procedures:**

ERA (835) files are available weekly in Trading Partner mailboxes on Mondays, and no later than Wednesday, except during holidays or unexpected office closures. If you do not receive your ERA by close of business on Wednesday, you may contact EDI Services at 225.291.4334 or email EDICH@bcbsla.com. Please include the Trading Partner ID, check number, check amount, check date and NPI.

EFT transactions are typically available at the provider’s bank on Wednesday. If you have not received your deposit by close of business on Wednesday, you may contact EDI Services by calling the **LINKLine** at 225.293.5465 or 1.800.216.2583.

For questions about the ERA Form, please contact EDI Services at 225.291.4334. Also visit [www.bcbsla.com/providers > Electronic Services > Clearinghouse](http://www.bcbsla.com/providers > Electronic Services > Clearinghouse).

To check the status of your ERA Form, you may submit your request via email to EDICH@bcbsla.com. Please include the provider or group name, NPI, TIN or EIN and Trading Partner ID. Please allow three to five business days for setup.

To check the status of your EFT Form, you may submit your request via email to network.administration@bcbsla.com. Please include the provider or group name, NPI and TIN or EIN. Please allow up to 15 business days for setup.

Provider’s NPI must already be on file with Blue Cross. For more information on reporting your NPI to Blue Cross, visit [www.bcbsla.com/providers > NPI](http://www.bcbsla.com/providers > NPI) or you may contact Network Operations at 1.800.716.2299, option 3.

Blue Cross does not set up ERAs for out-of-state providers.
To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions (included with this form).

**CONSENT**

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the iLinkBLUE Provider Suite.

**PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Provider Name</th>
</tr>
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<tbody>
<tr>
<td>Provider Address: Street</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
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**PROVIDER IDENTIFIERS INFORMATION**

<table>
<thead>
<tr>
<th>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)</th>
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<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
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**PROVIDER CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Provider Contact Name</th>
<th>Title</th>
</tr>
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<tbody>
<tr>
<td>Telephone Number</td>
<td>Email Address</td>
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</tbody>
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**RETAIL PHARMACY INFORMATION**

<table>
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<tr>
<th>Pharmacy Name</th>
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<tr>
<td>NCPDP Provider ID Number</td>
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**FINANCIAL INSTITUTION INFORMATION**

<table>
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<th>Financial Institution Name</th>
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<td>Financial Institution Routing Number</td>
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<th>Account Number Linkage to Provider Identifier</th>
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<tbody>
<tr>
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<tr>
<td>☑ National Provider Identifier (NPI): __________________________</td>
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</table>

~Over~
SUBMISSION INFORMATION

Reason for Submission
- New Enrollment

Include with Enrollment Submission
- Voided Check (temporary checks are not accepted)
  or
- Bank Letter

Authorized Signature

This information is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it. An EFT Termination/Change Form must be completed if any of the above information changes.

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Submission Date

RETURN INFORMATION

Please return your completed Electronic Funds Transfer Enrollment Form in one of the following ways:

Mail to: Attn: NAD/BCBSLA
  P.O. BOX 98029
  Baton Rouge, LA 70898-9029
  Fax: (225) 297-2750

Email: network.administration@bcbsla.com

If you have any questions about this form or your EFT enrollment status, please contact Network Operations at:

Phone: (800) 716-2299, option 3
Email: network.administration@bcbsla.com

For internal use only: iLB set up complete.
Section 5
REIMBURSEMENT

Allowable Charges
Blue Cross reimburses participating providers based on allowable charges. The allowable charge is the lesser of the submitted charge or the amount established by Blue Cross as the maximum amount allowed for provider services covered under the terms of the Member Contract/Certificate. You should always bill your usual charge to Blue Cross regardless of the allowable charge.

Allowable charges are available to participating providers to help avoid refund situations. They are for informational purposes and not intended for providers to establish allowable charges.

Blue Cross regularly audits our allowable charge schedule to ensure that the allowable charge amounts are accurate. From time to time we must adjust an allowable charge because it may have been incorrectly loaded into our system or the CPT code description has changed. Allowable charges are added periodically due to new CPT codes or updates in code descriptions.

Typically, Blue Cross reviews allowable charges for physician office injectables and administration codes twice a year, and HCPCS level II fees are reviewed annually. Notification of these updates is made through the provider newsletter or through messages on the Provider Payment Register/Remittance Advice or iLinkBlue Important Message page.

Please note: If you move to a new physical location within the state after signing your initial contract with Blue Cross, your allowable charges may be different. Blue Cross will notify you if there is a change once the necessary paperwork has been received and reviewed.

If you need an allowable charge, please access iLinkBlue at www.bcbsla.com/ilinkblue.

New Codes
Blue Cross’ policy for new code updates is to review the rationale for the change (e.g.AMA CPT Sequencing changes, AMA language revision, new technology, etc.) and the updated Medicare fees for the new code and similar codes in comparison to the provider’s current fees for these similar codes to develop a fair payment for the new service.

Additional policy reviews, such as, medical policy, multiple procedure reduction determination, code editing, etc. are performed. Any unusual findings/changes are reviewed with management and the Medical Director for final determination of fee.

Family Members Excluded
REMINDER: Any services rendered by a provider to a family member such as a spouse, child, stepchild, parent, stepparent or grandparent, etc. are excluded as services you may bill to Blue Cross.
Unlisted Codes
To expedite claims processing and payment, providers should submit the following information when filing unlisted codes:

- Description of service and operative report if surgery is involved
- Invoice if durable medical equipment (DME) is involved
- National Drug Code (NDC) and drug name if submitting a J code or other drug code and invoice for the drug(s) billed charges on a single date if service for injectable drug(s) exceeds $200

Unlisted Professional Drug Codes
When billing J3490, J3590 and J7799 as a compound drug and a pain pump refill the reimbursement amount will be the lesser of:

- 90 percent of AWP of the active ingredients plus $200 compounding fee (for supplies)
  
  Or

- Invoice plus 7 percent

If the drug is not a compound drug or a pain pump refill the reimbursement amount will be 90 percent of AWP.

Not Separately Reimbursable Codes
Blue Cross does not reimburse separately for certain codes such as, CPT Category II codes and most HCPCS Documentation, Measurement and Demonstration codes. These codes should not be used as a substitute for any services, unless otherwise instructed by Blue Cross.

Member Cost-sharing
Deductibles, coinsurance and copayments are the member’s contribution toward all services. As a participating provider, you have agreed to not waive these amounts. When the charge for an office visit is less than the member’s copayment, providers should collect the actual charge. If you collect any amount above the copayment for covered services, you must refund the member the excess amount collected within 30 days of notification of the overpayment.

Participating providers have also pledged to assist us in our efforts to keep our members’ costs down. Please be aware that members could pay higher copayments for certain covered services performed by different types of providers and facilities. The chart below illustrates an example situation of how a member’s cost share will increase if they go to an outpatient facility for services that may be performed at an in-network physician’s office, in-network independent lab or free-standing diagnostic imaging facility:
### In-Network Physician’s Office
- **Charge for the covered Service (i.e. Low-tech x-rays, machine tests and lab work):** $300
- **Allowable Charge:** $100
- **Blue Cross Pays:** $100 (100% Coinsurance)
- **Member Pays:** $0 (0% Coinsurance)

### In-Network Independent Lab or Free-Standing Diagnostic Facility
- **Charge for the covered Service:** $300
- **Allowable Charge:** $100
- **Blue Cross Pays:** $100 (100% Coinsurance)
- **Member Pays:** $0 (0% Coinsurance)

### Outpatient Facility
- **Charge for the covered Service:** $300
- **Allowable Charge:** $100
- **Blue Cross Pays:** $80 (80% Coinsurance)
- **Member Pays:** $20 (20% Coinsurance)

### Claims Disputes and Reviews
Blue Cross recognizes there may be times when participating providers disagree with the way a claim was adjudicated.

In those instances, providers may complete the Claims Dispute Form included in this manual. Our new Claims Dispute Form has replaced the Reimbursement Review Form. The Claims Dispute form is available online [www.bcbsla.com/providers >Forms for Providers](http://www.bcbsla.com/providers). Effective June 1, 2016, we no longer accept the Reimbursement Review Form.

Please be sure to complete the entire Claims Dispute Form and include any supporting documentation. Please return the form to Customer Service, P.O. Box 98029, Baton Rouge, LA 70898-9029.

### Tips for Completing the Claims Dispute Form
1) Be sure to check the box that most closely matches your provider type.

2) This form should be used when you believe a claim was:
   - Rejected as a duplicate
   - Denied for bundling
   - Denied for medical records
   - Denied as investigational or not medically necessary
   - Payment/denial affects your reimbursement (timely filing, authorization penalty, etc.)
   - Payment affects the member’s cost share (includes deductible, coinsurance or copayment)

3) Include the appropriate supporting documentation along with the Claims Dispute Form. For assistance in what to attach, see the “Must Include” section on the Claims Dispute Form for guidance.
4) The dispute will not be considered for claim review if:
   • The entire Claims Dispute Form is not completely filled out
   • More than one reason is selected on the form for requesting a claim review

5) Always attach a copy of the claim.

Online Claims Dispute Form
www.bcbsla.com/providers
>Forms for Providers
Complete this form to dispute a claim. This form must be included with your request to ensure that it is routed to the appropriate area of the company, thus avoiding delays in our review process. It is important to return the proper information (based on your reason for review) and that it is sent to the appropriate mailing address.

Please submit only one form per patient, per dispute.

**PROVIDER INFORMATION**

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<thead>
<tr>
<th>TYPE OF PROVIDER:</th>
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</thead>
<tbody>
<tr>
<td>☐ Professional</td>
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<tr>
<td>☐ Facility</td>
</tr>
<tr>
<td>☐ Other:</td>
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<table>
<thead>
<tr>
<th>Provider Name</th>
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</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
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<tr>
<td>Provider Tax ID</td>
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<tr>
<td>Name of Person Completing Form</td>
</tr>
<tr>
<td>Contact Email Address</td>
</tr>
<tr>
<td>Contact Phone Number</td>
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</table>

**PATIENT INFORMATION**

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<thead>
<tr>
<th>Member ID</th>
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<tbody>
<tr>
<td>Patient Name</td>
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<tr>
<td>Patient Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Claim Number</td>
<td></td>
</tr>
<tr>
<td>Date(s) of Service</td>
<td></td>
</tr>
<tr>
<td>Amount Charged</td>
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</table>

**GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION**

<table>
<thead>
<tr>
<th>SURGERY, ASSISTANT SURGERY OR ANESTHESIA</th>
</tr>
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<tbody>
<tr>
<td>1. Operative Report</td>
</tr>
<tr>
<td>2. Anesthesia Report</td>
</tr>
<tr>
<td>3. Pre-Op History and Physical</td>
</tr>
<tr>
<td>4. Asst. Surgeon Credential (If Not M.D.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOCTOR’S HOSPITAL VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discharge Summary</td>
</tr>
<tr>
<td>2. Hospital Progress Notes</td>
</tr>
<tr>
<td>3. History and Physical Notes</td>
</tr>
<tr>
<td>4. Pathology Report</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DOCTOR’S OFFICE/CLINIC VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Office Notes Pertaining to Date of Service</td>
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<tr>
<td>2. History and Physical Notes</td>
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<table>
<thead>
<tr>
<th>OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical Therapy Notes and Radiology/Lab Report</td>
</tr>
</tbody>
</table>

Page 2 of this form contains the list of reasons for your claims dispute. Please check only one reason per form. In order for us to review your claim dispute, we must receive the entire form.

A printable PDF of this form is available online at [www.bcbsla.com/providers](http://www.bcbsla.com/providers), then click on Forms for Providers.
# PLEASE REVIEW MY CLAIM FOR THE FOLLOWING REASON

*(Check only one reason per form)*

<table>
<thead>
<tr>
<th>REASON FOR REVIEW</th>
<th>MUST INCLUDE</th>
<th>TIME TO ALLOW FROM DATE SUBMITTED</th>
<th>WHERE TO SEND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim rejected as duplicate</td>
<td>• Supporting medical documentation</td>
<td>30 days</td>
<td>HARDCOPY: BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029</td>
</tr>
<tr>
<td>Claim denied for bundling</td>
<td>• Reason why current bundling logic is incorrect • Supporting medical documentation</td>
<td>14 days</td>
<td>HARDCOPY: BCBSLA Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031</td>
</tr>
<tr>
<td>Claim denied for medical records</td>
<td>• Copy of our letter of request for medical records • Supporting medical documentation</td>
<td>30 days</td>
<td>HARDCOPY: BCBSLA Medical Appeals P.O. Box 98022 Baton Rouge, LA 70898-9022</td>
</tr>
<tr>
<td>Claim denied as investigational or not medically necessary</td>
<td>• Formal letter of appeal including reason • Supporting medical documentation</td>
<td>30 days</td>
<td>HARDCOPY: BCBSLA Appeals and Grievances P.O. Box 98045 Baton Rouge, LA 70898-9045</td>
</tr>
<tr>
<td>Claim payment/denial affects the provider’s reimbursement • Timely filing • Reimbursement • Authorization penalty • Other</td>
<td>• Formal letter of dispute including reason • Supporting medical documentation • Proof of timely filing (only if denied for timely filing)</td>
<td>60 days</td>
<td>HARDCOPY: BCBSLA Appeals and Grievances P.O. Box 98045 Baton Rouge, LA 70898-9045</td>
</tr>
<tr>
<td>Claim payment affects the member’s cost share <em>(deductible, coinsurance, copayment)</em></td>
<td>• Formal letter of appeal including reason along with signed authorization from the member • Supporting medical documentation</td>
<td>30 days</td>
<td>HARDCOPY: BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9045 or FAX: 225-297-2727</td>
</tr>
<tr>
<td>Claim denied for a BlueCard® member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)</td>
<td>• Formal letter of appeal including reason • Supporting medical documentation</td>
<td>20 days</td>
<td>HARDCOPY: BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9045 or FAX: 225-297-2727</td>
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### Example
**PAYMENT REGISTER/REMITTANCE ADVICE**

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<tr>
<th>Date</th>
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<th>Contract Number</th>
<th>Patient Acct</th>
<th>Bphy Units</th>
<th>AdmitDt</th>
<th>DisDt</th>
<th>Cmplt Number</th>
<th>DrvRgn</th>
<th>SubRgn</th>
<th>Total Charges</th>
<th>Allow Amt</th>
<th>DOD</th>
<th>IOC Pay</th>
<th>DC</th>
<th>Code</th>
<th>DrdCoverd</th>
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**Totals:**

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**Note:** OGB Payment Registers/Remittance Advices have OGB listed.
Payment Register/Remittance Advice Explanation

Following is a description of each item on the Blue Cross Weekly Provider Payment Register/Remittance Advice.

1. **Patient's Name** - The last name and first five letters of the first name of the patient.
2. **Contract Number** - The member’s Blue Cross and Blue Shield identification number.
3. **Patient Acct** - The patient identification number assigned by the provider's office. This information will appear only if provided on the claim.
4. **Days/Units** - The number of visits that the line item charge represents.
5. **Admit/ Dis Dt** - The beginning and ending date(s) of service for a claim.
6. **Claim Number** - The number assigned to the claim by Blue Cross for document identification purposes. NOTE: When making inquiries about a specific payment, always refer to this number.
7. **CPT Code** - The code used to describe the services performed by the provider.
8. **Sch Drg** - Not applicable to providers.
9. **Total Charges** - The charge for each service and the total claim charges submitted to Blue Cross and Blue Shield.
10. **Above Allowable Amount** - The amount above the allowable charge. NOTE: This amount cannot be collected from the member.
11. **COB/OC Pay** - An asterisk in this column denotes that Blue Cross and Blue Shield is the secondary carrier.
13. **Not Covered Ded-Coin-Inel** - The total amount owed by a patient for each claim including deductible, coinsurance, copayment, noncovered charges, etc.
14. **Amt Paid** - The amount paid by Blue Cross.
15. **Performing/Prov** - The name and provider number of the provider who performed the service.
16. **Totals** - The total of days, charges, contract benefits, patient liability, above allowable amount, and amount paid for all patients listed.
17. **Provider Name** - Provider/Clinic name and address to which payment is made.
18. **Paid Prov** - Provider’s/Clinic’s NPI under which payment is made.
19. **Date** - Date the Provider Payment Register/Remittance Advice is generated by Blue Cross.
20. **Check Number** - The number assigned to the check mailed with the Payment Register.
Section 6
BILLING GUIDELINES

The following billing guidelines are included in this section:

- Ambulance page 88
- Anesthesia page 95
- Autism page 104
- Behavioral Health page 105
- Chiropractic and Therapy Services page 110
- Concierge Medicine page 114
- Delivery of Pregnancy page 115
- Dialysis page 117
- Dietitian page 118
- Drug Screening Assays page 120
- Durable Medical Equipment/Home Medical Equipment page 121
- Home Health Agency page 129
- Incident-to page 133
- Infusion Therapy page 136
- In-Office Procedure page 142
- Laboratory - Using Preferred Labs page 142
- Nurse Practitioners page 146
- Off-campus Services page 146
- Physical & Occupational Therapy Re-evaluations page 147
- Rural Health Clinic and Federally Qualified Health Clinic page 147
- Sleep Study page 149
  Home Sleep Study for Obstructive Sleep Apnea (OSA) page 149
- Specialty Pharmacy page 151
- Telemedicine Billing & Reimbursement page 153
- Urgent Care/After Hours Centers page 156
The Ambulance Transport Benefit

The ambulance transport benefit is a transport by an ambulance. The transport may be covered when the use of any other method of transportation is inadvisable due to the member’s condition and the additional requirements discussed below are met.

Blue Cross covers and processes two types of ambulance claims:

- Ground
  - ALS – advanced life support
  - BLS – basic life support
- Air

In addition to the participating provider responsibilities outlined in this manual, ambulance providers should:

- File only the codes listed in their contracts, if applicable. This will prevent returned claims and/or delays in claim processing.
- File claims for members even if you do not have the patient’s signature. Patient signatures are not required for filing claims.

Please note: Non-contracted, non-emergency ambulance services are paid to the member for all services but mileage. Mileage is paid to the ambulance provider.

Report Full Ambulance Miles

The Centers for Medicare & Medicaid Services (CMS) established a new rule for 2011 regarding how to report fractional mileage amounts for ambulance services. Their rule requires ambulance providers and suppliers to bill mileage that is accurate to a tenth of a mile.

At this time, Blue Cross is not able to accommodate this CMS change; therefore, we will not accept mileage billed in increments of less than a full mile. Mileage billed with decimal places will not be recognized for claims processing.

Ambulance Modifiers

Ambulance services must be reported with a combination of two modifiers listed below—the first character representing the origin and the second character representing the destination:

D Diagnostic or therapeutic site other than P or H when these are used as origin codes
E Residential, domiciliary or custodial facility
G Hospital-based dialysis facility
H Hospital
I Site of transfer between modes of ambulance transport
J Non-hospital based dialysis facility
The ambulance provider must retain all appropriate documentation on file for an ambulance transport furnished to a member. This documentation must be presented to Blue Cross upon request and may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category and any other criteria necessary for payment. The ambulance transport is not covered if some means of transportation other than ambulance could be used without endangering the member’s health, regardless of whether the other means of transportation is actually available.

**Ground Ambulance Transports**

A member may be transported on land for a reasonable and medically necessary ground ambulance transport. The following coverage requirements apply to ground transports:

- A Blue Cross member is transported
- The destination is local
- The facility is appropriate
- Due to the member’s condition, the use of any other method of transportation is inadvisable
- The purpose of the transport is to obtain a Blue Cross-covered service or to return from obtaining such service

Ground ambulance transports include the following:

- Basic Life Support (BLS) – Includes the provision of medically necessary supplies and services and BLS ambulance transportation as defined by the State where you provide the transport. An emergency response is one that, at the time you are called, you respond immediately. A BLS emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.

- Advanced Life Support, Level 1 (ALS1) – Includes the provision of medically necessary supplies and services and the provision of an ALS assessment or at least one ALS intervention. An ALS assessment is performed by an ALS crew as part of an emergency response that is necessary because the member’s reported condition at the time of dispatch indicates that only an ALS crew is qualified
to perform the assessment. An ALS assessment does not necessarily result in a determination that the member requires an ALS level of transport. An ALS intervention is a procedure that must be performed by an emergency medical technician-intermediate (EMT-Intermediate) or an EMT-Paramedic in accordance with State and local laws. An ALS1 emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.

- **Advanced Life Support, Level 2 (ALS2)** – Includes the provision of medically necessary supplies and services and:
  
  o At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids)
  
  o At least one of the following procedures:
    - Manual defibrillation/cardioversion;
    - Endotracheal intubation;
    - Central venous line;
    - Cardiac pacing;
    - Chest decompression;
    - Surgical airway; or
    - Intraosseous line.

- **Specialty Care Transport (SCT)** – Includes the provision of medically necessary supplies and services beyond the scope of an EMT-Paramedic. SCT is the inter-facility transportation of a critically ill or injured member that is necessary because the member’s condition requires ongoing care furnished by one or more professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training).

- **Paramedic Intercept (PI)** – When an entity that does not provide the ambulance transport provides ALS services. PI may be required when a provider can provide only a BLS level of service and the member requires an ALS level of service (such as electrocardiogram monitoring, chest decompression, or intravenous therapy).

If a member is admitted as an inpatient and requires medically necessary diagnostic services not otherwise available at the inpatient facility and requires ground ambulance transport to receive additional services, the inpatient hospital lacking the needed services is responsible for the costs of all ambulance services. The ambulance service should not be billed to Blue Cross in this instance as it is included in the inpatient reimbursement of the hospital lacking the needed services.

**Air Ambulance Transports**

A member may be transported by fixed wing (airplane) or rotary wing (helicopter) aircraft for a medically necessary air ambulance transport. The following coverage requirements apply to air transports:

- The member’s medical condition requires immediate and rapid ambulance transport.
• It cannot be furnished by BLS or ALS ground ambulance transport because one of the following pose a threat to the members’ survival or seriously endangers his or her health.
  • The Point-of-pick-up (POP) is not accessible by ground vehicle (this requirement may be met in remote or sparsely populated areas). POP is the location of the member at the time he or she is placed on board the ambulance. The ZIP code of the POP or the nearest zip code to the POP must be reported on the claim.
  • The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30 - 60 minutes).
  • The instability of ground transportation.

The medical conditions that may justify air ambulance transport include, but are not limited to, the following (this list is not intended to justify air ambulance transport in all localities):
  • Intracranial bleeding that requires neurosurgical intervention;
  • Cardiogenic shock;
  • Burns that require treatment in a burn center;
  • Conditions that require treatment in a Hyperbaric Oxygen Unit;
  • Multiple severe injuries; or
  • Life-threatening trauma.

Specialized medical services that are generally not available at all facilities include, but are not limited to, the following:
  • Burn Care
  • Cardiac Care
  • Trauma Care
  • Critical Care

An air ambulance transport to transfer a member from one hospital to another hospital must meet the following requirements:
  • A ground ambulance transport endangers the member’s health;
  • The transferring hospital does not have the needed hospital or skilled nursing care for the member’s illness or injury; and
  • The second hospital is the nearest appropriate facility.

**Include ZIP Codes on Air Ambulance Claims**

Effective for claims with a date of service on or after April 19, 2015, ambulance providers must include the 5-digit ZIP code of the point-of-pick-up. This is required for both emergent and non-emergent air ambulance services. This claims filing requirement also applies for Medicare crossover claims when
Medicare’s benefits do not cover the claim.

- For claims filed electronically through a clearinghouse, include the pick-up location zip code in the 2310E Ambulance Pick-up Location Loop of the ASC X12N Health Care Claim (837).

- For hardcopy and iLinkBlue-filed claims, include the pick-up location zip code on line 23 of the CMS-1500 claim form.

Claims that do not include the point-of-pick-up zip code on the claim will be denied for insufficient information.

Where to file air ambulance claims for dates of service on and after April 19, 2015:

If the pick-up location zip code is in Louisiana, the claim should be filed directly to Blue Cross and Blue Shield of Louisiana.

If the pick-up location zip code is outside of Louisiana, the claim should be filed to the local Blue Plan that covers the area of pick-up.

If the pick-up location is outside of the United States, Puerto Rico or U.S. Virgin Islands, the claim must be filed to the Blue Cross Blue Shield Global Core Program.

**Non-transport Ambulance Services**

In situations where an ambulance is called to transport a patient and upon arrival the patient is able to be stabilized by the ambulance personnel, eliminating the need for transport, the HCPCS code A0998 may be billed.

Participating Ambulance Providers Non-transport pricing rules are as follows:

- When A0998 is billed without transport services, one (1) unit per date of service is allowed
- When A0998 is billed with other ambulance transport services and mileage, the service is considered bundled as part of the transport being billed and thus not separately reimbursable.

Each ambulance visit should be billed on separate claims. In the event that more than one visit or date of service is billed on the same claim and one visit is a non-transport while another is a transport, the non-transport will be denied. When non-transport occurs on a different date of service than transport, provider should bill on separate claims.

**Non-Contracted/Non-Participating Ambulance Services**

Payment will be made directly to the member for non-emergency related services. Please collect ALL payments—including any applicable copayment, coinsurance or deductible amount—directly from the member.

Payment will be made directly to the ambulance company for true emergency-related services. Please collect any applicable copayment, coinsurance and/or deductible amounts from the member.
General Transportation Rules and Definitions

A Member/Subscriber is transported

When multiple ambulance providers and suppliers respond, payment is made only if you actually transport or treat the member. If you respond to a call for ambulance services and the member declines transportation, but you provided treatment; A0998 is the only billable service. Member benefits will be applied.

The destination is local

As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the member’s condition is covered. If two or more facilities meet this requirement and can appropriately treat the member, the full mileage to any of these facilities is covered.

The facility is appropriate

An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the member’s illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the member’s condition.

Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of healthcare, there must be clear evidence indicating that an ambulance transport to a more distant institution is the nearest appropriate facility. Some circumstances that may justify ambulance transport to a more distant institution include:

- The member’s condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered services that is not available at the facility where the member is a patient;
- No beds are available at the nearest institution.
- A ground or air ambulance transport to a more distant hospital solely to avail the member of the services of a specific physician or physician specialist is not covered. If a member is initially transported to an institution that is not equipped to provide the needed hospital or skilled nursing care for the member’s illness or injury and is then transported to a second institution that is adequately equipped, both ground ambulance transports will be covered provided the second transport is to the nearest appropriate facility. The medical documentation must support travel to the more distant facility.

When a ground ambulance transports a member to and from the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a Computerized Axial Tomography scan or cobalt therapy), the transport is covered only to the extent of the payment that would have been made to bring the service to the member. A ground ambulance transport from an institution to the member’s home is covered when the home is:

- Within the locality of the institution. Locality is the service area surrounding the institution to which individuals normally travel or expected to travel to receive hospital or skilled nursing services; or
• Outside the locality of the institution but in relation to the members home, it is the nearest appropriate facility.

**A member/patient is inpatient**

Ambulance providers can and do furnish ambulance transports that are covered under Blue Cross. However, an ambulance transport of an individual from one provider to another is generally included in the facility service the patient is admitted to at the time of the transport. Blue Cross should not be billed for the ambulance service in this scenario.

For example, a member who was admitted to a hospital, CAH or SNF may require patient transportation, which is transportation to another hospital or other site while he or she receives specialized care and maintains inpatient status with the original provider. This transportation is covered under the inpatient hospital or CAH service. Patient transportation is covered as part of the facility reimbursement as a SNF service when a member is a resident of a SNF and must be transported by ambulance for an intra-campus transfer between different departments of the same hospital, to receive dialysis or certain other high-end outpatient hospital services or for transfer to another SNF.

**Non-emergency Transport**

Blue Cross and HMO Louisiana member benefits may be available for ambulance services for local transportation of members for non-emergency conditions to obtain medically necessary diagnostic or therapeutic Outpatient services (e.g., MRI, CT scan, dialysis, wound care, etc.), when the member is bed-confined or his/her condition is such that the use of any other method of transportation is contraindicated.

The member must meet all of the following criteria for bed-confinement:

1. unable to get up from bed without assistance; and
2. unable to ambulate; and
3. unable to sit in a chair or wheelchair.

Transport by a wheelchair van is not a covered ambulance service.

**Ambulance Vehicles**

Ground and air ambulance vehicles must comply with State and/or local laws governing the licensing and certification of emergency medical transportation vehicles and must be designed and equipped to respond to medical emergencies. At a minimum, ambulance vehicles must be equipped with the following:

• A stretcher
• Linens
• Emergency medical supplies
• Oxygen equipment
• Other lifesaving emergency medical equipment and reusable devices (such as inflatable leg and arm splints, backboards and neckboards)
• Emergency warning lights, sirens and telecommunications equipment as required by State or local laws
• A 2-way voice radio or wireless telephone. In nonemergency situations, ambulance vehicles must be capable of transporting members with acute medical conditions.

**Ambulance Personnel**

A BLS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with State and/or local laws as an EMT-Basic and is legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with State and/or local laws as an EMT-Intermediate or an EMT-Paramedic.

**Statement about Ambulance Vehicles and Personnel**

To indicate that you meet the above requirements, include the following information about your ambulance vehicles and personnel in a statement you provide with your credentialing application:

- The first aid, safety and other patient care items with which the vehicles are equipped;
- The extent of first-aid training acquired by the personnel assigned to the vehicles;
- An agreement to notify Blue Cross of any change in operation that could affect the coverage of ambulance transports; and

Documentary evidence (such as a letter or copy of a license, permit or certificate issued by State and/or local authorities) indicating that the vehicles are equipped as required.

**Anesthesia Billing Guidelines**

**Definitions**

- **Anesthesia** - the introduction of a substance into the body by external or internal means that causes loss of sensation (feeling) with or without loss of consciousness.
- **Anesthesiologist** - a physician (M.D. or D.O.) who specializes in anesthesiology.
- **Certified Registered Nurse Anesthetist (CRNA)** - a registered nurse who is licensed by the State in which the nurse practices. The CRNA must be certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists or the CRNA must have graduated within the past 24 months from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and be awaiting initial certification.
• **Concurrent Medically Directed Anesthesia Procedures** - concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. The physician can medically direct two, three or four concurrent procedures involving qualified CRNAs.

• **Medical Direction** - occurs when an anesthesiologist is involved in two, three or four concurrent anesthesia procedures or a single anesthesia procedure with a qualified CRNA.

• **Medical Supervision** - occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures.

**Personally Performed Anesthesia**

We will determine the applicable allowable charge, recognizing the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time (unless otherwise stated) if:

- The physician personally performed the entire anesthesia service alone;
- The physician is continuously involved in a single case involving a student nurse anesthetist; or,
- The physician and the CRNA are involved in one anesthesia case and the services of each are found to be medically necessary upon appeal. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers through our appeal process. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-medically directed case.

**Medical Direction**

We will determine payment for the physician's medical direction service on the basis of 60 percent of the allowable charge for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified CRNAs in two, three or four concurrent cases and the physician performs the following activities that must be documented in the anesthesia record:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates only in the most demanding procedures in the anesthesia plan, when clinically appropriate;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available in the operating room and/or recovery areas for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

If the physician is involved with a single case with a CRNA, we will pay the physician service and the CRNA service in accordance with the medical direction payment policy outlined in these guidelines.
If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate that the services were furnished by physicians and identify the physician(s) who furnished them.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

If the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician’s services to the surgical patients are supervisory in nature and would not be considered medical direction.

**Filing Claims**

Anesthesia services by anesthesiologists or CRNAs must be filed using the appropriate anesthesia CPT code (beginning with the zero). One of the modifiers listed in this section must be submitted with each anesthesia service billed. Failure to submit one of the modifiers will result in a returned or rejected claim.

The allowable charge for medically necessary anesthesia services will be determined based on the applicable anesthesia conversion factor and the modifier submitted on the claim. The applicable anesthesia modifier will determine what percentage of the anesthesia conversion factor is to be applied to each claim, without regard to the order in which claims are received for both anesthesiologists and CRNAs.

If there are groups from which an anesthesiologist and a CRNA are working together on a case, we will continue to allow a single claim record to contain multiple line items for anesthesia services. We will also accept individual claims for each portion of the anesthesia service performed if more than one provider was involved in the anesthesia case. Each line item must indicate which provider performed the service by identifying the corresponding provider’s NPI on the CMS-1500 claim form in block 24J (or the equivalent field on electronic claims).

To ensure proper reimbursement when billing for anesthesia services, anesthesiologists and CRNAs must include:

1. Number of minutes of administration;
2. CPT anesthesia (00100-01999) codes with one of the required modifiers listed in this section;
3. American Society of Anesthesiologists’ (ASA) modifier code(s) for physical status and CPT codes appropriate for qualifying circumstances (see further in this section for details), if appropriate;
4. Proper identification by including any performing provider(s) NPI on the claim form.

**Required Modifiers - Anesthesiologist (M.D. or D.O.)**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier Description</th>
<th>Percentage of Allowable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services personally performed by an anesthesiologist</td>
<td>100 percent</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician; more than four concurrent anesthesia procedures or is performing other services while directing the concurrent procedures</td>
<td>60 percent</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three or four concurrent anesthesia procedures involving qualified CRNAs</td>
<td>60 percent</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one CRNA by an anesthesiologist</td>
<td>60 percent</td>
</tr>
</tbody>
</table>

**Required Modifiers - CRNA**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier Description</th>
<th>Percentage of Allowable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>QX</td>
<td>Billed by CRNA when providing the anesthesia service while being medically directed by an anesthesiologist</td>
<td>40 percent</td>
</tr>
<tr>
<td>QZ</td>
<td>Billed by CRNA when providing anesthesia services without medical direction by an anesthesiologist</td>
<td>100 percent</td>
</tr>
</tbody>
</table>
Listing of Acceptable and Non-Acceptable Modifiers for Subsequent Claims

Refer to this list when including the following modifiers, either on the same claim but on different service line(s) (in a group billing situation), or on a separate claim from a different provider.

<table>
<thead>
<tr>
<th>First Claim Received for Payment Consideration</th>
<th>Acceptable Modifiers for Subsequent Claims</th>
<th>Non-Acceptable Modifiers for Subsequent Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing provider #1 bills one of these modifiers.</td>
<td>Performing provider #2 bills one of these modifiers on a separate claim or separate service line item on the same claim.</td>
<td>No additional claim will be paid with these modifiers.</td>
</tr>
<tr>
<td>AA</td>
<td>AA, AD, QK, QX, QY, QZ</td>
<td></td>
</tr>
<tr>
<td>QZ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>QX</td>
<td>AA, AD, QK, QY, QZ</td>
</tr>
<tr>
<td>QK</td>
<td>QX</td>
<td>AA, AD, QK, QY, QZ</td>
</tr>
<tr>
<td>QY</td>
<td>QX</td>
<td>AA, AD, QK, QY, QZ</td>
</tr>
<tr>
<td>QX</td>
<td>AD, QK, QY</td>
<td>AA, QX, QZ</td>
</tr>
</tbody>
</table>

Please note: Our claims processing system edits all anesthesia claims for the appropriate use of modifiers. Should we receive a subsequent claim with inconsistent modifiers when comparing to the initial claim received, the subsequent claim will be denied. For example, if an initial claim is filed with the AA modifier indicating the service was personally performed by a physician, and a subsequent claim is received with a QX modifier indicating that a CRNA was involved in the anesthesia service, the initial claim would be the only claim expected; therefore, the CRNA claim would be denied or returned due to the inconsistent modifier. Further, if the anesthesia record reflects that more than one anesthesia provider was involved in the case, the provider who received the returned or denied claim should appeal the denial. When filing the appeal, the anesthesia record must be included as supporting documentation to justify a different reimbursement. If a decision is made to overturn the appeal in this scenario, a recoupment would be requested on the claim allowed at 100 percent in order to apply the appropriate payment split to both providers involved in performing the anesthesia service.

Base Units

The Base Unit is the value assigned to each CPT code and includes all usual services except the time actually spent in anesthesia care and the qualifying factors. This usually includes pre-op and post-op visits. When multiple anesthesia services are performed, only the anesthesia service with the highest base unit value should be filed with total time for all services reported on the highest base unit value code. The Base Units value should never be entered in the “units” field on the claim form.
Anesthesia Time and Calculation of Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. We consider anesthesia time to begin when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient is safely placed under post-anesthesia supervision.

Anesthesia time must be reported in minutes. Failure to include anesthesia time may result in the claim being either returned or denied. If anesthesia time is reported in units, incorrect payment will result. Minutes will be converted to units by assigning one unit to each 15 minutes of time, or any part of a 15-minute period that anesthesia was administered (exception is CPT 01967, which is based on a 60-minute unit). No additional time units are payable for add-on codes; therefore, total time must be reported on the primary procedure code. In the case where multiple procedures are performed, time for lower base unit value codes should be reported on the highest base unit value code. Note: We do not recognize time units for CPT 01996 (see this section for more on Pain Management). The physician who medically directs the CRNA would ordinarily report the same time as the CRNA reports for the CRNA service.

Blue Cross/HMO Louisiana uses the following table to calculate the number of time units:

<table>
<thead>
<tr>
<th>Time Range</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 minute to 15 minutes</td>
<td>1 unit</td>
</tr>
<tr>
<td>16 minutes to 30 minutes</td>
<td>2 units</td>
</tr>
<tr>
<td>31 minutes to 45 minutes</td>
<td>3 units</td>
</tr>
<tr>
<td>46 minutes to 60 minutes</td>
<td>4 units</td>
</tr>
<tr>
<td>61 minutes to 75 minutes</td>
<td>5 units</td>
</tr>
</tbody>
</table>

Qualifying Factors

Physical Status

If physical status modifiers are applicable, the modifier should be indicated on the CMS-1500 claim form (Block 24d or the equivalent field on electronic claims) by the letter P followed by a single digit from one (1) to six (6). Additional units may be allowed when the claim indicates any of the following:

<table>
<thead>
<tr>
<th>Physical Status Modifier</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal patient</td>
<td>0 units</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>0 units</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>1 unit</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>2 units</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>3 units</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain dead patient whose organs are being removed for donor purposes</td>
<td>0 units</td>
</tr>
</tbody>
</table>
Qualifying Circumstances
When any of the CPT codes defined in this section are provided in addition to anesthesia procedures, the allowable charge is the basis for reimbursement. Do not bill these procedures with anesthesia modifiers, physical status modifiers or anesthesia minutes; otherwise, delay or rejection of payment may occur.

• Qualifying circumstances are those factors that significantly affect anesthesia services. Examples are the extraordinary condition of the patient, notable operative conditions and unusual risk factors. These procedures would not be reported alone, but as additional procedures qualifying an anesthesia procedure or service. Each qualifying circumstance is listed here: 99100; 99116; 99135; 99140.

• Specialized forms of monitoring also fall into the category of Qualifying Circumstances. Those that qualify are listed below. Although there are other forms of monitoring that are not listed here, these are the only ones for which an additional amount may be allowed. Any other charges should be combined with the total charge without an additional allowable charge. When billed in conjunction with an anesthesia procedure, the following CPT codes or combination of CPT codes are reimbursed over and above the anesthesia procedure, based on the provider’s allowable charge and medical necessity.
  - Arterial line (36620 or 36625)
  - Central venous line (36555; 36556; 36568; 36569; 36580; or 36584)
  - Swan Ganz line (93503)

Obstetrical Anesthesia/Epidural
Obstetrical anesthesia/epidural procedures are reimbursed as indicated below. An additional allowable charge for emergency conditions may apply to reimbursement for epidural anesthesia (please refer to Qualifying Circumstances section).

<table>
<thead>
<tr>
<th>Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>01961</td>
<td>7 base units plus time units based on standard 15-minute time calculation</td>
</tr>
<tr>
<td>01967</td>
<td>8 units plus $50 per hour</td>
</tr>
<tr>
<td>01968</td>
<td>3 units (no additional time allowed)</td>
</tr>
</tbody>
</table>

Note: CPT 01968 is an add-on code to CPT 01967. If a cesarean delivery is performed after neuraxial labor analgesia/anesthesia, bill CPT 01967 with total time, plus CPT 01968.

Pain Management
Pain management codes should not be billed using anesthesia modifiers, physical status modifiers or anesthesia minutes. If claims are filed as such, delay in payment or incorrect payment may occur.

Outpatient Pain Management
1. An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral, single level should be coded 64483 and paid based on the appropriate allowable charge. Code 64484 should be billed for each additional level.

2. An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral is considered a surgical procedure for benefit purposes. Surgical procedures (including nerve blocks) should be
billed as “1” unit per CPT guidelines. The Base Units value should not be entered in the “units” field on your claim. The injection must be performed by an M.D. or D.O. for diagnostic or therapeutic purposes. If an injection is provided on the same day the surgery is performed, the service will be included in the base units and time charged for the administration of anesthesia. If an injection is provided on a day subsequent to the surgery, the procedure will be considered a surgical service and appropriate benefits allowed.

Post-operative Pain Management

1. **Epidural**: Daily management of epidural or subarachnoid drug administration should be coded 01996 for the professional charge, and the medication should be billed by the hospital as an ancillary charge. CPT 01996 should be utilized to bill for a pain management service when drug administration is being monitored by the provider or an injection is inserted into an existing catheter. Payment will be based on a maximum of three units per day for a maximum of three days of epidural management, including the day of surgery. Billing anesthesia minutes, anesthesia modifiers or physical status modifiers with CPT 01996 is not appropriate, and, if billed, a delay in payment or non-payment may occur.

2. **IV PCA**: Provider should bill CPT 99231* for the IV PCA daily management. The allowable charge is the basis for reimbursement. The set-up charge is included in the Evaluation and Management allowance of the daily management and should not be billed separately. Billing anesthesia minutes, anesthesia modifiers or physical status modifiers with CPT 99231 is not appropriate, and, if billed, a delay in payment or non-payment may occur.

   *Evaluation and Management Code 99231 is the recommended coding by the ASA and is the industry standard for this service. All components must be medically necessary and documented in the anesthesia record in order to bill this code.

3. **Pump Setup**: The pump setup is included in the allowable charge for the daily management fee for both IV PCAs (CPT 99231) and Epidural PCAs (CPT 01996), and should not be billed separately.

4. **Nerve Block Injections**: Nerve blocks performed for postoperative pain management, provided that they are not the mode of anesthesia and are distinct procedures, are eligible for reimbursement when identified by the Modifier-59 as a distinct procedure. These services should not be included as additional anesthesia time. Reimbursement is made only for services provided by a physician/CRNA when performed outside of the intraoperative area. Postoperative pain management will be appropriate for most major intrathoracic, intraabdominal, vascular and orthopedic procedures. The intent of the procedure should be documented as to why post-operative pain relief is not achievable through the use of alternative measures and be procedure specific as would be supported by acceptable peer-reviewed literature and guidelines. The documentation must support the medical necessity of the nerve block service performed by the anesthesiologist instead of the service being performed by the surgeon. Nerve block services will be considered for reimbursement only when there is written documentation that the surgeon has requested such a service. Surgical procedures (including nerve blocks) should be billed as “1” unit per CPT guidelines. The Base Units value should not be entered in the “units” field on your claim. The surgeon should manage post-operative pain...
except under unique circumstances. Operative notes, anesthesia procedure notes, anesthesia record and pre/post-operative orders should be available when requested to support claim review.

Clinical editing is applicable to all anesthesia services.

**Conscious Sedation**

Conscious sedation is considered an integral component to the primary (surgical) procedure and an additional allowable charge will not be considered when performed by performing physician or CRNA.

**Claims Example**

A Blue Cross member has a cholecystectomy that requires 50 minutes of anesthesia. Due to the fact that the member is over age 70, CPT 99100 is also billed. The claim submitted by the anesthesiologist to Blue Cross should include the appropriate information explained above. The claim for covered services is processed as follows to determine the Allowable Charge:

<table>
<thead>
<tr>
<th>M.D. Personally Performed or Non Medically Directed CRNA</th>
<th>M.D. Medically Directing 2-4 Concurrent Procedures</th>
<th>Medically Directed CRNA Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Base Units + Time Units + Physical Status Modifier Units) x Unit Value = Allowable Charge</td>
<td>[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 60% = Allowable Charge for each case being medically directed</td>
<td>[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 40% = Allowable Charge for each case being medically directed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT 00790 AA (or QZ)</th>
<th>CPT 00790 QK (or QY)</th>
<th>CPT 00790 QX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Units</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>+ Time Units (50 mins.)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total Units</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>x Unit Value</td>
<td>$40*</td>
<td>$40*</td>
</tr>
<tr>
<td>Allowable Charge</td>
<td>$440</td>
<td>$440</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT 00790 QK (or QY)</th>
<th>CPT 00790 QX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Units</td>
<td>7</td>
</tr>
<tr>
<td>+ Time Units (50 mins.)</td>
<td>4</td>
</tr>
<tr>
<td>Total Units</td>
<td>11</td>
</tr>
<tr>
<td>x Unit Value</td>
<td>$40*</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$440</td>
</tr>
<tr>
<td>Medically Directed</td>
<td>60%</td>
</tr>
<tr>
<td>Allowable Charge</td>
<td>$264</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT 00790 QX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Units</td>
</tr>
<tr>
<td>+ Time Units (50 mins.)</td>
</tr>
<tr>
<td>Total Units</td>
</tr>
<tr>
<td>x Unit Value</td>
</tr>
<tr>
<td>Subtotal</td>
</tr>
<tr>
<td>Medically Directed</td>
</tr>
<tr>
<td>Allowable Charge</td>
</tr>
</tbody>
</table>

*For illustration purposes only.*

The Base Units value should never be included in the "units" field of your claim.

**CPT 99100 (Payment is based on the allowable charge).** The totals noted in each of these examples do not include the payment for the qualifying circumstance CPT 99100 that was applicable in the example. Additional reimbursement for CPT 99100 will be based on the provider’s allowable charge.

If any modifiers were applicable for physical status, those units would be added to the above calculations as noted in the formulas. The **allowable charges represent the total amount collectable from Blue Cross and the member (if deductible, copayment and/or coinsurance apply). The difference between the provider’s charge and the allowable charge is not collectable from the member.**
**Documentation Requirements**
All billing should be supported by the anesthesia record. Records are required with claims submissions in the following cases:

- Submission of any miscellaneous procedure codes; for example, CPT 01999. Because the code does not provide sufficient information, the record is necessary to identify the actual procedure performed.
- Anesthesia administered for dental procedures. Because dental coverage guidelines may be limited, the anesthesia record will help us to make coverage determination on each case.
- If two different anesthesia services are billed on the same claim with the same performing provider identifier (NPI), the anesthesia record is needed to document that two different operative sessions occurred on the same day.
- If a procedure is billed that is not site-specific, we may request the anesthesia record to determine the site to ensure coverage should be allowed.

**Autism Billing Guidelines**
Louisiana law (Act 648, HB 958) mandates coverage of the diagnosis and treatment of autism (based on medical necessity) as a medical benefit for most policies. Note: This does not apply for Federal Employee Program (FEP) or individual policies and may vary for self-insured groups and BlueCard® members.

**Maximum Benefit Limitations**
Blue Cross group policies will have separate maximum benefit limitations for members under the age of 21 than for members 21 and under per benefit period. There is a single lifetime maximum per member that applies for all autism disorder benefits, regardless of age. **Note:** Coverage for members 21 and older does not include Applied Behavioral Analysis. Please verify member’s benefits to determine applicable benefit limitations and benefits.

**Authorization**
**Authorization is required for Applied Behavioral Analysis services,** because the diagnosis and treatment of autism is considered a medical benefit.

**Filing Claims:**
- **For Blue Cross Members—No Change:** Blue Cross claims related to the diagnosis and treatment of autism are filed directly to Blue Cross for processing.
- **For HMO Louisiana Members:** HMO Louisiana group policies now cover the diagnosis and treatment of autism as a medical benefit. Upon the member’s renewal date, claims related to the diagnosis and treatment of autism should be submitted directly to Blue Cross for processing. Blue Cross will apply medically necessary claims toward the member’s autism maximum benefit limitations, as applicable.
• **Modifiers**: One of the following modifiers is required on all claims. Failure to include the appropriate modifier may result in the claim being returned or denied.

<table>
<thead>
<tr>
<th>HP</th>
<th>Doctoral level</th>
<th>HO</th>
<th>Master’s degree level</th>
</tr>
</thead>
<tbody>
<tr>
<td>HN</td>
<td>Bachelor’s degree level</td>
<td>HM</td>
<td>Less than bachelor’s degree level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Modifiers Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0032</td>
<td>ABA-Initial assessment and plan development per hour up to 4 hours</td>
<td>HO, HP</td>
</tr>
<tr>
<td>H2019</td>
<td>ABA - Follow-up and reassessment per 15 minutes</td>
<td>HO, HP, HN, HM</td>
</tr>
<tr>
<td>G9012</td>
<td>Supervision of ABA follow-up/Parent Training per 15 minutes</td>
<td>HO, HP</td>
</tr>
</tbody>
</table>

**Examples of Applying Benefits BEFORE and AFTER Policy Renewal Date**

Currently, covered services such as speech therapy filed with the primary diagnosis code of autism are applied toward the limitations and/or maximums for speech therapy. Upon renewal of the member’s policy, claims filed with the diagnosis of autism will be applied toward the patient’s autism maximums and limitations instead.

<p>| Patient:  John Q. Smith, age 16 -  Renewal Date of Policy:  February 15, 2015 |</p>
<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Service Provided</th>
<th>Primary Diagnosis</th>
<th>Benefits Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15-2014</td>
<td>Speech Therapy</td>
<td>Autism Disorder</td>
<td>Copayment, Deductible, Coinsurance &amp; <strong>Speech Therapy</strong> Dollar Maximums</td>
</tr>
<tr>
<td>2-15-2014</td>
<td>Speech Therapy</td>
<td>Autism Disorder</td>
<td>Copayment, Deductible, Coinsurance &amp; <strong>Autism</strong> Dollar Maximums (does not affect speech therapy max)</td>
</tr>
<tr>
<td>2-15-2014</td>
<td>Applied Behavioral Analysis</td>
<td>Autism Disorder</td>
<td>Copayment, Deductible, Coinsurance &amp; <strong>Autism</strong> Dollar Maximums</td>
</tr>
</tbody>
</table>

**Note**: This would apply to certain grandfathered policies.

For claims filed with a secondary diagnosis of autism, Blue Cross will still apply benefits based on the primary diagnosis listed on the claim.

**Behavioral Health Billing Guidelines**

Effective January 1, 2016, there are changes to the behavioral health network for HMO Louisiana, Inc., Blue Connect, Community Blue and Federal Employee Program (FEP) members.

**Prior to January 1, 2016**

Magellan Health managed the behavioral health network for our HMO Louisiana, Blue Connect, Community Blue, Federal Employee Program (FEP) and Office of Group Benefit (OGB) Magnolia Local members.
Behavioral health claims with a 2015 date of service should be filed directly to Magellan. The runout period for Magellan to process these claims is 15 months.* On April 1, 2017, Magellan will no longer accept 2015 behavioral health claims for our members. Blue Cross will not process these claims.

*Claims are subject to the member’s timely filing standards, which may be less than 15 months.

2015 claims denied for timely filing or refused by Magellan on and after April 1, 2017, are not billable to the member or Blue Cross.

Effective January 1, 2016

Our members must access network behavioral health providers based on the provider network associated with their member benefit plan for in-network benefits. Claims for dates of service on and after January 1, 2016, should be submitted (electronically or hardcopy) directly to Blue Cross for processing.

Blue Cross has partnered with New Directions to manage the authorization, case and disease management processes for behavioral health services.

Refer to the chart on the next page for the appropriate provider network for each of our member benefit plans.
Our members receive a higher level of benefits when they use providers in their network. Benefits are reduced when services are rendered outside of the network meaning the member is subject to higher out-of-pocket costs. Always verify a member’s benefits prior to rendering services. Patient eligibility, claim status, allowable charges, payment information and medical policies are available online through iLinkBlue (www.bcbsla.com/iLinkBLUE). You may also call the number on the member’s ID card.

**Authorizations**

Authorizations are required for all inpatient behavioral health services. Authorizations may be required for some outpatient behavioral health services. Blue Cross has partnered with New Directions to manage the authorization process for behavioral health services requiring an authorization.

Authorizations: 1-800-991-5638

Behavioral health services that require an authorization:

- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)*
- Partial Hospitalization Program (PHP)*
- Residential Treatment Center (RTC)*
- FEP Residential Treatment Center (RTC)
  - Facility must be licensed and accredited and,
  - Member must be enrolled in Case Management and,
  - Prior approval must be obtained before admission

*FEP does not allow review for medical necessity if the member is admitted to RTC prior to requesting authorization.

- Applied Behavior Analysis (ABA) (requires completion and submission of the forms below, which are available online at www.bcbsla.com/providers >Behavioral Health)
  - Initial Assessment Request Form
  - Initial Treatment Request Form

<table>
<thead>
<tr>
<th>Benefit Plan Type</th>
<th>Network</th>
<th>Authorizations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPO</strong></td>
<td>Preferred Care PPO network of professional and facility providers</td>
<td></td>
</tr>
<tr>
<td>Blue Connect</td>
<td>Blue Connect network of professional and facility providers</td>
<td>New Directions 1-800-991-5638</td>
</tr>
<tr>
<td>Community Blue</td>
<td>Community Blue network for professional and facility providers</td>
<td></td>
</tr>
<tr>
<td><strong>HMO</strong> (HMO &amp; HMO POS)</td>
<td>HMO Louisiana network of professional and facility providers</td>
<td></td>
</tr>
<tr>
<td><strong>Federal Employee Program (FEP)</strong></td>
<td>Preferred Care PPO network of professional and facility providers</td>
<td></td>
</tr>
</tbody>
</table>
New Directions’ electronic authorization tool is available on iLinkBlue. Facilities must use the Behavioral Health authorizations portal to request authorizations for behavioral health services. By using this tool, WebPass, to request authorizations, facilities are able to eliminate telephone time in requesting authorizations.

Access to the Behavioral Health authorizations portal must be granted by your organization’s administrative representative. Additionally, without access to iLinkBlue, you cannot access the Webpass Portal. For more information about iLinkBlue, see the iLinkBlue section of this manual.

**Post-discharge Standards**

Discharge planning should include the utilization review staff, discharge planner, the member’s family, significant others, guardian or others as desired by the member.

Admitting facilities should ensure that patients are provided follow-up appointments within seven days of discharge from an acute inpatient setting with a behavioral health provider.

The seven day appointment does not need to be with a psychiatrist, instead can be scheduled with a therapist or other behavioral health provider.

**Autism Services**

We cover the diagnosis and treatment of autism for persons under the age of 21 on most policies.* Authorizations are required for ABA services—all reviews and authorizations related to the diagnosis and treatment of autism are handled by New Directions, effective January 1, 2016.

*Autism benefits do not apply for Federal Employee Program (FEP) members or some individual policies and may vary for self-insured groups and BlueCard® members. Always verify members’ benefits to determine applicable benefits and any maximum benefit limitations, through iLinkBlue (www.bcbsla.com/iLinkBlue).

**Applied Benefits Analysis (ABA)**

Use one of the following HCPCS codes with appropriate, required modifiers for ABA services:

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>Clinician Type</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0359T</td>
<td>1 hour</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td>0360T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TECH</td>
<td></td>
</tr>
<tr>
<td>0361T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TECH</td>
<td></td>
</tr>
</tbody>
</table>
Claims filed with a primary diagnosis of autism will be subject to the patient’s autism maximum and limitations. Claims filed with a secondary diagnosis of autism will be processed according to the primary diagnosis code listed on the claim.

**Psychotherapy E&M Codes**

We allow payment for evaluation and management (E&M) codes and the following psychotherapy codes when billed on the same claim:

- Psychiatrists and psychologists may bill E&M codes, if appropriate for the service provided and licensed to do so.
- Pharmacologic management CPT code 90863 will bundle as incidental to psychotherapy codes, which are already incidental to E&M codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>Clinician Type</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0364T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TECH*</td>
<td>HN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TECH</td>
<td></td>
</tr>
<tr>
<td>0365T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TECH*</td>
<td>HN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TECH</td>
<td></td>
</tr>
<tr>
<td>0366T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TECH</td>
<td></td>
</tr>
<tr>
<td>0367T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
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<td></td>
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<td>SCABA</td>
<td>TF</td>
</tr>
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<td></td>
<td></td>
<td>TECH</td>
<td></td>
</tr>
<tr>
<td>0368T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
</tr>
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<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
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<td>0369T</td>
<td>30 min</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td>0370T</td>
<td>1 hour</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td>0371T</td>
<td>1 hour</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
<tr>
<td>0372T</td>
<td>1 hour</td>
<td>LBA</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCABA</td>
<td>TF</td>
</tr>
</tbody>
</table>

*Registered Line Technicians with a Bachelor’s degree should report Modifier HN.

Failure to include a modifier may result in your claim being returned or denied.
Chiropractic and Therapy Services

Effective for dates of service on or after January 1, 2017, providers should adhere to the billing guidelines below for chiropractic and therapy services.

Date of Service
Services for a given date of service should be billed on one claim form with each code listed one time per date of service with the appropriate number of units. Date ranges or span dates should not be used on individual claim lines and could result in inaccurate payments.

Skilled, Reasonable and Necessary Care
Services should only be billed if they require direct or overall supervision of a therapist or provider licensed to perform skilled therapy services. Only services provided by a physical or occupational therapist, a physical or occupational therapy assistant, or a provider licensed to perform skilled therapy services and operating within the scope of their license, may be billed. If the service can be performed by the patient or an unskilled person without the supervision of a therapist or licensed provider, then it is not a skilled therapy service, and the service should not be billed. For example, after an exercise has been successfully taught to the patient, repeating the exercise and oversight of the completion of the exercise is not billable unless additional skilled care is provided.

Services should only be billed if they are reasonable and medically necessary. Any services rendered should be clinically appropriate for the patient’s condition in regards to the type, frequency and duration of treatment. These services should fall within the generally accepted standards of care.

Direct Patient Contact Required
CPT codes 97032-97039, 97110-97160 and 97530-97546 require direct patient contact. Time billed should be based on direct one-on-one constant contact by the provider with the patient. Only the actual time spent with the patient performing the service should be billed. Time that the patient spends resting or waiting for a piece of equipment should not be considered part of the treatment time.

Time Based Services
Blue Cross and Blue Shield of Louisiana follows the American Medical Association CPT guidelines for billing time-based codes. Time is the face-to-face time with the patient delivering skilled services. A unit of time is attained when the mid-point is passed unless specific CPT guidelines state otherwise. For example, 15 minutes is attained when eight minutes have elapsed. Incremental intervals of the same treatment at the same visit may be accumulated.

Untimed Services
Untimed services should only be billed once per day regardless of the number of areas treated (i.e. 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028).
No Duplication of Treatment
If patients receive physical and occupational therapy, they must have separate goal and treatment plans. There should be no duplication of treatment.

Reevaluation
Reevaluation codes will bundle to therapy services, however, a reevaluation may be allowed upon appeal for certain circumstances. Once an initial therapy evaluation is completed, the patient is not eligible for a reevaluation until three months after the initial evaluation. If there is a significant change to the patient's diagnosis or a surgical procedure is performed, then a reevaluation is allowed sooner than the three-month waiting period. Providers should appeal with medical records for these situations.

Treatment Sessions and Documentation
Typical physical or occupational therapy treatment times per session are usually 45 to 60 minutes. Audits will be performed periodically to ensure claims are submitted appropriately. Proper coding and documentation will avoid inappropriate payments that may result in recoupment.

Documentation Elements
1. Initial Evaluation
   • Medical diagnosis
   • History
   • Exam
   • Assessment
   • Plan

2. Plan of Care
   • Medical diagnosis
   • Treatment details
   • Long-term functional goals
   • Type of services
   • Frequency of treatment
   • Duration of treatment

3. Flow sheets
   • Must be legible
   • Patient's name
   • Name of licensed performing provider rendering services
   • Dates of service
   • CPT code and the activity performed
• Start time and total time that supports the service rendered and clearly differentiates each service
• Modalities to include specific locations treated

4. Daily Notes
• Documentation in addition to and in support of the flow sheet is required for every treatment session
• Patient feedback
• Concrete measurements
• Treatments performed, frequency, duration and equipment used
• Assessment of patient’s progression
• Continued plan or discharge note
• Licensed performing provider’s signature

Multiple Procedure Reduction
Blue Cross and Blue Shield of Louisiana will apply multiple procedure reductions to codes 64550, 95831-95852, 97010-97160, 97169-97799 and G0283 when billed on the same day. If services are provided on the same day by providers in different specialties (i.e. physical therapy and occupational therapy), the multiple procedure reduction applies separately for each provider specialty.

Individual CPT or HCPCS codes billed with multiple units will be reimbursed based on the allowable charge at:
• 100 percent for the first unit
• 90 percent for the second, third and fourth unit
• 5 percent for five or more units

Each CPT or HCPCS will be reduced as follows:
• 100 percent for the primary, secondary and tertiary procedure
• 50 percent for the fourth procedure
• 5 percent for any additional procedures

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Units</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>2</td>
<td>$19</td>
</tr>
<tr>
<td>97140</td>
<td>1</td>
<td>$10</td>
</tr>
<tr>
<td>97014</td>
<td>1</td>
<td>$10</td>
</tr>
<tr>
<td>97010</td>
<td>1</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Units</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>97140</td>
<td>2</td>
<td>$19</td>
</tr>
<tr>
<td>97110</td>
<td>2</td>
<td>$19</td>
</tr>
<tr>
<td>97014</td>
<td>1</td>
<td>$10</td>
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<tr>
<td>97012</td>
<td>1</td>
<td>$5</td>
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<tr>
<td>97110</td>
<td>2</td>
<td>$19</td>
</tr>
<tr>
<td>97010</td>
<td>1</td>
<td>$0</td>
</tr>
</tbody>
</table>

A $10 fee is used in the calculation examples above for ease of illustration purposes only.
**Supplies are Not Billed Separately**
Supplies (i.e. tape, gloves, electrical stimulation pads, hot and cold packs, etc.) are included in the service. Supplies should not be billed separately or directly to members.

**Hot and Cold Packs**
Hot and cold packs will not be reimbursed separately. They are included in the therapy service.

**Elastic Therapeutic Taping**
Elastic therapeutic taping is not separately billable. Elastic therapeutic tape is a supply, so its use is included in the reimbursement for the therapeutic procedure. Strapping codes (29000-29799) should not be used to bill for elastic therapeutic taping. Since strapping is intended to provide immobilization or restricted movement for acute injury treatment, it is not appropriate to bill elastic therapeutic taping with strapping codes.

**Application of Surface Neurostimulator**
Code 64550 (application of surface neurostimulator) should only be billed once per course of treatment. It is for the initial evaluation and placement of the electrodes and should not be billed continuously during treatment.

**Speech Therapy**
Speech therapy codes 92506, 92507 and 92508 are not time-based codes. They should only be reported one time per session.

**Therapeutic Activities and Neuromuscular Reeducation**
Codes 97530 (therapeutic activities) and 97112 (neuromuscular reeducation) should not be used to describe massage therapy.

**Manual and Massage Therapy Performed as Part of Chiropractic Care**
Physical medicine modalities that are used to relax or prepare the patient for manipulation are considered fundamental to the manipulation and are included in the manipulation reimbursement when they are performed on the same day.

However, when manual therapy (97140) or massage therapy (97124) is performed on an area of the body that is unrelated to the manipulation, then services may be eligible for separate reimbursement. In order for separate reimbursement to be considered, the code must be filed with Modifier 59 and the following conditions must be met:

- Treatment must be performed by a chiropractor.
- Code 97140 or 97124 should not be billed when manipulation is done in the same area.
• If 97140 and 97124 are billed, the following must be documented:
  1. Specific description of the area treated and the utilized technique for treatment (i.e. manual traction, myofascial release, etc.).
  2. Time treatment began and ended along with the total number of minutes of treatment.
  3. Clinical rationale for the separate service.

Since chiropractors usually do not perform manual therapy and massage therapy in areas unrelated to manipulation, audits will be conducted on a periodic basis to ensure claims are submitted appropriately. Proper coding prevents inappropriate payments that eventually result in recoupment.

If a licensed massage therapist employed by the chiropractor performs the service, the service should be billed by the massage therapist.

**Concierge Medicine**

Concierge medicine, (also known as direct care or membership medicine) is a relationship between a patient and a primary care physician which the patient pays an annual fee or retainer. In exchange for the retainer, doctors provide enhanced care, which includes boutique medicine, retainer-based medicine and innovative medical practice design services.

Some characteristics of concierge medicine may also include advanced wellness screenings and diagnostics, personalized wellness plans, one-on-one physician counseling, diabetes prevention and weight management. Concierge providers may also offer extended routine visits, same day appointments and enhanced coordination of care with specialists.

Blue Cross believes that many of the services offered as concierge medicine should already be part of the standard quality of care that our network providers give to our members without additional fees. These fees cannot include any services that are covered under the health plan.

Network providers may not ever apply any concierge fees towards services that are covered under the member’s contract, nor should Blue Cross be billed for any concierge fees. In the future Blue Cross will be looking at ways to monitor our network providers who provide concierge service to ensure that they are not charging a concierge fee for covered services.

Network providers who exclusively offer concierge services should refer Blue patients who do not wish to participate in the concierge program to another network provider.

Network providers who offer both non-concierge and concierge services should make it voluntary for Blue members and may not discriminate against the non-concierge patients in terms of reasonable access to medical care and quality or comprehensiveness of care. Also, additional administrative fees should not be charged unless it is the standard office process for all patients, regardless of retainer, and patients have first been notified in advanced in writing.
Network providers must notify Blue Cross in writing of their involvement in a concierge program prior to contacting our members about your new process. Notification should be made upon signing an agreement to become a concierge provider, or as soon as the decision is made to proceed with a concierge program. Providers choosing to participate in a concierge program will not be immediately removed from our network. We will work with you to ensure that your practice patterns are not in violation with your contract. Providers also agree to periodic audits by Blue Cross and HMO Louisiana to ensure all requirements are being consistently met.

Upon notification, concierge providers will be listed in our provider directories with a notation that they are providing concierge medicine. For our members who do not wish to or are unable to pay the fees associated with concierge medicine, we will help identify non-concierge providers in their network. Please send notification to the Network Administration Division, Attn. Concierge Program, P.O. Box 98029, Baton Rouge, LA 70898-9029 or network.administration@bcbsla.com. You may also speak to your Network Development representative if you have concerning concierge medicine. To find your representative, visit www.bcbsla.com/providers >Provider Tools >Provider Representative Map.

**Delivery of Pregnancy Billing Guidelines**

Elective deliveries for pregnancies less than 39 weeks gestation can pose both short and long term risks for the newborn. The risks that newborns face after early delivery, even at 37 and 38 weeks gestation include, but are not limited to, increased morbidity from respiratory distress, increased rates of pneumonia, ventilator use, hypoglycemia and NICU admission. The relative risk of neonatal mortality is 2.3 times greater at 37 weeks and 1.4 times greater at 38 weeks as compared to 39 weeks.

These guidelines are also included in the Member Provider Policy and Procedure Manual and are an extension of your network agreement. Use these guidelines to ensure proper reimbursement and avoid denied or returned claims. **Always verify members’ benefits prior to performing this or any other service as benefits may vary for some of our self-funded groups.**

Blue Cross considers **ELECTIVE deliveries**, whether vaginal or Cesarean, **prior to 39 weeks** to be not medically necessary and are not reimbursable. This includes claims for the delivering provider, anesthesiologist and facility. Claims denied as not medically necessary are NOT billable to the member. For global delivery claims (code 59400, 59410, 59510, 59610, 59614, 59515, 59618 or 59622) that have been denied as not medically necessary, the delivering provider may refile the ante-partum (59426) or post-partum (59430) care services for separate reimbursement consideration.

The provider performing the delivery is required to include a modifier. Use one of the following modifiers when billing for a delivery of pregnancy (CPT codes 59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622):
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB</td>
<td>Report when delivery is 39 weeks or more, whether spontaneous or elective</td>
</tr>
<tr>
<td>AT</td>
<td>Report when delivery is less than 39 weeks and medically necessary</td>
</tr>
<tr>
<td>GZ</td>
<td>Report when delivery is less than 39 weeks and NOT medically necessary</td>
</tr>
<tr>
<td>NO MODIFIER</td>
<td>Claim will DENY for incomplete information</td>
</tr>
</tbody>
</table>

All other related claims (anesthesia, facility, etc.) will be subject to recoupment of payments should the delivery be determined to not be medically necessary. Labor inductions and elective Cesarean deliveries for pregnancies less than 39 weeks gestational may be considered eligible for coverage when there is an established maternal or fetal risk in which the risk of continuing the pregnancy outweighs the risks of early birth. Management decisions should balance the risks of pregnancy prolongation with the neonatal and infant risks associated with early-term delivery. Maternal-fetal-medicine consultations are encouraged in the evaluation of pregnancies considered for early-term delivery and in the assessment of the risks/benefits from such delivery.

**Note:** The maternal patient should be provided with documentation that clearly explains the risks/benefits of early delivery.

Also, it is important to file ALL applicable diagnosis codes on a claim. It is equally important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing “not otherwise specified” (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.

**GLOBAL BILLING FOR MATERNITY CARE**

When a sole obstetrician or obstetricians within the same group covering for each other, provide routine maternity care from the beginning of a member’s pregnancy to delivery, our policy is to allow an initial evaluation and management service and a global delivery fee.

If a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and is there to confirm pregnancy, this visit may be reported with the appropriate level evaluation and management services code as a separately payable service, outside the global delivery package. Global obstetrical care begins after the initial visit when the obstetrical record is initiated as part of the physician’s comprehensive obstetrics work-up which includes the comprehensive history and physical.

The global period for the obstetrical care, represented by CPT codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 or 59622 includes all routine pregnancy-related evaluation and management office services, after the initial evaluation, and the delivery service.
If more than one obstetrician is involved in a patient’s routine maternity care, Blue Cross would expect to see itemized services specific to the care delivered by the obstetrician for that patient. For example, a patient begins treatment in another state and then relocates to Louisiana and a Louisiana obstetrician begins routine care for that patient in the third trimester of pregnancy, the physician would bill the appropriate evaluation and management code (99201-99215) or antepartum care CPT-4 procedure code (59425 or 59426) based on the number of visits, and the delivery code (with or without postpartum care) rather than a global delivery procedure.

Antepartum care for split providers should be billed as:

- 1 – 3 visits – bill evaluation and management codes (99201-99215)
- 4 – 6 visits – bill CPT-4 code 59425
- 7 or more visits – bill CPT-4 code 59426

**For More Information**

If you have any questions about the Elective Delivery of Pregnancy medical policy or if you would like a copy of another medical policy, please refer to the Medical Policy section of iLinkBlue or contact your Provider Relations Representative. To find your representative, use our interactive Provider Representative Map located at www.bcbsla.com/providers >Provider Tools >Provider Representative Map.

**Dialysis Billing Guidelines**

Dialysis providers should adhere to the following guidelines when filing claims for Blue Cross and Blue Shield of Louisiana and HMO Louisiana members:

- Providers must file dialysis claims under the appropriate revenue code for the type treatment provided as a single line item.
- The service units field must be used to indicate the number of treatments provided within the dates of service that appear on the claim.
- All other billed charges for services or products rendered must be itemized and the appropriate HCPCS code should be included on the claim.
- Providers should use one of the following revenue codes for the dialysis procedure when submitting a UB-04 claim form. CPT codes are not required when billing for dialysis services.

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>Type of Dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>821</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>831</td>
<td>Intermittent Peritoneal Dialysis</td>
</tr>
<tr>
<td>841</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
</tr>
<tr>
<td>851</td>
<td>Continuous Cycling Peritoneal Dialysis</td>
</tr>
</tbody>
</table>
Providers should use one of the following revenue codes, along with the appropriate HCPCS code, for Epogen when submitting a UB-04 claim form:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Type of Dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>634</td>
<td>EPO, less than 10,000 units</td>
</tr>
<tr>
<td>635</td>
<td>EPO, 10,000 or more units</td>
</tr>
<tr>
<td>J0886</td>
<td>Injection, epoetin alfa, 1000 units</td>
</tr>
<tr>
<td>Q4081</td>
<td>Injection, epoetin alfa, 100 units (for ESRD on dialysis)</td>
</tr>
</tbody>
</table>

**For example.** Epogen will be reimbursed at $12 per 1,000 units for J0886 or $1.20 per 100 units for Q4081. Providers should use revenue code 634 or 635 and HCPCS code J0886 or Q4081 when billing for Epogen. The per diem will only be applicable to the day(s) that the treatment is provided. Any services related to dialysis treatments, but rendered on dates of service other than the date of service for dialysis treatment is included in the per diem and is not separately reimbursable.

The service units field (line 46 of the UB-04 claim form) should include the appropriate units per the HCPCS code description for the total units provided. For example, if 60,000 units are provided then "60" (60,000 divided by 1,000) should be entered in line 46 if billing J0886. If billing code Q4081 and 5,000 units are provided, enter “50” on line 46.

- The per diem reimbursement only applies to the day(s) that the treatment is provided.
- Any services related to dialysis treatments, but rendered on dates of service other than the date of service for dialysis treatment, are included in the per diem and are not separately reimbursable.
- **Please note:** Blue Cross may expand and/or modify the reimbursement schedule for new, deleted or modified codes developed subsequent to the effective date of your Allied Health Professional Agreement. Blue Cross will notify providers 30 days prior to the effective date of the schedule change.

**Dietitian Billing Guidelines**

Dietitians should adhere to the following guidelines when filing claims for Blue Cross and HMO Louisiana, Inc. members regardless of the date of service. These billing guidelines are not an indication that services are necessarily covered. Coverage determinations are based on the member’s benefits. Always verify the member’s benefits prior to performing services to determine if services are covered.

Dietitian services as they pertain to Blue Cross and HMO Louisiana member benefits are defined as follows when rendered by a registered dietitian:

1. Nutritional Counseling – counseling to develop a dietary treatment plan to treat and/or manage health-related conditions other than diabetes.
   - No visit limitation
   - A maximum benefit limitation* per benefit period
   - Services that exceed the dollar limitation are considered non-covered and will not accrue toward the member’s out-of-pocket amount
2. Diabetes Counseling – counseling to develop a dietary treatment plan to treat and/or manage diabetes.

- Dietitian visits related to diabetes services are not subject to the nutritional counseling maximum benefit limitation. Services billed with diabetes diagnosis codes are instead subject to a member’s Diabetes Education and Training for Self-Management benefits.

- Members who have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin using diabetes need to be educated on their condition and trained to manage their condition, if prescribed by the Member’s physician. Coverage is available for self-treatment training and education, dietitian visits and for the equipment and necessary supplies for the training.

- Evaluation and training programs for diabetes self-management are covered subject to the following:

  a. The program must be determined to be Medically Necessary by a Physician and provided by a licensed health care professional who certifies that the Member has successfully completed the training program.

  b. The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

**Outpatient vs. Inpatient**

**Outpatient/Office Services**

- Services should be filed on a CMS-1500 professional claim form

- Payable to the dietitian

**Inpatient Services**

- Services should be filed on a UB04 facility claim form

- Payable to the facility

**Filing for Services**

Providers must file dietitian claims under the appropriate CPT or HCPCS code for the type of treatment provided as a single line item. Blue Cross and HMO Louisiana will accept the following codes on claims:

<table>
<thead>
<tr>
<th>Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>Each 15 minutes</td>
</tr>
<tr>
<td>97803</td>
<td>Each 15 minutes</td>
</tr>
<tr>
<td>97804</td>
<td>Each 30 minutes</td>
</tr>
<tr>
<td>G0108</td>
<td>Each 30 minutes</td>
</tr>
<tr>
<td>G0109</td>
<td>Each 30 minutes</td>
</tr>
<tr>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>G0270</td>
<td>Each 15 minutes</td>
</tr>
<tr>
<td>G0271</td>
<td>Each 30 minutes</td>
</tr>
<tr>
<td>S9470</td>
<td>Per session</td>
</tr>
<tr>
<td>S9452</td>
<td>Per session</td>
</tr>
</tbody>
</table>

- The service units field must be used to indicate the number of sessions provided within the dates of service that appear on the claim.

- All other billed charges for services or products rendered must be itemized and the appropriate HCPCS code should be included on the claim.

If you have any questions regarding these billing guidelines, please contact Provider Relations at 1-800-716-2299, option 4.

### Drug Screening Assays

We only accept claims with CPT drug screen codes.

**Presumptive drug screening: CPT codes 80305-80307**

- Blue Cross will only allow payment for one presumptive drug screen for drugs from Drug Class A and/or B (CPT codes 80305-80307) regardless of the number of services performed.

To ensure you have the most up-to-date information about our coverage guidelines, please review our Urinary Drug Testing medical policy (policy no. 00387). *This medical policy and all our other medical policies are available on iLinkBlue (www.bcbsla.com/ilinkblue) under the “Authorizations and Medical Policy” section.*

**Definitive Drug Testing:**

The definitive payment policy below is **effective for dates of service on and after July 1, 2015**.

Definitive drug testing codes will be subject to a multiple-service reduction as follows:

*(for the same patient for the same encounter)*

- First or initial lab will be considered for 100 percent of the allowable charge;
- Second lab will be considered for 100 percent of the allowable charge;
- Third lab will be considered for 50 percent of the allowable charge;
- Fourth lab will be considered for 25 percent of the allowable charge;
- Fifth lab and any additional labs will be considered for five percent of the allowable charge;
- Multiple services for urine validity will be bundled.

*Please note: Providers will not be separately reimbursed for validity testing, such as, urinary pH, specific gravity, nitrates, oxidants or urine specimens used for drug testing.*

Blue Cross requires that claims be filed using CPT codes 80305-80377 rather than the temporary Medicare
HCPCS codes G0477-G0483. Claims filed with HCPCS codes G0477-G0483 will be denied and must be refiled with current CPT codes.

**Durable Medical Equipment/Home Medical Equipment (DME/HME) Billing Guidelines**

Durable medical equipment/Home medical equipment (DME/HME) are items that are used to serve a specific therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness, injury or disease, and appropriate for use in the member’s home.

**General Guidelines**

Prior to submitting claims, there must be a valid detailed physician order on file.

DME/HME claims must be filed to the Blue Plan where the equipment is shipped to or purchased at a retail store. The ordering provider’s NPI must be included on the claim or it will be returned requesting that the claim be refiled with the ordering provider’s NPI number.

**Electronic Claims Requirements:**

837 Professional Electronic Submission:

- The patient address is populated in 2010CA loop
- The NPI of the ordering provider is populated in 2420E loop
- The POS of the member is populated in 2300 loop, CLM05-01
- The service facility location is populated in 2310C loop

**Paper Claim Requirements:**

CMS-1500 Health Insurance Claim Form:

- The patient address where the DME/HME was shipped to in Block 5
- The NPI of the ordering provider in Block 17B - NPI of referring provider or other source
- The place of service (POS) in Block 24B (this represents where the item is actually being used - not where dispensed)
- The service facility location in Block 32 (for retail store information or location other than the patient address)

If you are a DME/HME supplier that is not located in Louisiana, you must be a participating provider for the member’s plan, in the state (Louisiana) where the equipment or supply is shipped or purchased in a retail setting in order for the member to receive the highest level of member benefits. What does this mean to your office? If you are supplying DME/HME items to Blue Cross members residing in Louisiana, and you wish to receive payment directly and be identified in our provider directories, you may want to consider participating in our network. If you wish to inquire about participating in our networks please contact our Network Development team by calling 1-800-716-2299 and choosing option 1.
Scenario:
A durable/home medical equipment supplier in Mississippi receives and processes a request for DME/HME for a member in Louisiana. The equipment is then shipped to Louisiana for the member for pick up and/or purchase. The claim should be filed in Louisiana; the service area where the equipment is received/purchased.

If You Order DME/HME
If you refer your patients to a DME/HME supplier that is not in Louisiana, the out of state DME/HME supplier must be a participating provider for the member’s plan in the state (Louisiana) where the equipment or supply is shipped or purchased in a retail setting in order for the member to receive the highest level of benefits. What does this mean to your office? If you are writing an order for DME/HME for your patient, please refer them to a participating DME/HME supplier for the state in which your patient’s equipment/supplies will be delivered to and please provide your NPI so that it may be included appropriately when the DME/HME supplier files a claim for the requested supplies. Please help us ensure our members—your patients—receive the highest level of benefits available. Repeated use of a non-participating DME/HME supplier could subject you to a lower allowable charge.

Authorization
Authorization requirements are defined based on the member’s (subscriber’s) contract benefits. Authorization is performed prior to services being rendered. When a claim is submitted for medical necessity, DME certification is required after the services are rendered or equipment is received. PPO does not require authorization; however, authorization is required for HMO. Please research iLinkBlue prior to any service provided to fully understand benefits, authorization requirements, limitations and exclusions for your patient. More on authorization can be found on the appropriate speed guide located on the Provider page of www.bcbsla.com/providers >Education on Demand >Speed Guides.

For certain DME, a recertification to determine medical necessity of continued use may be required after the equipment has been rented for a specified number of months (such as SIDS Apnea Monitor). It is the member’s responsibility to ensure recertification takes place. The member and the participating DME supplier will be notified of the recertification requirements when the initial length of rental is approved. Any claims received beyond this approved period without a recertification of medical necessity will not be covered. DME Certification forms are available by calling Provider Services at 1-800-922-8866.

DME Notification Letter
All initial and recertified DME claims will be reviewed by Blue Cross to determine medical necessity and DME coverage status. Once the review is completed, a DME notification letter is mailed to the member with a copy to the participating DME supplier.
The DME notification letter will provide one of the following:
• Approval of rental for a specified number of months (including recertification requirements)
• Approval of rental up to purchase allowance
• Approval of purchase
• Denial of rental or purchase

The DME notification letter does not guarantee payment of benefits. It only confirms approval/denial of the medical necessity of the DME. Benefit payment is always subject to the terms of the member contract.

**DME Accreditation Requirement**

Blue Cross requires all new DME providers be accredited by the appropriate accrediting body as a condition of network participation. All existing DME providers must remain accredited by one of the following accrediting bodies to continue participation in the Blue Cross networks:

• Accreditation Commission for HealthCare, Inc. (ACHC)
• American Board for Certification in Orthotics & Prosthetics, Inc.
• Board of Certification/Accreditation International
• Commission on Accreditation of Rehabilitation Facilities (CARF)
• Community Health Accreditation Program (CHAP)
• HealthCare Quality Association on Accreditation (HQAA)
• National Association of Boards of Pharmacy (NABP)
• The Compliance Team, Inc.
• The Joint Commission
• The National Board of Accreditation for Orthotic Suppliers

Blue Cross will review each provider’s accreditation status during the provider’s regularly scheduled recredentialing cycle. Providers are recredentialed by Blue Cross every three years in accordance with URAC standards. Providers who do not maintain the required accreditation or do not abide by Blue Cross’ credentialing guidelines will be subject to termination from any networks in which they participate.

Proof of accreditation must be sent by email to network.administration@bcbsla.com or via fax to (225) 297-2750.

**DME Benefits**

Benefits for DME are provided in accordance with the benefit provisions of each specific member’s benefit plan. Benefits will be provided if the DME is covered by the member’s benefit plan and the prescribed equipment meets our DME and medical necessity requirements. Most member benefit plans provide for the rental of DME not to exceed the purchase allowance.

**Deductible, Coinsurance, Copay and Non-covered Services**

After the member’s deductible has been met, Blue Cross will pay a specified benefit for the remaining rental or purchase allowance for covered DME. The deductible and benefit amounts will vary according to the member’s contract.
The member is responsible for payment of any deductible, coinsurance and non-covered services. However, the DME provider cannot bill the member for any amount that exceeds the Blue Cross allowable charge for rented or purchased DME pursuant to your contractual agreement with Blue Cross. Sales tax on DME is considered a non-covered charge and the member’s responsibility according to most Blue Cross and HMO Louisiana member benefit plans.

**Payment Allowance**
Benefit payment for the rental of DME is based on the Blue Cross monthly rental allowance (not to exceed the purchase allowance). Benefit payment for the purchase of DME is based on the Blue Cross purchase allowance.

Rented DME is considered purchased once the monthly rental allowance equals the purchase allowance. The patient then owns the DME and neither the member nor Blue Cross can be billed for additional rental or purchase of the equipment.

**Rental vs. Purchase**
Blue Cross has the option of approving either rental or purchase of DME. Based on medical necessity, rental may be approved for a specified number of months, rental may be approved up to the purchase allowance, or purchase may be approved.

**Billing Guidelines**
DME must be billed using the most appropriate HCPCS code and appropriate modifiers in effect for the date of service. Claims billed with an inappropriate code/modifier combination will be returned to the Provider for submission of a corrected claim and will cause a delay of reimbursement.

**Purchase**
For purchased items, the appropriate HCPCS code must be billed with the NU modifier. See specific guidelines for insulin infusion pump billing and modifiers.

**Rentals**

**Daily Rental Codes**
- E0202 - PHOTOTHERAPY LIGHT WITH PHOTOMETER
- E0935 - CONT PSV MOT EXER DEVC KNEE ONLY
- E0936 - CONT PASS MOTION EXER DEVC NOT KNEE

Miscellaneous, unlisted, non-specific and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT or HCPCS code is not available. Components of the primary equipment should be billed with the most specific CPT or HCPCS code or the most specific unlisted or
miscellaneous code. DME billed with unlisted, miscellaneous, non-specific, and NOC codes must be billed with the name of the manufacturer, product number, and quantity.

Codes for durable medical equipment, medical supplies, orthotics, and prosthetics without an established allowable may require submission of the manufacturer name, product name, product number, and quantity.

Charges for rental equipment accessories should be included in the rental price of the equipment with no separate or itemized billing when submitting claims for consideration to Blue Cross. All DME requests for special or customized features should be submitted to the Blue Cross Medical Review Department for prior approval using the Medical Certification Form.

All DME/HME claims for supplies that exceed the usual and customary utilization may result in a request for medical records to determine medical necessity.

All supplies must be requested by an eligible member or caregiver. Supplies are not to be automatically dispensed on a predetermined regular basis.

**Monthly Rentals**

One unit should be billed for each month the item is rented, with the exception of the daily rental codes below. The maximum allowable for the rental is for a whole month. A Calendar Month is the period of duration from a day of one month to the corresponding day of the next month and is determined based on the “From” date reported on the claim. If a code is submitted with modifier RR with units greater than 1, or multiple times during the same Calendar Month, Blue Cross and Blue Shield of Louisiana will only reimburse one monthly rate per Calendar Month to the Provider except for daily rental codes as noted below.

Providers must use modifier UE (used durable medical equipment) when billing for used equipment. Used equipment will be reimbursed at a 25 percent discount.

**Deluxe/Luxury and Special Features**

Certain DME is considered “deluxe” equipment due to its mechanical or electrical feature(s). For example, electric hospital beds are considered to be deluxe equipment. Deluxe equipment is covered only if Blue Cross determines that the deluxe equipment is both medically necessary and therapeutic in nature. Deluxe equipment ordered primarily for the member’s comfort and convenience and determined to be not medically necessary and therapeutic will not be paid.

When the member requests deluxe equipment, and the medical necessity for the deluxe feature(s) of covered DME is not documented, benefits will be based on the rental or purchase allowance for standard/economical equipment.

A DME provider may deliver deluxe/luxury items as long as they could provide a standard product and the member or her/his representative has specifically requested the excessive or deluxe items or services with knowledge of the amounts to be charged. An Advance Beneficiary Notification (ABN) is required as
documentation that the member has made such an informed request. If the ABN has been obtained, the DME/HME item would be submitted to Blue Cross with a Modifier GA appended as informational. The member is financially responsible for the difference in the allowable charge for the standard equipment and the billed charge and is not to be held financially responsible for the discounted amount agreed to in your provider contract. The charge to the member for the difference should be calculated based on the following example:

DME offers a standard item at $500 and a deluxe item at $800. The Blue Cross allowable is $375. The member’s additional out of pocket cost is $800-($500-375) plus any deductible, coinsurance or copay.

Due to certain conditions, illnesses or injuries, medical necessity may require DME with special or customized features. All equipment of this type is subject to individual payment consideration and prior approval of Blue Cross.

Charges for rental equipment accessories should be included in the rental price of the equipment with no separate or itemized billing when submitting claims for consideration to Blue Cross. All DME requests for special or customized features should be submitted to the Blue Cross Medical Review Department for prior approval using the Medical Certification Form.

**Breast Pumps**
Blue Cross provides the durable medical equipment (DME) benefit for the standard manual breast pump model (E0602) covered for purchase at 100 percent of the allowable charge. However, unless prior authorized for medically necessity, a hospital-grade breast pump (E0603), is considered a deluxe/luxury item and reimbursed at the same rate as the electric breast pump (E0603), with the member being responsible for any amount above the allowable charge. ([Please refer to the special instructions for deluxe/luxury items](#)). Only when prior authorization is approved, Blue Cross will allow for special processing of hospital grade breast pumps, and these authorizations are subject to periodic review.

**CPAP Supplies**
CPAP supplies will be limited as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Units/Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4604</td>
<td>1 per 3 months</td>
</tr>
<tr>
<td>A7027</td>
<td>1 per 3 months</td>
</tr>
<tr>
<td>A7028</td>
<td>6 per 3 month or 2 per month</td>
</tr>
<tr>
<td>A7029</td>
<td>6 per 3 month or 2 per month</td>
</tr>
<tr>
<td>A7030</td>
<td>1 per 3 months</td>
</tr>
<tr>
<td>A7031</td>
<td>3 per 3 months or 1 per month</td>
</tr>
<tr>
<td>A7032</td>
<td>6 per 3 months or 2 per month</td>
</tr>
<tr>
<td>A7033</td>
<td>6 per 3 months or 2 per month</td>
</tr>
<tr>
<td>A7034</td>
<td>1 per 3 months</td>
</tr>
<tr>
<td>A7035</td>
<td>1 per 6 months</td>
</tr>
</tbody>
</table>
Infusion Pumps
In an effort to appropriately align reimbursement to the types and cost of equipment provided modifier(s) are required on infusion pump code E0784 effective for dates of service beginning July 1, 2015. These items are for purchase only.

For Omnipod pumps, bill Modifier NU in the first position; for Medtronic pumps, bill Modifier SC in the first position and NU in the second position; for pumps other than Omnipod and Medtronic bill Modifier KD in the first position and NU in the second position.

Coding Examples for Infusion Pumps
E0784NU – Omnipod infusion pump purchase
E0784SCNU – Medtronic infusion pump purchase
E0784KDNU – Infusion Pump purchase other than Omnipod or Medtronic brand/model

Orthotics
Evaluation, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis and are not separately billable.

Repairs to an orthosis are billable when they are necessary to make the orthosis functional. The reason for the repair must be documented in the supplier’s record. If the expense for repairs is greater than providing another entire orthosis, no payment will be made for the amount in excess.

Replacement of a complete orthosis or component is billable if Medically Necessary.

Labor for replacing an orthosis component that is coded with a specific “L” HCPCS code is included in the allowance for that component.

Billable orthosis components and labor must be billed on the same claim form.

Oxygen Concentrator
Oxygen Concentrators can be rented or purchased. The rental amount will be allowed for 15 months at which time, the item will be considered purchased. Maintenance and servicing charges can be billed using HCPCS code K0740 every six months after the end of 15 months of continuous use or the end of the manufacturer’s warranty.
**Prosthetics**

The following items are not separately billable and are included in the reimbursement for a prosthesis:

- Evaluation of the residual limb and gain;
- Cost of component parts and labor contained in the HCPCS codes;
- Fitting of the prosthesis to include adjustments of the prosthesis or prosthetic component; and
- Routine periodic servicing to include testing, cleaning, and checking of the prosthesis.

**Repair or Maintenance other than Prosthetic and Orthotic DME**

The repair or maintenance of rented DME/HME is the responsibility of the participating DME/HME supplier at no additional charge to the member. Rental rates include reimbursement for repair, adjustment, maintenance, and replacement of equipment and its components related to normal wear and tear, defects, or aging. If the expense for repairs is greater than the estimated expense of purchasing another entire item, no payments can be made for the amount of the excess. Repairs to Member-owned DME are billable using the appropriate code (K0739 or K0740) when necessary to make the item functional. For ventilators see section below.

For facial prostheses codes L8040 thru L8047, providers must bill using modifiers KM or KN when the prosthesis is being replaced.

- KM Replacement of facial prosthesis including new impression/moulage
- KN Replacement of facial prosthesis using previous master model

**Ventilators**

Effective January 1, 2016, Ventilator HCPCS codes are to be billed and reimbursed as rental using the RR modifier, which includes maintenance. One additional rental rate at 50 percent (upon prior authorization) will be allowed in the same calendar month for a backup ventilator reported with a rental modifier (RR) plus Modifier TW (backup equipment), appended to HCPCS codes. **Note: Members may be allowed to purchase the ventilators if authorized.** Maintenance fees may be allowed for this purchased/member owned equipment using code K0740.

**Wheelchairs (customized)**

Please follow the billing guidelines below when you bill Blue Cross for customized wheelchairs:

File the entire customized wheelchair claim using HCPCS code E1220, and we will reimburse the entire claim at Manufacturer’s Suggested Retail Price (MSRP) minus 25 percent discount of charges. These claims require detailed invoices to be submitted. To expedite this process, please submit hardcopy paper claims and supporting documents.

- Evaluation and set-up fees will not be reimbursed separately.
- Use K0739 to bill for equipment maintenance that is not covered under the warranty. Reimbursement will be based on the allowable charge.
Wheelchairs (non-customized)
Wheelchair accessories must be billed on the same claim form as the wheelchair itself. Multiple accessories using code K0108 should each be billed on a separate line.

For purchased DME/HME, the participating DME/HME supplier must provide a one-year warranty agreement to the member. This warranty agreement may include some nominal monetary fee that is billable to the member. The participating DME/HME supplier must always inform the member about any DME/HME warranty provided by the manufacturer.

The DME/HME supplier agrees to provide all DME/HME services and supplies and orthotic and prosthetic devices, if applicable, according to the following standards:

- Free delivery;
- Free installation;
- Seven day-a-week, 24-hour emergency services by both technicians and professionals;
- Rental equipment repair and maintenance service (same day service, if required);
- Clinical professionals for patient education and home management, and, where necessary, written graphically-illustrated patient education and instruction manuals; and
- Availability of standard/economical models that meet the patient’s needs and quality standards.

Home Health Agency Billing Guidelines
Blue Cross recognizes the need to maintain consistency of billing requirements for both Blue Cross and Medicare wherever possible. Therefore, we require home health agencies to file claims using the UB-04 claim form (see instructions in the Claims Submission section of this manual) in accordance with Medicare guidelines with the following exceptions:

1. The revenues codes accepted by Blue Cross and which may be entered in UB-04 field 42 are limited, and revenue code descriptions for field 43 have been modified. These modifications are necessary due to member contract/certificate variations.

   Revenue codes 551 and 559 and their respective descriptions have been changed to identify services provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). This change is necessary because reimbursement rates are different for RNs and LPNs.

   Revenue code 261, IV Therapy Pump, requires a modifier in order for the correct type of service to be assigned (see page 76 and 77 for detailed information).

   The revenue codes with descriptions accepted by Blue Cross from participating home health agencies listed in this manual. The appropriate HCPCS or CPT code must be included in field 44 of the UB-04 when billing revenue codes with double asterisks (**), shown under the column heading “Code Req’d.” This is necessary for proper pricing and payment of the service. (Please refer to your Blue Cross Home Health Agency Member Provider Agreement and Reimbursement Appendix for information on reimbursement).
2. Accumulative billing of services will be accepted by utilizing a "From" and “Through” date with the total units of service for a specific revenue code or HCPCS code. However, some member contracts/ certificates and/or groups require that the individual date of service be shown for each day on which services where provided. When this situation applies, you will be notified when you authorize services and also via the written confirmation of the authorization.

**Authorization is required for all home health care.** Blue Cross requires 48 hours advance notice of all home health care to be provided. The authorization will include the service and/or code to be provided and in some cases, the quantity/units of services authorized. The services that we will generally approve are included in this manual and include the range of HCPCS/CPT codes that should be billed with the revenue code. To obtain authorization, please call Provider Services at 1-800-523-6435.

**Home Health Agency Revenue Codes Accepted by Blue Cross and Blue Shield of Louisiana**

Visit charge is defined as a consecutive period of time up to two hours during which home health care is rendered. Hourly charges exceeding two hours require additional authorization from Blue Cross.

Hourly charges for home health aides and private duty nursing (in shifts of at least eight continuous hours) must be billed using the revenue codes appropriate to the level of professional training.

<table>
<thead>
<tr>
<th><strong>Revenue Code</strong></th>
<th><strong>Description</strong></th>
<th><strong>HCPCS/ CPT Range</strong></th>
<th><strong>Code Req'd</strong></th>
<th><strong>Program Rate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>258</td>
<td>Pharmacy - IV Solutions</td>
<td>J0000 thru J9999, B4150 thru B5200</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>261*</td>
<td>IV Therapy - Infusion Pump</td>
<td>E0781 thru E0784, E1520, A4220</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>264</td>
<td>IV Therapy - IV Therapy Supplies</td>
<td>A4230 thru A4232, A4221, A4222, B4034 thru B4083, B9000 thru B9999</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>271</td>
<td>Medical/Surgical Supplies &amp; Devices, Nonsterile Supply</td>
<td>A4206 thru A6404</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>272</td>
<td>Medical/Surgical Supplies &amp; Devices, Sterile Supply</td>
<td>A4206 thru A6404</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>274</td>
<td>Medical/Surgical Supplies &amp; Devices, Prosthetic/Orthotic Devices</td>
<td>L0000 thru L4999, L5000 thru L9999</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>291</td>
<td>DME (Other than Renal), Rental</td>
<td>E0100 thru E1406, E1700 thru E1830</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>292</td>
<td>DME (Other than Renal), Purchase of New DME</td>
<td>E0100 thru E1406, E1700 thru E1830</td>
<td>Allowable Charge</td>
<td></td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Description</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>293</td>
<td>DME (Other than Renal), Purchase of Used DME</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>294</td>
<td>DME (Other than Renal), Supplies/Drugs for DME Effectiveness</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300-319</td>
<td>Laboratory</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>421</td>
<td>Physical Therapy - Visit Charge</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>424</td>
<td>Physical Therapy - Evaluation or Re-evaluation</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>431</td>
<td>Occupational Therapy - Visit Charge</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>434</td>
<td>Occupational Therapy - Evaluation or Re-evaluation</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>441</td>
<td>Speech-Language Pathology - Visit Charge</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>444</td>
<td>Speech-Language Pathology - Evaluation or Reevaluation</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>550**</td>
<td>Skilled Nursing-Hourly Charge (Licensed Practical Nurse)</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>551**</td>
<td>Skilled Nursing-Visit Charge (Registered Nurse)</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>552**</td>
<td>Skilled Nursing-Hourly Charge (Registered Nurse)</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>559**</td>
<td>Skilled Nursing-Visit Charge (Licensed Practical Nurse)</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>561</td>
<td>Medical Social Services - Visit Charge</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>571**</td>
<td>Home Health Aide - Visit Charge</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>600</td>
<td>Oxygen (Home Health)</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>999</td>
<td>Other Patient Convenience Items</td>
<td>Allowable Charge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Allowable charges for revenue codes that are not specifically listed above will be established periodically.

* More on IV Therapy - Infusion Pump (Revenue Code 261) below
** More on Skilled Nursing Revenue Codes below
## More on Revenue Codes for Skilled Nursing

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>550</td>
<td>Skilled Nursing – Hourly Charge – Licensed Practical Nurse (Private Duty Nursing)</td>
</tr>
<tr>
<td>552</td>
<td>Skilled Nursing – Hourly Charge – Registered Nurse (Private Duty Nursing)</td>
</tr>
<tr>
<td>572</td>
<td>Home Health Aide – Hourly Charge</td>
</tr>
</tbody>
</table>

The Allowable Charge for revenue codes 550, 552 and 572 for private duty nursing or home health aide services will be considered for approval during the private duty nursing or home health aide services authorization process. Services and procedures (CPT/HCPCS) not listed on the above schedule will be reimbursed at the lesser of the billed charge or an amount established by Blue Cross. The presence of a revenue code or allowable charge on this listing is not to be interpreted as meaning that the patient has coverage or benefits for that service.

The allowable charge for revenue codes 551 and 559 for skilled nursing includes, but is not limited to:

1. Pre- and post-hospital assessment
2. IV infusion
3. Administration of medication: PO, IM, SQ
4. Training and educating patient, family and caregiver
5. Wound care management
6. Patient monitoring
7. Laboratory blood drawing
8. Physician case conference
9. Discharge assessment
10. All medical equipment and supplies associated with one through nine above whether reusable or non-reusable including, but not limited to:
   - Alcohol prep sponge
   - Band-Aids
   - Gloves
   - Incontinent cleaners
   - Lotion
   - Non-sterile gauze
   - Non-sterile specimen
   - Over the counter – for skin tears
   - Personal care items
   - Sharps disposable containers
   - Tape
   - Thermometer cover
   - Vacutainers with needles

The allowable charge for revenue codes 551 and 559 for skilled nursing includes, but is not limited to, the following HCPCS/CPT codes:

<table>
<thead>
<tr>
<th>99070</th>
<th>A4330</th>
<th>A4490</th>
<th>A4640</th>
<th>A5071-A5073</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4206-A4210</td>
<td>A4335</td>
<td>A4495</td>
<td>A4649</td>
<td>A5081</td>
</tr>
<tr>
<td>A4212</td>
<td>A4364</td>
<td>A4500</td>
<td>A4663</td>
<td>A5082</td>
</tr>
<tr>
<td>A4215</td>
<td>A4398</td>
<td>A4510</td>
<td>A4670</td>
<td>A5093</td>
</tr>
<tr>
<td>A4233-A4236</td>
<td>A4402</td>
<td>A4550</td>
<td>A4770</td>
<td>A5120</td>
</tr>
<tr>
<td>A4244-A4246</td>
<td>A4421</td>
<td>A4554</td>
<td>A4913</td>
<td>A6216-A6221</td>
</tr>
<tr>
<td>A4250</td>
<td>A4450</td>
<td>A4627</td>
<td>A4927</td>
<td>A6260</td>
</tr>
<tr>
<td>A4259</td>
<td>A4452</td>
<td>A4630</td>
<td>A5051-A5055</td>
<td>E2360</td>
</tr>
<tr>
<td>A4328</td>
<td>A4455-A4456</td>
<td>A4635-A4637</td>
<td>A5061-A5063</td>
<td></td>
</tr>
</tbody>
</table>
The following is a list of modifiers that must be included with IV Therapy - Infusion Pump (Revenue Code 261):

BP  The beneficiary has been informed of the purchase and rental options and has elected to purchase the item.
BU  The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision.
BR  The beneficiary has been informed of the purchase and rental option and has elected to rent the item.
LL  Lease/Rental (use the LL modifier when DME equipment rental is to be applied against the purchase price).
NU  New Equipment.
Q0  Investigational clinical service provided in a clinical research study that is in an approved clinical research study.
RR  Rental (use the RR modifier when DME is to be used).
UE  Used durable medical equipment.
NR  New when rented (use the NR modifier when DME that was new at the time of rental is subsequently purchased).

Incident-to Billing Guidelines

Blue Cross follows the Centers for Medicare & Medicaid Services (CMS) Incident-to Guidelines for processing incident-to claims.

"Incident-to" means that services performed must be furnished as an integral, although incidental, part of a physician’s personal professional services in the course of diagnosis or treatment of an injury or illness. Services billed directly (not part of the physician's personal professional services) are not “incident-to.”

General requirements for services to be considered incident-to are as follows:

• The service provided must be reasonable and medically necessary, must be within practitioners scope of practice as defined in state law where they are licensed to practice, and performed in collaboration with a physician
• The practitioner must be an employee or independent contractor to the physician, physician’s group or physician’s employer
• Supervising physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary
• An office/clinic must have identifiable boundaries when part of another facility and services must be furnished within the identifiable boundary; where this office is one room, the physician must be in it to supervise
• Physician has performed initial service and subsequent services of a frequency that reflect his/her active participation in and management of the course of treatment
• The professional identity of the staff furnishing the service must be documented and legible

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Note: a counter signature alone is not sufficient to show that the incident-to requirements have been met.

The chart on the following pages notes E&M codes and their status under the incident-to guidelines.

<table>
<thead>
<tr>
<th>CPT Code/Service Description</th>
<th>Incident-to Eligibility/Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205 Office E&amp;M New</td>
<td>Not Allowed</td>
</tr>
</tbody>
</table>
| 99211-99215 Office E&M Established | • Notes from dates of service in addition to the date of service under review (initial office visit and subsequent visits that will establish that the physician performed the initial exam and is still very actively participating in the patient’s care)  
OR  
• Notation by supervising physician that he/she did perform the initial exam and is still actively participating in the patient’s care  

Note: If E&M service is furnished incident-to a physician’s service, but not as part of the physician’s service, the physician should bill 99211 for the service |
| 99217 Observation Care DC    | Not Allowed                       |
| 99218-99220 Care New/Established | Not Allowed                       |
| 99221-99223 Initial Hospital  | Not Allowed                       |
| 99231-99233 Subsequent Hospital | Not Allowed                       |
| 99281-99285 Emergency Room   | Not Allowed                       |
| 99291-99292 Critical Care    | Not Allowed                       |
| 99293-99300 Critical Care/Continuing Intensive Care-Neonatal | Not Allowed                       |
| 99304-99306 Unit Nursing Facility Care | Not Allowed                       |
| 99307-99310 Subsequent Nursing Facility Care | If the physician established an office within a nursing home or other institution, it must be confined to a separately identified part of the facility that is used solely as the physician’s office and cannot be construed to extend throughout the entire institution. Only services performed inside the designated office area qualify if all other incident-to requirements are met (POS on claim will be office – POS 11).  

• Notes from dates of service in addition to the date of service under review (initial office visit and subsequent visits that will establish that the physician performed the initial exam and is still actively participating in the patient’s care)  
OR  
• Notation by supervising physician that he/she did perform the initial exam and is still actively participating in the patient’s care |
<p>| 99315-99318 Nursing Facility DC Services | Not Allowed                       |</p>
<table>
<thead>
<tr>
<th>CPT Code/Service Description</th>
<th>Incident-to Eligibility/Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>99324-99328 Domiciliary, Rest Home or Custodial Care Services-New Patient</td>
<td>Not Allowed</td>
</tr>
</tbody>
</table>
| 99324-99337 Domiciliary, Rest Home or Custodial Care Services-Established Patient | If the physician established an office within a nursing home or other institution, it must be confined to a separately identified part of the facility that is used solely as the physician’s office and cannot be construed to extend throughout the entire institution. Only services performed inside the designated office area qualify if all other incident-to requirements are met (POS on claim will be office – POS 11).  
• Notes from dates of service in addition to the date of service under review (initial office visit and subsequent visits that will establish that the physician performed the initial exam and is still actively participating in the patient’s care)  
OR  
• Notation by supervising physician that he/she did perform the initial exam and is still actively participating in the patient’s care |
| 99339-99340 Domiciliary, Rest Home, Custodial Care or Home Care    | Not Allowed                                                                                         |
| 99341-99345 Home Services-New Patient                             | Not Allowed                                                                                         |
| 99347-99350 Home Services-Established Patient                   | • Notes from dates of service in addition to the date of service under review (initial office visit and subsequent visits that will establish that the physician performed initial exam and is still actively participating in the patient’s care)  
OR  
• Notation by supervising physician that he/she did perform the initial exam and is still actively participating in patient’s care  

*Note: It must be obvious in the notes for the date of service under review that the physician was physically present in the patient’s home at the time of service.* |
| 99354-99359 Prolonged Services                                   | Not Allowed                                                                                         |
| 99361-99499 Other E&M Services                                   | Not Allowed                                                                                         |
Infusion Therapy Billing Guidelines

Infusion therapy providers should adhere to the following guidelines when filing claims for Blue Cross and HMO Louisiana members.

Claim Form
• A CMS-1500 claim form is required to bill for both Home Infusion and the Infusion Suite services.

Referring Physician NPI
• The referring physician NPI number must be included on line 17b of the CMS-1500 claim form.

Authorizations
• An authorization for services may be required per the member’s benefits.
• Authorizations will always be required when nursing visits exceed two hours in duration.

It is important to file ALL applicable diagnosis codes supported by your medical record on a claim.

It is equally important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing not otherwise specified (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.

Categories of Billable Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Per Diem</th>
<th>Nursing Services</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Injectable:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-administered Drugs</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Other Drug Administration</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

Please reference the executed Reimbursement/Services Schedule of your Allied Health Provider Agreement for the billable codes and allowables. Codes not listed are considered incidental to other services billed for that member on that day. The presence of a code or fee on the schedule, such as enteral therapy is not to be interpreted as meaning that the patient has coverage or benefits for that service.

Per Diems
Per diem reimbursement is allowed only once each calendar day when the patient is receiving:
1. An actual infusion of medication through intravenous or other authorized drug delivery routes of infusion therapies, as prescribed by the ordering physician.
2. The administration of self-injectable drugs, as prescribed by ordering physician.
**Self-injectable**

Drugs considered as self-injectable may be considered eligible for benefits under the member’s drug prescription card in most cases and may not be delivered or billed by the Home Infusion Therapy provider. Some exceptions may be made for initial member training.

**Multiple per diems are reimbursable if performed concurrently and through a separate infusion administration access site.** A multiple procedure reduction will apply to these per diems and will reimburse at 20 percent of the per diem.

**For billing of per diem services, span dates may only be used for single sites. Each date of service must be billed on separate lines when billing per diems for multiple infusion administration access sites.**

**Change Items/services not separately billable:**

The following items/services are not separately billable under any circumstance:

- Pharmacy compounding fees
- Procurement and stocking of intravenous medication
- Equipment rental including pump and IV pole
- Delivery of medications, supplies, and equipment to the member’s home
- Clinical pharmacy services and kinetic dosing
- Patient care and coordination with other providers and case management if applicable
- 24 hour a day, on call availability and patient telephone consultation
- Monitoring, consultations and records maintenance by a dietician where applicable (e.g. enteral therapy)
- Waste disposal
- Medical supplies which include but are not limited to the following: needles, syringes, tubing, flushing supplies and needleless connectors and all other supplies from the injection port out. The peripheral IV start kits or IV start catheters and dressing are also included.
- Drug administration
- Postage/shipping costs
- Training and education of patient, family and caregiver
- Laboratory blood drawing and tests done by nurse
- All services including nursing and supplies associated with self-injectable drug administration

**Nursing Services**

Nursing services can be billed separately using CPT codes 99601 and 99602 (additional hours) for both home infusion and infusion suite services except for self-administered injectable drugs and their related services. A nursing service visit is defined as consecutive periods of time up to two hours during which clinical nursing services are rendered. The first two hours (99601) will be reimbursed at the per visit rate identified in your agreement. Hourly nursing charges (99602) exceeding two (2) hours require an authorization and will be reimbursed at a reduced hourly rate per your agreement terms. A nursing service
visit should be billed as one unit per visit in the Units field of the CMS-1500 claim form. When billing for additional hours beyond the nursing service visit of two (2) hours, the home infusion provider must include the number of additional hours for the services rendered in the Units field of the CMS-1500 claims form.

A nursing service visit includes but is not limited to:

- Assessments
- IV infusion and/or enteral services
- Administration of medication: PO, IM, SQ, IV and for enteral services
- Training and education of patient, family and caregiver
- Wound care management
- Patient monitoring
- Laboratory blood drawing and tests done by nurse
- Patient care and coordination with other providers and case management if applicable
- All medical equipment and supplies associated with the above services whether re-usable or non-reusable

**Drugs**

- Most drug codes are to be billed separately. Report the appropriate CPT/HCPCS and corresponding units for appropriate compensation. Listings of the allowable charges for drug codes are available under the Manuals section of iLinkBlue (www.bcbsla.com/ilinkblue).
- Renal Failure/Dialysis: when a member is receiving dialysis for treatment due to a diagnosis of renal failure from another provider, the AHP (Allied Health Provider) will not be reimbursed for infusion of drugs (for example, epogen, etc.), or other related services. Services not related to dialysis infusion therapy (for example, TPN) would be eligible for reimbursement in accordance with the Member Contract/Certificate when not performed at a dialysis center.

When a member is inpatient, the inpatient facility is responsible for billing the infusion therapy services.

**Edits**

Edits will be established to ensure only the agreed upon procedure codes are priced. If the Infusion Therapy provider bills a code not shown below, the service is considered incidental to other services billed for that member on that day and is not separately payable and the member will be held harmless. Reimbursement information can be found in Reimbursement/Services Schedule of your executed Allied Health Provider Agreement.

Standard code editing logic applies.
## List of Infusion Therapy Services

<table>
<thead>
<tr>
<th>Codes Accepted</th>
<th>Description: Therapies &amp; Conditions</th>
<th>Allowable Charge for Home Infusion &amp; Infusion Suite</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drugs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td>Drug(s)</td>
<td>Drug Allowable Charges¹</td>
</tr>
<tr>
<td><strong>Nursing Visits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99601</td>
<td>Nursing Service</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>99602</td>
<td>Nursing Service (prior approval)</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td><strong>Infusion Therapy - Antiviral/Antibiotics/Antifungal:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9497</td>
<td>Once every 3 hours, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9500</td>
<td>Once every 24 hours, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9501</td>
<td>Once every 12 hours, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9502</td>
<td>Once every 8 hours, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9503</td>
<td>Once every 6 hours, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9504</td>
<td>Once every 4 hours, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td><strong>Chemotherapy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9330</td>
<td>Continuous Chemotherapy infusion (24 hours or more), per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9331</td>
<td>Intermittent Chemotherapy infusion (less than 24 hours), per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td><strong>Hydration Solutions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9374</td>
<td>Up to one liter per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9375</td>
<td>More than one liter but no more than two liters, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9376</td>
<td>More than two liters but no more than three liters, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9377</td>
<td>More than three liters, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td><strong>Enteral Nutrition: (limited benefits, please refer to our Medical Policies)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9340</td>
<td>Home Infusion therapy, enteral nutrition, per diem</td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>B4034</td>
<td>Enter feed supkit syr by day</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4035</td>
<td>Enteral feed supp pump per diem</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4036</td>
<td>Enteral feed sup kit grav by</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4087</td>
<td>Gastro/jejuno tube, std</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4088</td>
<td>Gastro/jejuno tube, low-pro</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4149</td>
<td>EF blenderized foods</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4150</td>
<td>EF complet w/intact nutrient</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4152</td>
<td>EF calorie dense=&gt;/=1.5Kcal</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4153</td>
<td>EF hydrolyzed/amino acids</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4154</td>
<td>EF spec metabolic noninheret</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4155</td>
<td>EF incomplete/modular</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4157</td>
<td>Entral f cmpl inherited dz metabol</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4158</td>
<td>Entral f ped nutrition complete</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>B4159</td>
<td>Entral f ped nutrition cmpl soy basd</td>
<td>HCPCS Allowable Charges for DME¹</td>
</tr>
<tr>
<td>Codes Accepted</td>
<td>Description: Therapies &amp; Conditions</td>
<td>Allowable Charge for Home Infusion &amp; Infusion Suite</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>B4160</td>
<td>Enteral f ped nutritn cmpl cal dense</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td>B4161</td>
<td>Enteral f ped hydrolyzed/aa proteins</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td>B4162</td>
<td>Enteral f ped inherited dz metab</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td></td>
<td><strong>Total Parenteral Nutrition (T.P.N.)</strong></td>
<td></td>
</tr>
<tr>
<td>S9364</td>
<td>Home Infusion therapy, total parenteral nutrition (TPN), <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>B4185</td>
<td>TPN per 10 grams lipids</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td>B4189</td>
<td>TPN Protein (10-51GM)</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td>B4193</td>
<td>TPN Protein (52-73GM)</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td>B4197</td>
<td>TPN Protein (74-100GM)</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td>B4199</td>
<td>TPN Protein (Over 100GM)</td>
<td>HCPCS Allowable Charges for DME³</td>
</tr>
<tr>
<td></td>
<td><strong>Pain Management:</strong></td>
<td></td>
</tr>
<tr>
<td>S9326</td>
<td>Continuous pain management infusion (24 hours or more), <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9327</td>
<td>Intermittent pain management infusion (less than 24 hours), <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9328</td>
<td>Implanted pain management infusion, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td></td>
<td><strong>Catheter Care:</strong></td>
<td></td>
</tr>
<tr>
<td>S5520</td>
<td>Up to one liter <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S5521</td>
<td>More than one liter but no more than two liters, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td></td>
<td><strong>Other Specific Infusion Therapies or Treatments:</strong></td>
<td></td>
</tr>
<tr>
<td>S9061</td>
<td>Aerosolized drug therapy (e.g. pentamidine), <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9338</td>
<td>HIT immunotherapy, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9345</td>
<td>HIT anti-hemophil, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9346</td>
<td>HIT alpha-1-proteinas, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9347</td>
<td>HIT longterm infusion, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9348</td>
<td>HIT sympathomim, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9349</td>
<td>HIT tocolysis, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9357</td>
<td>HIT enzyme replace, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9359</td>
<td>HIT anti-tnf, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9361</td>
<td>HIT diuretic infus, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9363</td>
<td>HIT anti-spasmotic, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9490</td>
<td>HIT corticosteroid, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9538</td>
<td>HIT blood products, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
<tr>
<td>S9351</td>
<td>HIT cont antiemetic, <strong>per diem</strong></td>
<td>Agreement Allowable Charges²</td>
</tr>
</tbody>
</table>
1. Drug Allowable Charges – We perform a routine biannual review of drug and drug administration code pricing and update the reimbursement schedule for drug codes accordingly. In our review, we consider the current pricing methods for Medicare, Average Wholesale Price, Specialty Pharmacy pricing and generic drug availability along with the impact the allowable charge change may have on our network providers’ practice. One change that we are making, effective September 1, 2014, is that we will no longer publish a separate drug allowable listing for durable medical equipment and infusion therapy. We are aligning all listings to one standard listing that includes durable medical equipment and infusion therapy drug codes and allowables.

2. Agreement Allowable Charges – These are the allowable charges that are specific to your agreement with Blue Cross for services unique to infusion therapy.

3. HCPCS Allowable Charges for DME – In April of this year we notified providers of the updated allowables for HCPCS codes in the durable medical equipment (DME) category. A limited number of these codes are billable when performed by infusion providers (the presence of a HCPCS code/allowable does not mean it can be billed by infusion providers). Appropriate billing of infusion services includes only those DME HCPCS codes included in the attached billing guidelines. Claims submitted for DME HCPCS codes not included in the Infusion Therapy Services Billing Guidelines will not be considered for benefits/reimbursement and the member is NOT billable for these services. The inclusion of an allowable charge on this report does not mean that the service is necessarily covered. Coverage determinations are based on the Member’s Contract/Certificate.

### Infusion Therapy Billing Examples

#### RSV Injection Given To Patient In Home or Suite

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JXXXX</td>
<td>RSV Injection Given To Patient In Home or Suite</td>
</tr>
<tr>
<td>99601</td>
<td></td>
</tr>
</tbody>
</table>

#### Self Injectable In Home or Suite

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JXXXX</td>
<td>Self Injectable In Home or Suite</td>
</tr>
<tr>
<td>S9542</td>
<td></td>
</tr>
</tbody>
</table>

#### Chemotherapy Infusion in Home without Nurse

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JXXXX</td>
<td>Chemotherapy Infusion in Home without Nurse</td>
</tr>
<tr>
<td>S9330</td>
<td></td>
</tr>
</tbody>
</table>

#### Chemotherapy Infusion in Home with Nurse

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JXXXX</td>
<td>Chemotherapy Infusion in Home with Nurse</td>
</tr>
<tr>
<td>S9330</td>
<td></td>
</tr>
<tr>
<td>99601</td>
<td></td>
</tr>
</tbody>
</table>

#### Drug Infusion in Suite Over 2 Hours

*Note: additional nursing requires prior authorization*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JXXXX</td>
<td>Drug Infusion in Suite Over 2 Hours</td>
</tr>
<tr>
<td>SXXXX</td>
<td></td>
</tr>
<tr>
<td>99601</td>
<td></td>
</tr>
<tr>
<td>99602</td>
<td></td>
</tr>
</tbody>
</table>
**In-Office Procedure Guidelines**

Blue Cross does not recognize, nor do we reimburse separately for, a “facility fee” or “treatment room” fee in an office setting as this is included in the overhead component of the professional service(s) the member is receiving. Consistent with our policies regarding services that are an integral part of another service, there should be no separate charge to the member for a “treatment room” or “facility fee.”

Utilizing outside companies to supply services to physicians performing certain surgeries and procedures in the physician's office is not covered by Blue Cross and is not billable to our members.

The facility fees charged by these companies are not covered, even when they are billed by or through a network physician. Not all of the companies nor the physicians' offices utilizing these companies, are licensed by the Louisiana DHH as ambulatory surgery facilities. Thus, none are eligible for benefit payment for these facility charges.

For any eligible in-office procedures you normally perform, you should accept your contracted allowable charge as payment in full. Do not submit claims for the services of these outside companies to Blue Cross.

Please ensure that your Blue Cross patients are able to receive network benefits for the service they receive from you by using participating providers. Use of or referral to non-network providers to deliver facility and procedure services will result in your patients incurring additional costs for those facility/procedure charges and is a violation of your participating provider agreement.

**Laboratory Billing Guidelines**

**Using Preferred Reference Labs**

All providers participating in the Preferred Care PPO network **must** refer members to preferred reference lab vendors when lab services are needed and are not performed in the provider’s office. Physicians who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts.

Please refer to the preferred lab requirements listed below to ensure your patients with Preferred Care PPO coverage receive the maximum benefits to which they are entitled. A list of preferred reference labs that **must** be used is also included in this manual.

---

**Online Preferred Reference Lab Speed Guides**

[www.bcbsla.com/providers](http://www.bcbsla.com/providers) > Education on Demand
Preferred Labs
We use a preferred lab program with multiple statewide and regional lab vendors. Laboratory services provided to Preferred Care PPO Louisiana members must be submitted to one of the following labs:

<table>
<thead>
<tr>
<th>Statewide Preferred Reference Lab Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology Labs</td>
<td>1-800-595-1275</td>
</tr>
<tr>
<td>Laboratory Corporation of America (LabCorp)</td>
<td>1-800-621-8037</td>
</tr>
<tr>
<td>Quest Diagnostics</td>
<td>1-800-MYQUEST (1-866-697-8378)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Preferred Reference Lab Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baton Rouge Region</td>
<td></td>
</tr>
<tr>
<td>Mobile Tech Medical, Inc.</td>
<td>(225) 267-6860</td>
</tr>
</tbody>
</table>

| Lafayette Region                               |                                 |
| Acadiana Family Practice Lab, Inc.            | (337) 334-7558                  |
| Acadia Laboratory LLC                          | (337) 783-0961                  |
| Eunice Medical Laboratory, Inc.               | (337) 457-5562                  |

| Lake Charles Region                            |                                 |
| The Pathology Laboratory                       | (337) 436-9557                  |

| New Orleans Region                             |                                 |
| Advanced Clinical Laboratory                   | (504) 520-8970                  |
| Laboratory Management Services                 | (318) 841-9526                  |
| Morgan City Lab & X-Ray                        | (985) 384-3848                  |
| Physicians Group Laboratories LLC              | (985) 872-5572                  |

| Shreveport Region                              |                                 |
| Drs Lab                                        | 1-800-828-9227                  |

*Please note* that this is the current list of preferred statewide and regional reference labs as of the date this manual was published. To view the most current list of preferred labs, visit our website at [www.bcbsla.com/providers](http://www.bcbsla.com/providers) >Doctor & Hospital Search and enter the member’s ID number or network, City, Parish or Zip, type Laboratory for Specialty or Keyword and click search.

Requirements for PPO and HMO Louisiana Providers
Laboratory services provided to PPO members must be submitted to preferred reference labs, if not performed in your office. Some laboratory services may be covered under the member’s office copayment. Preoperative lab services rendered before an inpatient stay or outpatient procedure may be
performed by Preferred Care PPO or HMO Louisiana participating hospitals or the member’s selected hospital but otherwise should be sent to one of our preferred reference labs.

If you perform laboratory testing procedures in your office, we require that a copy of your Clinical Laboratory Improvement Act (CLIA) certification be provided along with your Louisiana Standardized Credentialing Application when applying for credentialing or recredentialing with Blue Cross.

**Working With Preferred Reference Labs**

Contact preferred reference labs directly to obtain the necessary forms for submitting lab services for your PPO patients.

Physicians who do not collect specimens in their offices may refer their PPO patients to a preferred reference lab draw site. You may use our online provider directories available at www.bcbsla.com or the list included in this manual to locate preferred reference lab draw sites. No specimen collection billing would be appropriate in this situation.

**Out-of-state Labs**

If you refer your patients to a reference lab that is not in Louisiana, the out-of-state reference lab must be a participating provider for the member’s plan in the state where the specimen is drawn in order for the member to receive the highest level of member benefits. If you are collecting the specimen* and sending the specimen to an out-of-state reference lab, you need to ensure that the out-of-state reference lab you are using is participating with Blue Cross and Blue Shield of Louisiana, otherwise your patient will be subject to a much higher cost share for this service. In addition, using a non-participating reference lab could subject you to a lower allowable charge.

**Ordering Physician Requirements**

The ordering/referring provider NPI is required on all laboratory claims otherwise the claim will be returned requesting that the claim be refiled with the ordering provider’s NPI number. If you are CLIA certified to provide lab services in your office and you are billing Blue Cross for these services, please include the ordering provider NPI information on the claim form. For more information on NPIs, visit www.bcbsla.com/providers >NPI.

Place the NPI in the indicated blocks of the referenced claim forms:

- CMS -1500: Block 17A
- UB-04: Block 78
- 837P: 2310A loop, using the NM1 segment and the qualifier of DN in the NM101 element
- 837I: 2310D loop, segment NM1 with the qualifier of DN in the NM101 element

**Scenario**

An independent laboratory receives and processes the Louisiana member’s blood specimen. The member’s blood was drawn in Louisiana* but processed in Texas by a reference lab. The out-of-state
reference lab should file the claim to Blue Cross and Blue Shield of Louisiana; the service area where the specimen was drawn. The Texas reference lab should be participating with Blue Cross and Blue Shield of Louisiana in order for the member to receive the highest level of benefits.

*Where the specimen was drawn will be determined by which state the referring provider is located.*

**Pass-Through Billing Not Permitted**
Pass-through billing occurs when the ordering provider requests and bills for a lab service, but the lab service is not performed by the ordering provider or the CLIA-certified lab owned and operated by the ordering provider. The expectation is that we will receive lab claims billed from:

- The performing provider at a CLIA-certified lab, owned and operated by the ordering physician, or
- The ordering provider who owns and operates a CLIA-certified lab, or
- An in-network reference lab

Blue Cross and HMO Louisiana do not permit pass-through billing. Only the performing provider should bill for these services. You may only bill for lab services that you perform in your office. Providers may bill for the following indirectly performed services:

- The service of the performing provider is performed at the place of service of the ordering provider and is billed by the ordering provider, or
- The service is provided by an employee of a physician or other professional provider (e.g. physician assistant, surgical assistant, advanced practice nurse, clinical nurse specialist, certified nurse midwife or registered nurse first assistant), who is under the direct supervision of the ordering provider and the service is billed by the ordering provider.

**Urine Drug Screens**
Laboratory providers are classified as independent allied providers who are CLIA certified for the sole purpose of performing laboratory services. Laboratory providers who perform urine drug screens using instrumented systems should report the following codes:

*These procedures are limited to one unit per date of service.*

- **80100** (Drug screen)
- **G0431** (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay, per patient encounter))

We will only reimburse for one test when a single testing mechanism is used to screen for multiple drug classes.

*This procedure is limited to one unit.*

- **80101** (Drug screen)

**Please Note:** Only positive qualitative drug screens can be confirmed with quantitative drug confirmation codes. Only one unit for each drug confirmation test will be allowed.
Routine periodic audits will be performed. Providers discovered to be billing inappropriately will be subject to a more detailed review and possible recoupment of overpayment.

**Specimen Collection/Handling Fee**
To compensate physicians for their time and effort associated with collecting specimens and handling lab tests sent to preferred reference labs, physicians may be paid a specimen collection handling fee per member/per visit when no other in-office lab tests are performed and billed on the same day. To be paid the specimen collection handling fee, you must bill CPT code 36415 or 99000. Please note: If you perform the lab test(s) in your office and send out any lab test(s) on the same date of service, you are not eligible to bill and receive separate reimbursement for specimen collection.

**Special Arrangements**
Special arrangements for weekend or after-hour pickups may not be available at all preferred reference labs. Please contact the preferred reference labs directly to make special arrangements.

**Provider Inquiries and Satisfaction**
Providers can access member’s benefits, eligibility and allowable charges using the iLinkBlue. If you have questions regarding a member’s coverage, please call Provider Services at 1-800-922-8866. Please let us know if any quality issues arise so we can work with the appropriate lab to improve service and ensure that you and your patients receive the service you expect and deserve.

**Nurse Practitioner Billing Guidelines**
Nurse practitioners are eligible to participate in our Preferred Care PPO and HMO Louisiana networks. Nurse practitioners who join our networks must complete the credentialing process. Nurse practitioners who participate in our networks must also follow the Incident-to Guidelines contained in this manual when performing services in conjunction with a physician. Nurse practitioners who perform services independently, or at a freestanding facility should file claims with their individual NPI.

**Off-campus Services Billing Guidelines**
Effective January 1, 2016, there will be separate place of service codes for on campus and off-campus services that should be reported.

- Report place of service code 19 when a patient obtains services from a portion of the hospital’s off-campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons but does not require hospitalization or institutionalization.

- Report place of service code 22 when a patient obtains services from a portion of the hospital’s main campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons but does not require hospitalization or institutionalization.
Physical & Occupational Therapy Re-evaluation Billing Guidelines

Blue Cross’ standard for billing physical or occupational therapy evaluations allows a patient an initial therapy evaluation. However, a re-evaluation is covered once every three months. Should the patient’s diagnosis significantly change, the re-evaluation can be allowed sooner than the standard three-month waiting period.

Rural Health Clinic and Federally Qualified Health Clinic Billing Guidelines

Blue Cross and Blue Shield of Louisiana defines a rural health clinic (RHC) as a medical clinic located in a rural (not urban) area for the purpose of providing healthcare services to persons in the rural area. The purpose is to service an area that does not otherwise have healthcare services available (medically underserved area). RHCs may be a primary care practice (offers at least one of the following: family practice, general practice, internal medicine or pediatric services).

Blue Cross defines a federally qualified health clinic (FQHC) as a medical clinic located in a rural or urban area for the purpose of providing healthcare services to persons who are not otherwise eligible for healthcare coverage and/or in a medically underserved area. FQHCs must provide primary care for all life-cycle ages; therefore specialty practices such as pediatric- or geriatric-only clinics are not eligible for FQHC status.

We require that each healthcare professional associated with a RHC or FQHC be individually credentialed, allowing us to identify each provider in our directories. Claims should be reported based on the services provided by each individual healthcare professional within the clinic. Additionally, the rendering/performing providers’ NPI must be reported on RHC/FQHC claims.

The allowable charges for RHC and FQHC services are based on each individual performing provider’s specialty. Services are not reimbursed at the clinic level. Use iLinkBlue (www.bcbsla.com/ilinkblue) to view and research your allowable charges.

On the next page are Blue Cross’ requirements as they apply for RHCs and FQHCs:
<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorizations</td>
<td>• Authorizations are required for some services per the member’s benefits. See the Medical Management section of this manual for the list of services that require an authorization. You may also use iLinkBlue (<a href="http://www.bcbsla.com/ilinkblue">www.bcbsla.com/ilinkblue</a>) to verify if services require an authorization or view the list of services that require an authorization in our network speed guides (available online at <a href="http://www.bcbsla.com/providers">www.bcbsla.com/providers</a> &gt; Education on Demand).</td>
</tr>
<tr>
<td>Claims Filing</td>
<td>• Use a CMS-1500 claim form. • File claims electronically through your clearinghouse or iLinkBlue (<a href="http://www.bcbsla.com/ilinkblue">www.bcbsla.com/ilinkblue</a>). • Report the individual services performed at the RHC/FQHC. • Effective for claims with a date of service on and after January 1, 2015, report the individual provider’s name and NPI as the rendering provider on claims (block 24J of the CMS-1500 claim form or the electronic equivalent). • File claims hardcopy, only when unable to bill electronically. • File ALL applicable diagnosis codes on a claim. It is important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing “not otherwise specified” (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>RHCs and FQHCs that provide laboratory tests/services on site must comply with CLIA requirements for the actual services delivered.</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>RHCs must provide medical emergency procedures as a first response to common injuries and acute illnesses, the same as what is commonly provided by a physician’s office. FQHCs are required to provide emergency care either on site or through clearly defined arrangements for access to healthcare for medical emergencies during and after the regularly scheduled hours (24/7).</td>
</tr>
<tr>
<td>After-hours Coverage</td>
<td>Network providers are responsible for assuring access of services 24 hours a day, 365 days a year. This includes arrangements to assure coverage after hours by another participating physician.</td>
</tr>
<tr>
<td>Member Benefits</td>
<td>Blue Cross applies the member’s primary care provider level benefits instead of referral specialist benefits, regardless of the provider type and/or specialty. <em>Still, members’ benefits may vary so please always verify eligibility and benefits prior to rendering services. Member benefits are available anytime on iLinkBlue (<a href="http://www.bcbsla.com/ilinkblue">www.bcbsla.com/ilinkblue</a>).</em></td>
</tr>
<tr>
<td>Credentialing</td>
<td>Refer to the Credentialing Program section of this manual for full information on the individual/professional credentialing process and requirements.</td>
</tr>
<tr>
<td>Provider Directories</td>
<td>Each healthcare professional associated with a RHC or FQHC is separately listed in our provider directories based on their specialty. This is in addition to the RHC/FQHC being listed in our directories.</td>
</tr>
</tbody>
</table>
Home Sleep Study Services for Obstructive Sleep Apnea (OSA)

When benefits are available, Blue Cross considers home sleep to be eligible for coverage. Home Sleep Studies (HST) do NOT require authorization, except for a few ASO groups. Make sure to check the members Prior Authorization requirements prior to providing services.

Patients without any type of comorbidities and are over the age of 18 will be directed to a HST.

Uncomplicated OSA patients diagnosed with a HST will be required to utilize an APAP (Auto-Titrating/Auto-adjusting CPAP) trial in the home setting.

Billing Guidelines for Home Sleep Study Services for OSA

Use the guidelines below to ensure proper reimbursement and avoid denied or returned claims. Always verify member benefits prior to performing this or any other service as benefits may vary for some of our self-funded groups.

CPT codes 95800, 95801, and 95806 are not appropriate codes for billing home sleep study services.

Credentialing Requirements for Network DME Providers Performing Home Sleep Studies

Blue Cross recognizes two types of durable medical equipment (DME) providers: full-service DME providers and sleep study DME providers. A full list of acceptable accreditation organizations for full service DME providers can be found in the DME section of this manual.

Blue Cross requires that sleep study DME providers must be accredited by at least one of the following organizations in order to participate in our provider networks:

- The Joint Commission (TJC);
- American Academy of Sleep Medicine (AASM); or
- Accreditation Commission for Healthcare (ACHC)

Sleep Study Billing Guidelines

Sleep lab facilities, DME providers and physicians should adhere to the following guidelines when filing claims for Blue Cross and HMO Louisiana members:

Facility Based Polysomnograms/Sleep Studies

 Eligible Sleep Lab Facilities

- Free standing accredited sleep labs (non-hospital based)
- Hospital-based accredited sleep lab
Sleep studies payment eligibility when:
- Services are performed in accredited sleep lab
- Services are medically necessary

Authorization and Accreditation Required for Sleep Lab Services
All Blue Cross and HMO Louisiana member policies, issued or renewed, require authorization for sleep lab services. It is required that facility based sleep studies be performed in an accredited sleep center. Authorizations are not to be issued by Blue Cross to non-accredited sleep lab providers. Call the Blue Cross Authorizations line at 1-800-523-6435 to obtain authorization for sleep lab services.

InterQual criteria are used in the authorization process to determine medical necessity. Unauthorized facility based sleep study services are not eligible for benefits. Please verify member eligibility for sleep study services as authorization is not a guarantee of benefits.

Sleep Lab InterQual Guidelines
When benefits are available, InterQual (IQ) criteria are used to determine if a sleep lab service is eligible for coverage. Medical records such as progress notes and Epworth sleepiness scales may be required in reviewing authorization requests.

Patients with complicated comorbidities such as congestive heart failure, chronic obstructive pulmonary disease, central sleep apnea syndromes, and hypoventilation syndromes associated with obesity, chronic opioid use, and neuromuscular disease affecting respiration will be considered for a facility based sleep study.

Network Requirements & Reimbursement
Sleep centers must meet all credentialing criteria to be eligible for Blue Cross and HMO Louisiana network participation including specific sleep center accreditation by either:
- The Joint Commission (TJC);
- American Academy of Sleep Medicine (AASM); or
- Accreditation Commission for Healthcare (ACHC)

In order for the medically necessity of facility based sleep studies to be considered for authorization and maximum member benefits, services must be performed by an in-network accredited free-standing or hospital-based sleep lab that has been surveyed and approved by TJC, AASM or ACHC.

For more information regarding the credentialing process, visit [www.bcbsla.com/providers >Credentialing](http://www.bcbsla.com/providers/Credentialing) or call Network Administration at 1-800-716-2299, option 2.
**Coding and Claims Filing**

Total or technical-only components are allowed if billed by an accredited sleep lab and are medically necessary based on IQ criteria.

The professional component of a medically necessary facility based sleep study may be billed by a physician in accordance with CPT guidelines.

Free-standing sleep centers and rehabilitation and long term acute care facilities with sleep labs should use “office” as the place of service (POT 3) along with their Blue Cross sleep studies provider number when filing claims.

Acute care hospital-based sleep labs should use “outpatient hospital” as the place of service (POT 2) and the hospital’s Blue Cross acute care provider number when filing claims. Please do not use other ancillary provider numbers, such as “rehab.” Sleep study services filed with a provider number other than the hospital’s acute care provider number will not be considered as eligible providers for sleep lab services.

Sleep lab facilities should use the appropriate CPT or HCPCS codes when submitting sleep study services.

**Specialty Pharmacy Billing Guidelines**

Specialty Pharmacy typically involves the use of specialized therapeutics and biologicals for chronic, complex and/or rare diseases, ordered by a healthcare professional as defined by the plan.

Specialty Pharmacy generally includes injectables, infusion therapies and certain oral medications that require complex and/or advanced care methodologies. Examples of major conditions these drugs treat include, but are not limited to, cancer, HIV/AIDS, rheumatoid arthritis, multiple sclerosis and hemophilia.

Specialty pharmacy providers should adhere to the following guidelines when filing claims for Blue Cross and HMO Louisiana, Inc. members regardless of the date of service.

- Specialty pharmacies must be directly contracted with Express Scripts, Inc. (ESI) before consideration for participation in our networks can be made.
- Specialty Pharmacy services that are covered under the Blue member’s medical benefits should be filed directly to the local Blue Plan as determined by the referring/ordering physician’s location, on a CMS-1500 claim form or 837 Professional Electronic Submission.
  - Report HCPCS for the appropriate specialty pharmacy drug(s)
  - Include appropriate diagnosis coding to the highest level of specificity. Non-specific diagnosis may cause delay in claims adjudication.
  - Do not report administration fees separately
  - Do not report supplies separately
- Specialty Pharmacy services that are covered through the Blue member’s pharmacy benefits should be filed directly to their pharmacy carrier.
- The referring physician must be a Louisiana provider to file claims directly to Blue Cross.
• The referring physician NPI number must be included on line 17b of the CMS-1500 claim form or loop2310A on electronic submissions. Failure to include the referring/ordering physician’s NPI will result in your claims being returned without adjudication.
• An authorization for services may be required per the member’s benefits.
• Blue Cross reviews the reimbursement of our drug code pricing biannually. Providers are notified 90 days prior to the effective date of reimbursement changes. Listings of our drug allowables are available on iLinkBlue (www.bcbsla.com/ilinkblue) under the Manuals section, then click on “Allowable Charges.”

Ancillary Billing Guidelines for BlueCard® Claims

Definitions:
Ancillary Provider - Specialty Pharmacies located within Blue Cross’ service area are classified as ancillary providers as they have a unique opportunity to contract with other Blue plans and provide services outside of Louisiana.

Remote Provider - Specialty pharmacies located outside of Blue Cross’ service area that are contracted with BCBSLA under a license agreement to act as a local provider solely for services rendered in our service area.

Where to File Claims
• The local plan is determined as the plan in whose service area the referring/ordering physician is located.
• If a remote provider contract is in place with the local plan, the claim must be filed to that plan, and it would be considered a participating provider claim.
• If a remote provider contract is not in place with the local plan, the claim must be filed to that plan, and it would be considered a nonparticipating provider claim.

Examples
Example 1: A specialty pharmacy in Louisiana receives a prescription order for a non-routine, biological therapeutic drug for a Blue Cross member who lives in Tennessee. The drug is ordered by a Tennessee provider. The drug is then shipped to the Blue Cross member living in Tennessee. The claim should be filed in Tennessee; the service area where the drug was ordered based on the ordering physician’s location.

Example 2: A specialty pharmacy in Louisiana receives a prescription order for a non-routine, biological therapeutic drug for a Blue Cross member who lives in Louisiana but who has a referring/ordering physician in Texas. The drug ordered by the Texas physician would be filed to Texas.

Example 3: A specialty pharmacy in Louisiana receives a prescription order for a non-routine, biological therapeutic drug for a Blue Cross member who lives in Louisiana and who has a referring/ordering physician in Louisiana. The drug ordered by the Louisiana physician would be filed to Louisiana.
Telemedicine Billing and Reimbursement Guidelines

Coverage is subject to the terms, conditions and limitations of an individual member contract and policy criteria listed below.

Description

Blue Cross defines telemedicine services as the healthcare delivery, diagnosis, consultation, treatment and transfer of medical data by a network physician or nurse practitioner (herein referred to as “provider”) using interactive telecommunication technology that enables the network provider and the member at two locations separated by distance to interact via two-way video and audio transmission simultaneously. Telemedicine does not include the use of audio-only telephone, facsimile machine or email.

Telemedicine is used to support healthcare when the provider and patient are physically separated. Typically, the patient communicates with the provider via an interactive means that is sufficient to establish the necessary link to the provider who is working at a different location from the patient. This section documents Blue Cross’ position on services defined as telemedicine and identifies when these services may be eligible for reimbursement.

Policy

Reimbursement for telemedicine services may be available when provided through BlueCare (Blue Cross’ telemedicine platform) or when provided by a network provider utilizing their own telemedicine platform, however, the billing rules may be different for each scenario, as discussed in the Coding and Billing section below. The appropriate place of service is based on where the member is located when the service is performed.

1. Real time (synchronized) telemedicine services may be eligible for reimbursement under the Member contract when such services are equivalent to similar in-person (face-to-face) services. Reimbursement for telemedicine services is limited to services involving the use of interactive audio-video or other interactive electronic media for the purpose of diagnosis, consultation or treatment, and for those codes as listed in these guidelines.

2. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telemedicine services. A provider rendering in-person services at the presentation/origination site should report the appropriate code for the in-person services.

3. The following are examples of services that are not eligible for reimbursement as telemedicine services:
   - Non-direct patient services (e.g. coordination of care rendered before or after patient interaction).
   - Services rendered by audio-only telephone communication, facsimile, email or any other non-secure electronic communication.
   - Any services that are not eligible for separate reimbursement when rendered to the patient in-person.
• Presentation/origination site facility fee.
• Services/Codes that are not specifically listed below.

**Coding and Billing**

Reimbursement for telemedicine services may be available when provided through 1) BlueCare; or 2) when provided by a Blue Cross provider utilizing their own telemedicine platform, however, the coding requirements differ for each.

1. BlueCare allows members the opportunity to speak with a provider, ask questions and get diagnoses using a home or office computer, smartphone, tablet or other Internet-accessible device.
   a. For those providers who are contracted directly with our third party vendor to provide on-demand telemedicine services to Blue Cross members and who utilize and bill through the BlueCare platform, the following CPT code is eligible for reimbursement:
      **CPT Code:**
      • 99444
   b. For those Quality Blue providers who utilize the BlueCare platform to provide telemedicine services to Blue Cross members, but who bill through the Quality Blue providers electronic claims filing system, the following CPT codes/code ranges and HCPCS codes, along with Modifier GT, are eligible for reimbursement. These are the codes that ordinarily describe direct face-to-face services, but also signify telemedicine services when used with Modifier GT:
      **CPT Codes:**
      • 99201
      • 99202
      • 99211
      • 99212
      • 99495
      • 99496
      • 97802
      • 97803
      • 90832
      • 90833
      • 90834
      • 99406
      • 99407
      **HCPCS codes:**
      • G0436 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
      • G0437 – Smoking and tobacco cessation counseling visit for the asymptomatic patient;
2. For those providers providing telemedicine services utilizing their own telemedicine platform, the following CPT codes/code ranges and HCPCS codes, along with Modifier GT, are eligible for reimbursement. These are the codes that ordinarily describe direct face-to-face services, but also signify telemedicine services when used with Modifier GT:

**CPT Codes:**
- 99201
- 99202
- 99211
- 99212
- 99495
- 99496
- 97802
- 97803
- 90832
- 90833
- 90834
- 99406
- 99407

**HCPCS codes:**
- G0436 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
- G0437 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes
- G0446 – Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
- G0447 – Face-to-face behavioral counseling for obesity, 15 minutes

**Note:** All other codes are not eligible for reimbursement and will be denied as not Medically Necessary in that Blue Cross has determined that it is not clinically and medically appropriate to deliver the service via a telemedicine encounter. The provider may not bill a member for services determined to be not Medically Necessary.
Other Requirements

- The telemedicine encounter must be fully documented (including all supporting diagnosis codes) in the patient’s medical record, just as if the patient were seen in person.
  - For new patients, the provider must establish a medical history.
  - For existing patients, the provider must maintain and update the member’s medical history.
  - If the attending provider is not the patient’s primary care physician (PCP), the patient’s medical records should be made available to the patient’s PCP.
- The attending provider must be licensed to practice medicine in the state where the member is located.
- The attending provider must be able to prescribe medication, as applicable, or have staff on hand that can prescribe medication in the state where the member is located.
- Use the most specific diagnosis codes(s) when filing the claim.
- Prescribing controlled substances during a telemedicine encounter is not permitted.
- Reimbursement for telemedicine services are based on each performing provider’s agreed-upon Allowable Charge and the member’s applicable benefits.
- Authorizations are required for some services per the member’s benefits. See the Medical Management section of this manual for the list of services that require an authorization or use iLinkBlue (www.bcbsla.com/ilinkblue) to verify if services require an authorization.

Note: These Telemedicine Billing and Reimbursement Guidelines do not apply to physician to physician telemedicine or telehealth consultation/services rendered in an inpatient hospital, outpatient hospital or emergency room setting.

Urgent Care/After Hours Centers Billing Guidelines

Blue Cross recognizes Urgent Care/After Hours Centers as establishments that are similar to physician offices. We realize that physicians could rotate out of the office; therefore, we contract with Urgent Care/After Hours Centers as a group and do not contract individually with any physician who may practice at the center.

An Urgent Care Center is a clinic with extended office hours that provides urgent and minor emergency care to patients on an unscheduled basis without the need for an appointment. Extended office hours include being open Monday through Friday until at least 8 p.m. and at least eight (8) hours either Saturday or Sunday. A physician must be on site. The clinic cannot be part of a participating network Primary Care Physician or Specialist’s regular practice or hospital emergency room. The Urgent Care Center does not provide routine follow-up care or wellness examinations. Patients will be referred (through the normal referral process) back to their primary physician for such follow-up care.

Urgent care is defined as a sudden, acute and unexpected medical condition that requires timely diagnosis and treatment, but does not pose an immediate threat to life or limb. Examples of urgent care or routine care that do not qualify as emergencies include: colds and flu, sprains, stomachaches, nausea.
Reimbursement for services provided in the Urgent Care/After Hours setting is consistent with the reimbursement for services rendered in a physician’s office. CPT/HCPCS codes are used to identify the services performed and the CMS-1500 claim form or the electronic equivalent is used to submit a claim for reimbursement. Blue Cross does not recognize, nor do we reimburse separately for, a “facility fee” or “treatment room” fee in these settings as this is included in the overhead component of the professional service(s) the member is receiving. Consistent with our policies regarding services that are an integral part of another service, there should be no separate charge to the member for a “treatment room” or “facility fee.”

To assure that your claims get processed quickly and accurately, please follow these guidelines:

**S9088** – Services provided in an urgent care center (list in addition to code for service). Urgent Care/After Hours Clinics should not bill this code for a “facility fee” or “treatment room” fee. The intent of this code is informational only and identifies the setting or place of treatment where the urgent care or after hours service(s) were performed. S9088 will not be separately reimbursed nor should the member be billed for this code. This is consistent with our policies regarding services that are an integral part of another service.

**99050** – This code is separately reimbursed when the service provided is outside of the facility’s regularly scheduled “posted hours” of operation. For example, if the facility is regularly opened Monday through Friday, 9 a.m. to 9 p.m., and the physician is requested to see a patient in the urgent care center at 10 p.m. on a Wednesday night, then the physician may report 99050 in addition to the appropriate evaluation and management code. The medical record should reflect the medical necessity and services rendered.

**99051** – Blue Cross does not intend to reimburse a provider additionally for seeing patients during their regularly scheduled hours of operation. CPT code 99051 will not be separately reimbursed. Any “after hours” services that may be appropriate to identify separately, are meant to be defined as after the normal operating office hours of the urgent care center.

**99053** – Urgent care centers are generally not set up to operate as a 24-hour facility. CPT code 99053 will not be separately reimbursed.

**Blue Cross policy for after hours CPT codes**

After hours Physicians’ CPT codes are reimbursed as follows:

- 99050 pays separately when billed with one of the following E&M codes: 99201 - 99215
- 99056 and 99058 pay separately when billed with one of the following E&M codes: 99241 - 99245

After hours CPT codes are only reimbursed separately when submitted with the E&M codes listed above. The provider’s documentation should support the need for these services.

CPT codes 99051, 99053 and 99060 are not reimbursed separately.
Section 7
FEDERAL EMPLOYEE PROGRAM

The Federal Employee Program (FEP) Service Benefit Plan is based on a Preferred Provider Organization plan that has benefit incentives encouraging the use of Preferred Care PPO providers. FEP members may choose from two types of coverage: Standard Option and Basic Option.

**Standard Option**
With Standard Option, members do not need referrals for any provider, including out-of-network providers. However, if a member chooses to use non-Preferred Care PPO providers, their out-of-pocket expenses will be greater.

**Office Visits:** Members have a $25 copayment when they see a Preferred Primary Care provider. If members go to a specialist, they have a $35 copayment for the office visit.

**Routine Physicals and Screenings:** Members are covered at 100 percent for periodic routine physicals performed by preferred providers. During these visits, members are also covered at 100 percent for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings. Preventive care benefits are limited to one per calendar year.

**Maternity Care:** Members pay nothing for covered physician and hospital services related to maternity care when they use Preferred Care PPO providers. Well child visits are paid in full.

**Basic Option**
With Basic Option, members must use preferred providers for all their medical care. Benefits are only available for care provided by non-network providers in certain situations, such as emergency care. Under Basic Option, there is no calendar year deductible. Basic Option benefits are paid in full or in full after members pay a copayment amount when they use Preferred Care PPO providers.

**Office Visits:** Members have a $30 copayment for office visits to PCPs. If members go to a specialist, they pay $40 for the office visit.

**Routine Physicals and Screenings:** Members are covered at 100 percent for periodic routine physicals performed by preferred providers. During these visits, members are also covered at 100 percent for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings. Preventive care benefits are limited to one per calendar year.

**Maternity Care:** Members pay nothing for covered pre-natal and post-natal care rendered by a Preferred Care PPO provider. Benefits for the inpatient hospital admission to a Preferred Care PPO hospital for the delivery are paid in full, after the member pays a $175 copayment. Well child visits are paid in full.
Cancer Screening
There are no age or frequency limitations applicable to covered cancer screenings.

Provider Tips
• Determine the member’s financial responsibility by contacting the customer service department listed on the back of the member’s ID card before requesting payment.
• Ask members for their ID card regularly.
• First check eligibility and benefits through iLinkBlue. Or, call the FEP dedicated customer service line at 1-800-272-3029.

FEP Non-Network or No Network Claims Processing
Blue Cross pays FEP members directly for all services performed by any provider who does not have a contract with us.

There are two classifications of non-contracted providers:

1. A non-participating provider is defined as one that has chosen not to sign a contract with Blue Cross.
2. A non-network or no network provider is a provider/specialty type that Blue Cross does not offer contracts to.

Claims Submission and Contact Information
FEP Customer service
📞 1-800-272-3029  🌐 www.fepblue.org

Claims Address
All completed claim forms for FEP claims should be forwarded to the following addresses for processing:

Blue Cross and Blue Shield of Louisiana – FEP Claims
 pó Box 98028
Baton Rouge, LA 70898-9028

For FEP Q & A and other information, see our website, www.bcbsla.com/FederalEmployees.
Section 8
MEDICAL MANAGEMENT

Overview
Medical management is a system for a comprehensive approach to healthcare delivery. Blue Cross established the Care Management Department to ensure that our members receive the highest quality healthcare that is medically appropriate and cost-effective. See the end of this section for an overview of our Quality Management Program.

Utilization Review Organization
Blue Cross is authorized as an Utilization Review Organization (URO) and therefore follows the regulations promulgated by the Department of Insurance that governs these entities. However, certain employer groups, primarily self-funded employer groups and the Federal Government plan, are not subject to the legislation that created these regulations. Since Blue Cross handles a wide range of fully funded and self-funded employer groups, it is not possible to have a uniform policy in all instances. The following descriptions note where differences occur.

Authorization Process
The authorization process ensures that members receive the highest level of benefits to which they are entitled and that the most appropriate setting and level of care for a given medical condition are provided.

A Blue Cross nurse reviews all pertinent information submitted by physicians and providers and applies defined criteria to determine if a service is medically appropriate. The criteria used by the nurses is reviewed and approved by physicians at least annually, and more often if indicated. If the information received from a physician or other provider varies from the defined criteria, a nurse will forward the information for review by a Blue Cross physician.

Pre-service Authorizations
A pre-service authorization is the review and authorization of a procedure prior to the service being rendered. The medical necessity and appropriateness of selected surgical procedures, selected diagnostic procedures and various other services are reviewed prior to the service being performed. A listing of services that require authorization is provided in this manual. Authorization requirements may vary slightly by product. The following describes the process and procedural steps for obtaining pre-service authorizations:

- The provider must initiate the authorization process at least 48 hours prior to the service by contacting the Authorization Unit:
  Phone: 1-800-523-6435
  Fax: 1-800-586-2299
The Authorization Coordinator will request the following information:
1. Patient/Member name, date of birth, BCBS ID/contract number;
2. Physician’s name, NPI, address and telephone number;
3. Name of the facility at which the service will be rendered;
4. Anticipated date of service;
5. Requested length of stay (if applicable);
6. Diagnosis (to include ICD-10-CM codes), procedures (CPT and/or HCPCS codes), plan of treatment, medical justification for services or supplies and complications or other factors requiring the requested setting; and
7. Caller’s name and phone number.

The initial request received prior to a scheduled inpatient admission or outpatient procedure is classified as a pre-service authorization. Decisions are made within 15 calendar days of receipt of claim, regardless of whether all information is received.

If the request is approved, the contact person is notified within 24 hours of the determination. Confirmation for continued hospitalization or services includes the date of admission or onset of services, the number of extended days or units of service, the next anticipated review point, and the new total number of days or services approved. Types of notification include verbal (by telephone at the time of the call) voice mail or electronic means including email and fax. A letter of confirmation is also sent to the member, physician and hospital, if applicable, within two working days of the decision being made.

If the decision is to non-certify the authorization, the contact person is notified of the principal reasons for determination not to certify and appeal rights verbally (by telephone or voice mail) within 24 hours of the determination. A non-certification letter is sent to the member, physician and hospital, if applicable, within one working day of the decision. The letter will list appeal rights based on regulatory guidelines.

**Urgent Care Authorizations**

- The initial request for authorization of an urgent illness is processed as soon as possible based on the clinical situation, or within 72 hours of the request regardless of whether all information is received.
- If the request is approved, the contact person/practitioner is notified by telephone and a confirmation letter is sent to the member, physician and hospital, if applicable.
- If the request is denied, the contact person is notified by telephone and is given the reason for the denial and the procedure for initiating the expedited appeal process. A letter is sent to the member, physician and hospital, if applicable, within one business day of the decision. The notification will list appeal rights based on regulatory guidelines.

**NOTE:** The authorization process is designed only to evaluate the Medical Necessity of the service. AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT OR A CONFIRMATION OF COVERAGE FOR BENEFITS. Payment of benefits remains subject to all other Subscriber Contract/Certificate terms, conditions, exclusions and the patient’s eligibility for benefits at the time expenses are incurred.
Notification of Admission/Status Change
A pre-service authorization is valid for 15 days. Occasionally, it may be necessary to change or cancel a service, or the circumstances may require an adjustment to the anticipated length of stay. When a change in the nature, duration or reason(s) for an authorized service occurs, the provider should notify the Authorization Unit of the change. This will help prevent confusion and unnecessary delay or errors when processing claims for services associated with the service. Another certification must be obtained if the approved service does not occur within 15 days of the originally scheduled admission date.

Concurrent Review
The Concurrent Review Unit evaluates the medical and service needs of patients confined to an inpatient facility. Concurrent review promotes and works to ensure optimal outcomes, continuity of care, development of a timely discharge plan and ongoing quality of care.

The Concurrent Review Nurse is the central focus and link of communication between a hospitalized member, a Member Provider and the Care Management Department. Concurrent Review nurses conduct telephonic review of all new admissions or continued care cases prior to the end of an approved length of stay. Concurrent Review nurses use clinical information made available and nationally recognized criteria to authorize extensions for additional inpatient care. If the Concurrent Review nurse is not able to authorize an extension based on medical necessity with the clinical information made available and the criteria, the case is referred to a Blue Cross Medical Director for a determination.

If additional services or days are requested, the provider should contact the Concurrent Review Unit. You may either contact the Concurrent Review Nurse assigned to your facility or you may contact the Blue Cross authorizations line at 1-800-523-6435. A Concurrent Review Nurse, in collaboration with the Medical Director, will conduct a review of the information provided to document the medical necessity for continued stay. This review will be done either in person or by telephone.

A decision is made within one working day of receiving all necessary information from the provider. If the decision is to approve the continued stay or course of treatment, the provider rendering the service is notified by telephone or via fax. If a decision to deny the continued stay or course of treatment is made, the provider rendering the service is immediately notified and given the reason for the denial and the procedure for initiating the appeal process.

Self-funded employer groups handled by Blue Cross will generally be handled in the same way as fully funded groups for operational efficiency. Insureds not subject to URO regulations may have denial determinations issued on a retrospective basis if a review is not requested prior to discharge from service or prior to receipt of the initial claim for payment.
Case Management
The Case Management Unit systematically identifies high-risk members and assesses opportunities to assist with coordinating care. The focus of case management is to assist with coordinating services and resources for members with catastrophic or chronic health conditions in an attempt to resolve barriers to optimum health outcomes and decrease future risk.

Case Management Nurses encourage collaborative relationships among a member’s healthcare providers, and they help members and their families maximize efficient utilization of available healthcare resources.

Members can be referred to Case Management through a variety of sources, including direct referrals from practitioners, claims data or referrals from inpatient and outpatient utilization review nurses. Members who may benefit from case management include:

- Patients with a newly diagnosed chronic condition, such as diabetes mellitus
- Patients with an acute phase of an illness requiring coordination of multiple services
- Patients with unstable chronic illnesses
- Patients identified by Health Risk Assessments
- Patients and families who experience catastrophic illness
- Patients with depression having an adverse affect on medical outcomes

After a member has been referred to Case Management, the Case Management nurse conducts a thorough and objective assessment of the member’s current status. Using this data, the nurse identifies the immediate, short-term and long-term needs of the member, as well as whether or not the member’s needs can be best be met in a disease management or case management program.

You may contact Case Management by calling 1-800-317-2299.

Disease Management
Blue Cross' Population Health (Disease) Management program is a system of coordinated care interventions and member communications for populations with chronic health conditions such as diabetes and heart failure. Members have access to a personal nurse who can, along with their physician and other health care professionals, help them address their current health status as well as their long term health. We focus on the full continuum of care and offer health coaching that encourages member empowerment, life style modification and self-care techniques that can lead to better health.

Key Components of the Population Health Improvement Model Include
- Population identification strategies and processes;
- Comprehensive needs assessments that assess physical, psychological, economic, and environmental needs;
- Proactive health promotion programs that increase awareness of the health risks associated with
certain personal behaviors and lifestyles;
• Patient-centric health management goals and education which may include primary prevention,
behavior modification programs, and support for concordance between the patient and the primary
care provider;
• Self-management interventions aimed at influencing the targeted population to make behavioral
changes;
• Routine reporting and feedback loops which may include communications with patient, physicians,
health plan and ancillary providers;
• Evaluation of clinical, humanistic and economic outcomes on an ongoing basis with the goal of
improving overall population health.

The Population Health Improvement Model
• Encourages patients to have a provider relationship where they receive on-going primary care in
addition to specialty care;
• Complements the physician/practitioner and patient relationship and plan of care across all stages,
including wellness, prevention, chronic, acute and end-of-life care;
• Assists unpaid caregivers, such as family and friends, by providing relevant information and care
coordination;
• Offers physicians additional resources to address gaps in patient health care literacy, knowledge of the
health care system, and timeliness of treatment;
• Assists physicians in collecting, coordinating and analyzing patient specific information and data from
multiple members of the health care team including the patients themselves;
• Assists physicians in analyzing data across entire patient populations;
• Addresses cultural sensitivities and preferences of individuals from disparate backgrounds;
• Promotes complementary care settings and techniques such as group visits, remote patient
monitoring, telemedicine, telehealth, and behavior modification and motivation techniques for
appropriate patient populations.

For additional information about our Disease Management Programs, or to refer a member, please call
1-800-317-2299.

Retrospective Review
Blue Cross’ Retrospective Review Unit reviews claims to ensure that the services rendered were medically
appropriate and meet the definition of covered services under the Subscriber Contract/Certificate. A
retrospective review may be performed to assess the medical need and correct billing level for services
that have already been performed.
As part of this review process, staff members examine diagnoses, treatments or procedures, including but not limited to cosmetic, experimental or investigational procedures, that may be limited or excluded by the Subscriber’s Contract/Certificate. Nurses also conduct medical reviews for possible pre-existing conditions.

**Medical Policy Inquiry**

Provider inquiries related to medical policy coverage eligibility guidelines or investigational status determination of treatments, procedures, devices, drugs or biological products will be considered upon written request by a member provider. All current medical policy coverage guidelines are available on iLinkBlue.

Requests for consideration must be accompanied by peer-reviewed scientific evidence-based outcomes that substantiate why the specific treatment, procedure, device, drug or biological product is addressed within a medical policy.

**Supporting Data Will be Assessed Against the Following Criteria:**

- Have final approval from the appropriate government regulatory body;
- Have the scientific evidence that permits conclusions concerning the effect of the technology on health outcomes; or
- Improve the net health outcome; or
- Be as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

**Procedure**

Member providers who contact Blue Cross to address coverage eligibility or investigational status of a treatment, procedure, device, drug or biological product addressed in a Blue Cross medical policy will be directed to submit:

- A written request that includes the nature of their inquiry; AND
- Pertinent peer-reviewed scientific evidence-based outcomes specific to the coverage eligibility guidelines or investigational status of the treatment, procedure, device, drug or biological product addressed within the medical policy.

A. Written requests must include a return address or fax contact number and should be submitted to:

![Medical Director of Medical Policy](address) (225) 298-2906 (fax)

Attn: Medical Director of Medical Policy
Blue Cross and Blue Shield of Louisiana
P.O. Box 98031
Baton Rouge, LA 70809-9031

B. Supporting data will be reviewed by the Medical Director of Medical Policy and or appropriate Plan medical directors and consultants.
C. Upon determination of review outcome written notification will be directed to the requesting provider within 60 days of receipt of request.

Direct Access
Direct Access allows HMO Louisiana’s POS members to receive care through their network PCP or they may go directly to the network specialist of their choice without a referral.

As a part of the Direct Access Program, HMO Louisiana’s POS members are responsible for different copayments for physician services—one for PCPs, one for specialists, one for urgent care clinics and one for emergency room services. This means that members will pay a lower copayment when they receive services from PCPs.

The following provider specialties are considered primary care under HMO Louisiana’s POS. Physicians who specialize in these areas of medicine and who are classified as PCPs by Blue Cross should collect the PCP copayment from members with Direct Access:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Please note: The following specialties also should collect the PCP copayment when they perform services for members with Direct Access:

- Chiropractors
- Rural Health Clinics (Federally qualified)
- Occupational Therapists
- Physical Therapists
- Speech Therapists
- Therapy Assistants

The member’s identification card will list the copayment amount you should collect. Authorizations are still required for some services under the Direct Access Program. Please review the following lists of services that require authorization from the Plan. Authorization requirements may vary by group. For any questions about the Direct Access Program, please call Provider Services at 1-800-922-8866.

- Alcohol/Drug Abuse Treatment
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment that exceeds $300
- Drugs Requiring Authorization – Complete list of drugs that require authorization available online at: www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations; see the following pages of this manual for more on drug authorization
- Electric & Custom Wheelchairs
Services That Require Authorization Prior to Rendering Services

The following services and/or procedures may require Blue Cross/HMO Louisiana approval. The lists below may vary for self-insured groups. Please always verify the member’s eligibility, benefits and limitations prior to providing services. To do this, use iLinkBLUE (www.bcbsla.com/ilinkblue). See the following pages of this manual for more information on drug and high-tech imaging authorizations.

### Preferred Care PPO
- Air Ambulance - Non-Emergency
- Applied Behavior Analysis
- Bone Growth Stimulator
- Compound Drugs greater than $250
- CT Scans**
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000 (including but not limited to defibrillators and insulin pumps)
- Inpatient Hospital Services (except routine maternity stays)*
- Intensive Outpatient Programs
- MRI/MRA**
- Nuclear Cardiology**
- Partial Hospitalization Program
- PET/SPECT Scans**
- Certain Prescription Drugs - the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations.
- Private Duty Nursing
- Prosthetic Appliances
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Stereotactic Radiosurgery (including but not limited to gamma knife and cyberknife procedures)
- Transplant Evaluations & Transplants
- Vacuum Assisted Wound Closure Therapy

### HMO Louisiana, Inc., Blue Connect and Community Blue
- Air Ambulance - Non-Emergency
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Compound Drugs greater than $250
- CT Scans**
- Day Rehabilitation Programs
- DME greater than $300
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000 (including but not limited to defibrillators and insulin pumps)
- Infusion Therapy – includes home and facility administration (exception: physician's office, unless the drug to be infused may require authorization)
- Inpatient Hospital Services (except routine maternity stays)*
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA**
- Nuclear Cardiology**
- Oral Surgery (major medical only)
- Orthotic Devices greater than $300
- Outpatient Pain Rehabilitation/Pain Control Programs
- Partial Hospitalization Programs
- PET/SPECT Scans**
- Certain Prescription Drugs - the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations
- Private Duty Nursing
- Prosthetic Appliances
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Stereotactic Radiosurgery (including but not limited to gamma knife and cyberknife procedures)
- Transplant Evaluations & Transplants
- Vacuum Assisted Wound Closure Therapy

* **Maternity Admissions:**
  Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for Cesarean section delivery.

** **Authorization Requests:**
  Request for authorization for these services may also be completed online through iLinkBLUE using AIM's Provider Portal.
OGB Plan Services Requiring Authorization
Plan approval is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary to another Blue Cross Blue Shield plan (Louisiana providers only). When Medicare is primary, an authorization is required once the combined benefit limit of 50 visits of PT/OT have been achieved. Providers may request authorization by calling 1-800-523-6435 or fax request to 1-800-586-2299. Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans effective January 1, 2017.

**INPATIENT**
- Inpatient Hospital Services (except routine maternity stays*) including continued stay review (CSR)
- Mental Health/Substance Abuse Services (including residential treatment center and partial hospitalization program services)
- Skilled Nursing Facility
- Transplant Services (organ, bone marrow)

**OUTPATIENT**
- Air Ambulance (non-emergency)
- Applied Behavioral Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Day Rehabilitation Programs
- Dialysis
- DME greater than $300 (including electric & custom wheelchairs)
- High-tech Diagnostic Imaging Services (including but not limited to CT/CAT Scan, MRI/MRA, Nuclear Cardiology and PET Scan)**
- Home Health Care
- Hospice Care
- Hyperbarics
- Implantable Medical Devices over $2000 (including but not limited to defibrillators and insulin pumps)
- Infusion Therapy (includes home and facility administration)
  Exception: Infusion therapy performed in a physician's office (the drug to be infused may require authorization)
- Intensive Outpatient Programs
- Low Protein Food Products
- Oral Surgery (not required when performed in the physician’s office)
- Orthotic Devices greater than $300
- Outpatient Non-Surgical Procedures (exceptions: x-rays, lab work, speech therapy and chiropractic services do not require prior authorization. Non-surgical procedures performed in a physician's office do not require prior authorization.)
- Outpatient Pain Rehabilitation/Pain Control Programs
- Outpatient Surgical Procedures (not performed in the physician’s office)
- Partial Hospitalization Programs
- Physical/Occupational Therapy for visits over the combined benefit limit.
- Prosthetic Appliances greater than $300
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Specialty Pharmacy (see billing guidelines in the Professional Provider Office Manual, available online at www.bcbsla.com/providers > Education on Demand.
- Stereotactic Radiosurgery (including but not limited to gamma knife & cyberknife)
- Transplant Evaluations and Procedures (organ, bone marrow)
- Vacuum Assisted Wound Care Therapy

* Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for Cesarean section delivery.

**Request for prior authorization for these services may be completed online through iLinkBlue (www.bcbsla.com/ilinkblue) using AIM’s Provider Portal. For more information on Imaging Authorizations, visit www.bcbsla.com/providers > Imaging Authorizations.

Failure to obtain prior authorization for these services for OGB members will result in denial of payment for services.

Blue Cross and Blue Shield of Louisiana Professional Provider Office Manual December 2016
Authorization for High-tech Imaging Services

Blue Cross and HMO Louisiana are contracted with AIM Specialty Health (AIM), an independent company, to administer authorization services for select elective outpatient high-tech imaging studies. All authorization requests should be made through iLinkBlue using the ProviderPortal™.

Ordering physicians must contact AIM directly for authorization of the services mentioned in this section for Blue Cross, HMO Louisiana and Federal Employee Program (FEP) members. AIM conducts authorization services for the following outpatient, non-emergent imaging services for Blue Cross and HMO Louisiana:

- Computerized Tomography (CT) Scans
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI) – excluding CPT 70336 as these authorizations are handled directly by Blue Cross. Most Blue Cross member contracts do not cover this service; however, a few large employers do provide some level of coverage.
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology Procedures
- Positron-Emission Tomography (PET) Scans

Please note: Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or 30-hour observations are not included in this radiology program.

Ordering physicians (whether a primary care physician (PCP) or specialist) are required to provide AIM with basic clinical information and patient demographics to obtain the authorization. The PCP will not be expected to obtain the authorization number if a specialist orders the test. Hospitals and freestanding facilities that perform the technical component of the imaging services cannot obtain an authorization number and should not obtain authorizations for ordering physicians; however, they may check the status of an authorization request through iLinkBlue.

Blue Cross implements a full utilization review program in which all clinical information provided by the ordering physician will be reviewed against AIM’s clinical guidelines for medical necessity. If a request for authorization is denied, AIM notifies the ordering physician of the denial and the process for appeals. Reconsiderations and first-level appeals on authorizations denied for medical necessity and experimental/investigational should be sent directly to Blue Cross. Please allow ample time in scheduling diagnostic services to insure the authorization process is completed and approved before the patient receives services.

Ordering physicians should contact AIM to obtain authorization in one of two ways:

1. Use iLinkBlue to access AIM’s web-based application, ProviderPortal™. Ordering physicians can easily enter authorization requests and get immediate response for most requests. Additionally, both ordering and performing providers can check authorization status and view authorization numbers using the ProviderPortal™.
2. Contact AIM directly by calling 1-866-455-8416.
Please Note: AIM’s ProviderPortal℠ authorization process can issue one authorization number for multiple diagnostic services for the same patient and same date of service. Simply enter the first authorization request, confirm that you have additional services when prompted, then enter authorization request(s) for the additional diagnostic services(s).

Blue Cross medical policies determine if a service is experimental/investigational. There will continue to be denials for services that are experimental/investigational and those that are out-of-network. You may search and view all Blue Cross medical policy coverage guidelines on iLinkBlue. AIM’s clinical guidelines can be found under the forms section of their website.

Drug Authorizations
Blue Cross and HMO Louisiana have contracted with Express Scripts, Inc. (ESI), a pharmacy benefit manager, to perform prior authorizations for targeted medications. Ordering physicians are required to contact ESI to complete authorizations for targeted medications for members of our Preferred Care PPO and HMO Louisiana networks.

To request a prior authorization, providers can continue to use the same phone number used for authorizations or by calling ESI directly at 1-800-842-2015, 24 hours a day, seven days a week.

Prior authorization for non-targeted medications will continue to be handled by Blue Cross. Please do not contact ESI for these medications. Additionally, ESI services do not affect the current processes for Benefit Management Services (BMS) and Federal Employee Program (FEP) members. For BMS and FEP members, please continue to contact the member’s current pharmacy benefit manager for these members. For more information on covered drugs, see www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations or www.bcbsla.com/pharmacy.

Appeals for drugs denied for medical necessity or experimental/investigational are handled by ESI or Blue Cross depending the member’s network.

Authorization Penalties for Providers
Outpatient Authorization Penalty (PPO and HMO Louisiana/POS Providers)
A 30 percent penalty will be imposed on Preferred Care PPO and HMO’s POS network providers for failing to obtain authorization prior to performing outpatient services that require authorization on a PPO or HMO Louisiana POS member. 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. This does not apply to PPO providers of other Blue Plans outside of Blue Cross. Failure to authorize service(s) for an OGB member will result in a claim denial. OGB does not authorize Blue Cross to reconsider these denials at the appeal level.
Inpatient Authorization Penalty (HMO Louisiana/POS Facilities)

A $1,000 penalty will be applied to inpatient hospital claims if the patient’s policy requires an inpatient stay to be authorized, and the provider fails to obtain the authorization prior to the stay. This penalty will be applied to inpatient stays of patients covered by any Blue Cross and/or Blue Shield plan or subsidiary, when the patient’s policy requires the authorization to be performed.

When a patient is covered by Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc., and the patient’s policy contains a different penalty for failure to authorize an inpatient stay, the terms of the patient’s policy will control and not this $1,000 penalty provision. Examples are the policies with OGB or HMO (failure to prior authorize an inpatient stay results in a claim denial). Failure to authorize service(s) for an OGB member will result in a claim denial. OGB does not authorize Blue Cross to reconsider these denials at the appeal level.

When a patient is covered by a policy issued by another (non-Louisiana) Blue Cross and/or Blue Shield plan or subsidiary, and the patient’s policy contains a different penalty for failure to authorize an inpatient stay, this $1,000 penalty provision will control and not the terms of the patient’s policy.

Medical Records

Providers should maintain current, organized, well-documented medical records to facilitate communication, coordination and continuity of care. Records should document all care provided to members.

Blue Cross performs office reviews and Ambulatory Medical Record Review (AMRR) as a commitment to quality improvement. AMRR and site reviews may be conducted for any provider in the following circumstances:

• When requested by one of the medical directors based on quality indicator or provider corrective action processes; or
• At the discretion of the Health and Quality Management staff.

The purpose of the review will be to:

• Objectively monitor and evaluate the structural and operational aspects of the office site; and
• Conduct an overview discussion and assessment regarding the adequacy of medical record practices.

Results from the record keeping review will be used to initiate actions to improve practice management or medical record documentation.

Adult and Pediatric Ambulatory Medical Review Definition of Guidelines

Pediatric: Any child between infancy and puberty.
Adult: A fully grown and mature person.
Time Frame: Review all entries for the two years preceding the last visit.
Part I – Demographic Guidelines
1. All pages with entries in the record contain patient identification.
   
   Definition: Name, social security number or other unique patient identifier is on all pages with entries.
2. Personal biographical data.
   
   Definition: The personal biographical data should include: address, employer, home and work telephone numbers and marital status. If the patient has no phone, the record should state “no phone.” For pediatric cases, the employer of at least one parent, as well as the home and work phone numbers of at least one parent should be included.

Part II – Documentation Guidelines
1. Each entry in the record contains the author’s name or initials.
   
   Definition: An entry means documentation in the progress notes. This may include medication renewals and telephone orders. Author identification may be handwritten signature, an initialed -stamped signature, or unique electronic identifier. Each entry has the author’s name or initials. Documentation entered by other than the practitioner, must be counter-signed or counter-initialed. All signatures should be completed prior to billing for the service.
2. Each entry is dated.
   
   Definition: This includes progress notes, problem list, medication list, assessment form, etc.
3. Each entry is legible.
4. Smoking habits and history of alcohol or substance abuse usage is noted.
   
   Definition: For patients 14 years and older, smoking habits, ethyl alcohol (ETOH) use and substance abuse are noted in the history and physical progress notes. Counseling in reference to avoiding tobacco use, underage drinking and illicit drug use including, but not limited to, avoiding ETOH/drug use while swimming, boating, etc., are noted. For patients seen three or more times, query a substance abuse history.
5. A history and physical is noted for each visit.
   
   Definition: The reason for the visit or chief complaint is noted. There is appropriate subjective and objective information noted pertinent to the patient’s presenting complaints to include but not limited to height, weight and blood pressure.
6. Labs and other studies are ordered as appropriate.
7. Each encounter has follow-up care, calls or visits noted.
   
   Definition: Each physician encounter has a notation regarding follow-up care, calls, or visits, unless there is a notation that previous problem has been resolved. The specific time of return is noted in days, weeks, months or PRN (as needed).
8. At each encounter, problems from previous visits are addressed, if applicable.
   
   Definition: There is evidence of continuity and coordination of care between primary and specialty physician. There is evidence of appropriate use of consults.
10. Consultant’s report or note from consultant is received, if applicable.
   
   Definition: If there was consult, there is a report of the consult in the record.
11. Consultation, lab and imaging reports filed in the chart are initialed and signify review.
12. Immunization.

**Definition:** There should be an up-to-date immunization record for children. For adults, an appropriate history should be made.

13. Preventive Healthcare

**Definition:** Documentation that preventive screenings and services are offered in accordance with current Preventive Medicine Guidelines. See this manual or [www.bcbsla.com/providers](http://www.bcbsla.com/providers) > Education on Demand.

**Guidelines – Critical Elements**

1. The record contains an updated, completed problem list or summary of health maintenance exams.

**Definition:** An updated, completed problem list summarizing significant illnesses, medical conditions, past surgical procedures, or chronic health problems that is updated as new problems are encountered, as evidenced in the progress notes. The problem list can be in a separate section or can be listed as a problem in the progress notes. If no past or current illnesses, conditions, or past surgical procedures, there is a statement that no current or past problems are noted. In this case, there is a summary of health maintenance exams such as well woman exam, well child exam, routine check up or complete physical exam.

2. Allergies and adverse reactions to medications are prominently displayed.

**Definition:** The patient’s medication allergies and adverse reactions must be conspicuously listed in the ambulatory medical record or on the front or inside cover of the medical record folder. If allergies to medications are absent, “No Known Allergies” (NKA) or “NA” or “None” is conspicuously documented in the ambulatory medical record or on the front or inside cover of the medical record folder. Conspicuously means in an obvious location, e.g., upper corner or left or right side of the progress note. You should not have to search for this information.

3. There is a past medical history in the record.

**Definition:** For patients seen three or more times, a past history should be easily identified. “Easily identified,” means it should be in one central area, not scattered throughout the chart. An inpatient history and physical taken by the provider, is acceptable. For children and adolescents under the age of 18, past medical history will relate to prenatal care, operations, childhood illnesses, and birth, to include, but not limited to: evidence of Hemoglobinopathy screening, Phenylalanine level, T4 and/or TSH and ocular prophylaxis. For patients seen less than three times, there is a past history noted for the current condition. For example, when there is a visit for hypertension, a family history, a patient history and a progress note for hypertension will be documented. (For females more than 18 years of age, there must be an obstetrics and gynecological history.) If there has been no break in the patient/physician relationship and there is a past history in the chart that was completed while the patient had another form of insurance, the guideline is satisfied.

4. Working diagnoses are consistent with findings.

5. Treatment plans are consistent with diagnoses.

6. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.
Quality Management Program
The goal of the Quality Management (QM) Program is to continuously maximize and improve the healthcare services delivered to members. The scope of the QM Program includes, but is not limited to, the following:

- Quality of Care Issues
- Grievance and Appeal Resolution
- Health Management and Wellness Activities
- Performance Measures

The Program is designed to objectively and systematically monitor and evaluate aspects of healthcare including the delivery of care that is medically appropriate and readily accessible.

This is achieved in several ways:

- Development of Preventive Medicine Guidelines (see the Preventive Medicine Section of this manual)
- Implementation of clinical quality improvement projects
- Distribution of member wellness reminders
- Review and evaluation of member complaints and grievances
- Review and evaluation of quality of care referrals from members, providers and internal staff

The QM Program has been established to facilitate the exchange of information and ideas for identifying opportunities for improvement as well as maintaining high standards of performance.

Step Therapy Program
Step Therapy requires the member to try a generic drug, within select drug classes, prior to trying a more costly brand-name drug. A benefit of this program is to lower out-of-pocket costs, ultimately decreasing the member’s likelihood to stop taking medications due to the cost.

**Step 1** – The member first tries the generic “Step 1 Medication” or generic drug to treat a medical condition before Blue Cross/HMO Louisiana will cover* a “Step 2 Medication” for that condition.

**Step 2** – If the generic drug is not clinically appropriate or has been tried and does not work for the member, then Blue Cross/HMO Louisiana will cover* a brand-name prescription for that condition.

The following drug categories are examples of prescription drugs that are included in the Step Therapy program:

- Blood Pressure Medications Including Beta Blockers
- Acne Treatment Medication
- Bone Medications
- Frequent Urination Medications
- Respiratory/Allergy Medications Including all strengths of Crestor®
- Cholesterol Medications
- Stomach Acid Medications
- Pain and Inflammation Medications
- Long-Acting Pain Medications
- Sleep Medications
- Depression Medications
- Oral Diabetes Medications
- Triptan Migraine Medications
For information on drug authorizations, visit our website at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations or www.bcbsla.com/pharmacy. When a provider writes a new** prescription for a brand-name drug within the classes listed above for a member with Step Therapy, the prescription will be denied at the point of sale at the pharmacy if the member has not already tried a Step 1 drug. The pharmacy will inform the member and then contact the provider and advise of the member’s Step Therapy benefits. If the provider determines one of the Step 1 drugs isn’t appropriate for the member, then the provider can complete a Step Therapy authorization form found on our website and fax it to 1-877-837-5922, or call 1-800-842-2015, for an authorization, and if approved, the provider can prescribe a Step 2 drug. If the providers’ request does not meet the necessary criteria to start a Step 2 drug without first trying a Step 1 drug, or if the provider or member insists on the brand-name, then the member is responsible for the full cost of the medication.

For information on specific drugs under the program, visit our website at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations >Step Therapy Drug List.

* Coverage determination is subject to the member’s eligibility and benefits.
** Members with an existing prescription for a “Step 2” brand-name drug that has been filled within four (4) months prior to the implementation of Step Therapy to their policy benefits will not be required to revert to a “Step 1” generic drug.

**Maternity Management Program - Healthy Blue Beginnings**

Our maternity management program, Healthy Blue Beginnings, helps promote early and compliant prenatal care and offers case management support when required. If a provider has patients who are pregnant or are thinking of becoming pregnant, they should notify our maternity program staff who will assess the patient for risks and provide lifestyle risk modification coaching, and reliable information resources. Providers can go to www.bcbsla.com/providers >Care Management >Blue Touch and click on “Maternity” under the Areas of Case Management section. There is a link to the Care Management Disease Management (CMDM) Referral Form here. Providers should complete it and return via fax to (225) 298-3184 to have a patient enrolled. Providers may also contact us directly at 1-800-226-9947, or have the patient call Blue Cross and ask to speak with a nurse. Once a patient is enrolled, providers will receive the following:

- Written or telephonic notification of the patient’s enrollment along with the nurse’s contact information.
- Notification when the Blue Cross nurse identifies the patient may be in need of healthcare services via a care coordination nurse call.
- Access to claims-based Blue Health Records with up to three years of claims history (through iLinkBlue).
- When members self-refer to the program who don’t have an established physician relationship, providers receive a patient referral by Blue Cross nurses.

A successful maternity management program is dependent on early identification of patients planning to become pregnant, or who have recently identified they are pregnant. The physician plays a key role in the delivery of the program and this program is intended only to compliment the medical care received from providers.
Section 9
MEDICAL APPEALS

Medical Appeals are clinical in nature and involve adverse benefit determinations of not medically necessary or investigational. All other Appeals are considered Administrative Appeals and are handled by the Administrative Appeals and Grievance Department. The process and contact information for this department is located elsewhere in this document.

We recognize that disputes may arise between members (member’s provider) and Blue Cross regarding covered services. An appeal is a written request from the member or authorized representative to change a prior decision that Blue Cross has made about covered services. Examples of issues that qualify as appeals include denied authorizations, claims based on adverse determinations of medical necessity or investigational denials, and benefit determinations. A rescission of coverage is also eligible for an appeal.

The Member has the right to appoint an authorized representative to speak on their behalf in their Appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an internal or external review of a denial. The authorized representative may be the Member’s treating Provider, if the Member appoints the Provider in writing.

The Member, their authorized representative, or a Provider authorized to act on the Member’s behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Member's receipt of an initial adverse Benefit determination. Requests submitted to Us after one hundred eighty (180) days of Our initial determination will not be considered.

Member appeals processes vary due to variations in state and federal laws. We will apply the law that governs the benefits purchased by the member or the member’s employer. In some instances this is state law, and in others, it is federal law. The member’s contract or certificate describes the appeals processes applicable to the member. We will follow the language in the member’s contract or certificate, should there be any variance between that language and what is printed below.

Due to variations between federal and state laws, appeals for ERISA members are handled differently from non-ERISA member appeals. There are some plans that are not governed by either the state laws or the ERISA laws. Examples are some plans for whom we provide administrative services only and the Federal Employee Program. For these members, we will follow the appeals processes stated in their member contracts. The majority of appeals should fall within the ERISA or non-ERISA (state) processes.

If members are unsure which process applies to them, they should contact their employer, Plan Administrator, Plan Sponsor or Blue Cross at 1-800-599-2583 or (225) 291-5370. Members and providers are encouraged to provide Blue Cross with all available information and documentation at the time of the appeal request to help Us completely evaluate the appeal.

Louisiana laws apply to individual contracts of insurance, employer insurance plans that are not governed by ERISA, and non-federal government insurance plans. Blue Cross generally refers to these processes as “Non-ERISA” processes. We will follow internal appeal and external review laws as required by state and
federal law. External reviews are only available for adverse determinations that involve an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or a rescission of coverage.

**Standard Administrative Appeal**

**First Level Administrative Process**

Administrative Appeals involve contractual issues other than or Investigational denials and those denials that do not require medical judgment.

If the Member is not satisfied with Our denial or partial denial of a claim (adverse benefit determination), the Member, their authorized representative, or a Provider acting on their behalf (with signed authorizations from the member), must submit a written request to Appeal within one hundred eighty (180) days following the Member’s receipt of an initial adverse benefit determination. Appeals should be submitted in writing to:

**Medical Benefits:**

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
PO Box 98045
Baton Rouge, LA 70898-9045

**Pediatric Dental Care Benefits:** (applicable to Non-Grandfathered Individual and Small Group ONLY)

Blue Cross and Blue Shield of Louisiana
Dental Customer Service
PO Box 69420
Harrisburg, PA 17106-9420

**Pediatric Vision Care Benefits:** (applicable to Non-Grandfathered Individual and Small Group ONLY)

Blue Cross and Blue Shield of Louisiana
c/o Davis Vision
PO Box 791
Latham, NY 12110

Note: Requests submitted to Blue Cross after one hundred eighty (180) days of the denial will not be considered.

We will investigate the Member’s concerns. If We change Our original decision at the Appeal level, We will process the Member’s Claim and notify the Member and all appropriate Providers, in writing, of the first level Appeal decision. If the Member’s Claim is denied on Appeal, We will notify the Member and all appropriate Providers, in writing, of Our decision within thirty (30) calendar days of the Member’s request; unless We mutually agree that an extension of the time is warranted. At that time, We will inform the Member of the right to begin the second level Appeal process, if applicable.
Second Level Administrative Process (If Applicable)

Within sixty (60) calendar days of the date of Our first level Appeal decision, a Member who is not satisfied with the decision may initiate, with assistance from the Customer Service Unit, if necessary, the second level of Appeal process. Requests submitted to Us after sixty (60) days of the denial will not be considered.

A Member Appeals Committee not involved in any previous denial will review all second level Appeals. The Committee’s decision is final and binding as to any administrative Appeal and will be mailed to the Member within five (5) days of the Committee meeting.

Standard Medical Appeal

Internal Process

Medical Appeals involving a denial or partial denial based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational.

If the Member is not satisfied with Our denial of services, the Member, their authorized representative, or a Provider acting on their behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Member’s receipt of an initial adverse Benefit determination. Appeals should be submitted in writing to or fax to:

Blue Cross and Blue Shield of Louisiana, Inc.
Medical Appeals
PO Box 98022
Baton Rouge, LA 70898-9022
Fax: (225) 298-1837

HMO Louisiana, Inc.
Medical Appeals
PO Box 98022
Baton Rouge, LA 70898-9022
Fax: (225) 298-1837

Note: Requests submitted to Blue Cross after one hundred eighty (180) days of the denial will not be considered.

We will investigate the member’s concerns. All Appeals of Medical Necessity denials will be reviewed by a physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. If our initial denial is overturned on the Member’s Medical Necessity Appeal, We will process the claim and will notify the Member and all appropriate Providers, in writing, of the Internal Appeal decision. If our initial denial is upheld, We will notify the Member and all appropriate Providers, in writing, of our decision and advise the Member of their right to request an External Appeal. The decision will be mailed within thirty (30) days of the member’s request, unless the member or their authorized representative and We mutually agree that an extension of the time is warranted. At that time, We will inform the member of their right to begin the External Appeal process if the claim meets the criteria.
External Process

If the Member still disagrees with our determination on their Claim following the internal review process, the Member or their authorized representative may request an External Appeal conducted by a non-affiliated Independent Review Organization (IRO). The Member must send their written request for an external Appeal, within one hundred twenty (120) days* of receipt of the Internal Appeal decision. The Member must grant permission for the request of an External Review by completing and submitting at the time of External Appeal request the form "I want to ask for an External Appeal." Any external review requested without the required form will not be considered.

Blue Cross and Blue Shield of Louisiana, Inc.

Medical Appeals
PO Box 98022
Baton Rouge, LA 70898-9022
Fax: (225) 298-1837

HMO Louisiana, Inc.

Medical Appeals
PO Box 98022
Baton Rouge, LA 70898-9022
Fax (225) 298-1837

We will provide the IRO all pertinent information necessary to conduct the Appeal. The IRO decision will be considered a final and binding decision on both the Member and Us. The external review will be completed within forty-five (45) days of Our receipt of the request and the IRO will notify the Member or their authorized representative and all appropriate Providers of its decision.

* Requests submitted to us after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered.

Expedited Internal Medical Appeals

We provide an Expedited Appeal process for review of an Adverse Determination involving a situation where the time frame of the standard Appeal would seriously jeopardize the Member’s life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard Internal Appeal decision.

The Expedited Appeal process allows for expedited appeal decisions no later than seventy-two (72) hours of our receipt of an Expedited Appeal request that meets the criteria for Expedited Appeal.

An Expedited Appeal is a request for immediate review of an initial non-certification determination concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who is requesting emergency services or has received emergency services.
but has not been discharged from a facility or if waiting for the standard appeal 30 day process could seriously jeopardize the member’s life, health or ability to regain maximum function or in the treating physician’s opinion, the patient would be subjected to severe pain without care or treatment. Expedited Appeals are not provided for services previously rendered.

Blue Cross and Blue Shield of Louisiana, Inc.
Expedited Appeal - Medical Appeals
PO Box 98022
Baton Rouge, LA 70898-9022
Fax: (225) 298-1837

HMO Louisiana, Inc.
Expedited Appeal - Medical Appeals
PO Box 98022
Baton Rouge, LA 70898-9022
Fax (225) 298-1837

In any case where the Expedited Internal Appeal process does not resolve a difference of opinion between Us and the covered person or the Provider acting on behalf of the covered person, the Appeal may be elevated to an Expedited External Appeal.

**Expedited External Medical Appeals**

An Expedited External Appeal of an adverse decision is available when requested by the Member, their authorized representative or a provider acting on behalf of a member.

An Expedited External Appeal is a request for immediate review of an initial non-certification determination concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who is requesting emergency services or has received emergency services but has not been discharged from a facility or if waiting for the standard Appeal 30 day process could seriously jeopardize the member’s life, health or ability to regain maximum function or in the treating physician’s opinion, the patient would be subjected to severe pain without care or treatment.

Expedited External Appeals are not provided for review of services previously rendered.

An Expedited External Appeal is also available if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is deemed Investigational; and the covered person’s treating Physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated. The request may be simultaneously filed with a request for an expedited internal review, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt.
We will forward all pertinent information for Expedited External Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

All external review decisions are binding on Us and You for purposes of determining coverage under a health Contract. This Appeals process shall constitute Your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary, except to the extent that other remedies are available under state or federal law.

Please Note: Although submission of additional information is not required at the time an appeal request is requested, an explanation and/or supporting documentation for an appeal is recommended.

Multiple requests to Appeal the same Claim, service, issue, or date of service will not be considered, at any level of review.
Section 10
GENERAL DISPUTE RESOLUTION & ARBITRATION PROCESS

Dispute Resolution
Blue Cross has established a general dispute resolution process to resolve any problems and disputes concerning Blue Cross’ right of offset or recoupment. To initiate the general dispute resolution process, providers should send a written notice with a brief description of their dispute to:

Blue Cross and Blue Shield of Louisiana
Provider Dispute
P.O. Box 98021
Baton Rouge, LA 70898-9021

Within sixty (60) calendar days of our receipt of the provider’s notice, Blue Cross and the provider will assign appropriate staff members who are to arrange to discuss and seek resolution of the dispute, consistent with the terms of the provider’s agreement with Blue Cross. Any and all dispute resolution procedures are to be conducted only between Blue Cross and the provider and shall not include any Blue Cross or HMO Louisiana member unless such involvement is necessary to the resolution of the dispute. Blue Cross, in its sole discretion, will determine if the member’s involvement is necessary to the resolution of the dispute.

If Blue Cross and the provider are unable to reach resolution within the initial sixty (60) day period, then management from both Blue Cross and the provider, who were not involved in the initial discussion, will have an additional thirty (30) days to resolve the dispute. This time period may be extended by mutual agreement between Blue Cross and the provider. Blue Cross and the provider, as mutually agreed, may include a mediator in such discussions. Blue Cross and the provider shall share the costs of the mediation equally. In any event, if additional meetings are held and no resolution of the dispute is reached within sixty (60) days from the initial meeting, Blue Cross and the provider shall elect binding arbitration as described in the Arbitration section below in order to resolve the dispute. Blue Cross or the provider’s failure to participate in the arbitration proceedings means that they have accepted the other’s demands. If resolution of the dispute occurs, Blue Cross and the provider shall express the resolution in written form or amend the provider’s agreement to include the resolution, if appropriate.

Arbitration
Both Blue Cross and the provider shall abide by the following procedures for the arbitration process:

• The party (Blue Cross or the provider) who is initiating the arbitration process shall send written notice to the other party setting forth the basis of the dispute and their desire to arbitrate. Blue Cross and the provider shall share the costs of the arbitration equally. Arbitration shall be in accordance with the rules and procedures of either the American Arbitration Association or the American Health Lawyers’ Association or another nationally recognized arbitration association acceptable to both Blue Cross and the provider.
• Arbitration shall be conducted in Baton Rouge, Louisiana, before a single arbitrator mutually agreed upon by both Blue Cross and the provider.

• The arbitrator shall be bound by the terms and conditions set forth in the provider’s agreement and the Member Contract/Certificate.

• The arbitrator may not award consequential, special, punitive or exemplary damages. The arbitrator may award costs, including reasonable attorney’s fees, against Blue Cross or the provider. If the decision of the arbitrator does not include such award, both Blue Cross and the provider shall share the costs of the arbitration equally.

• The decision of the arbitrator shall be final and in writing and shall be binding on both Blue Cross and the provider and enforceable under the laws of the state of Louisiana.

• This provision shall survive the termination of the provider’s agreement.

The general dispute resolution and arbitration processes described above do not supersede or replace the member appeals and grievances process for medical necessity and appropriateness, investigational, experimental or cosmetic coverage determinations as described in the Appeals section of this manual.

Notwithstanding the foregoing, benefits and utilization management determination issues (for example, Medical Necessity or Investigational determinations) shall be handled in accordance with the Subscriber Contract/Certificate and as outlined in this manual.
Section 11

PREVENTIVE MEDICINE

Benefit for Women’s Preventive Services

The Patient Protection and Affordable Care Act (PPACA) requires coverage for the preventive services listed below when the member’s benefit plan includes the PPACA requirements:

• Contraceptive methods and counseling
• At least one well-woman visit annually
• Counseling for sexually transmitted infections when services are provided at a well-woman visit
• Counseling and screening for HIV when services are provided at a well-woman visit
• Screening and counseling for interpersonal and domestic violence when services are performed at a well-woman visit
• Screening for gestational diabetes
• Human papillomavirus (HPV) DNA testing

Copayment, coinsurance and deductible will not be applied to these services when performed by a network provider.

Contraceptive Exemption: Churches and religious order groups (IRS 603.3 groups) are exempt from the contraceptive services coverage requirement.

Temporary Exemption (applies to non-exempt groups): Non-grandfathered groups, maintained by non-profit organizations, will have a temporary safe harbor for one year, if they did NOT have covered contraceptive services for religious reasons since February 10, 2012.

Grandfathered individual policyholders and groups will be exempt as long as they maintain grandfather status.

Preventive Medicine Guidelines

Staying current with preventative recommendations is an important of overall wellness. Preventative medicine guidelines identify preventative services for customers based on age, gender and risk level. The guidelines outline screening tests for early disease detection, immunizations to prevent infections or disease, counseling to reduce risks and recommendations on prenatal care. The guidelines are based on industry standards and reviewed by the Blue Cross Medical Quality Management Committee which includes network physicians.

Find the most recent preventive medicine guidelines and services recommended by the U.S. Preventive Services Task Force (USPSTF) via a link found on our website at www.bcbsla.com/providers > Education on Demand > Preventive Medicine.

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Section 12
COMMUNICATING WITH BLUE CROSS AND BLUE SHIELD OF LOUISIANA

Electronic Benefit Verification - iLinkBlue
You may verify benefits, inquire about claims status, and a whole lot more using iLinkBlue, (www.bcbsla.com/ilinkblue). Providers who access iLinkBlue can use the website to:

- research Blue Cross patient eligibility
- research coverage and deductible information
- research paid and/or rejected claims and rejection reasons
- view and print Weekly Provider Payment Registers
- check allowable charges.

For electronic system help: Call EDI Service Department at (225) 295-2085.

For electronic claims filing and/or accessing iLinkBlue help:
Email iLinkBlue.ProviderInfo@bcbsla.com
Call 1-800-216-BLUE (1-800-216-2583)

Provider Services Voice Response Telephone System Call Center
You may call Provider Services to obtain a member’s claims status, eligibility, and deductible/coinsurance/copayment amounts or to check on the status of an authorization request. Just call 1-800-922-8866. Instructions are provided throughout the call to guide you through the steps to obtain the information you need.

Have your NPI, the member’s Blue Cross ID number, the member’s eight-digit date of birth and the date of service ready when you place your call, then listen carefully to the instructions.

Helpful Hints
- Speaker telephones and loud background noise will inhibit the performance of the voice response system.
- Speak numeric “zero,” instead of alpha “O.”
- The system will accept three efforts to identify provider and/or member contracts; after the third attempt, your call will be routed to the appropriate representative.
- Facility and professional providers must say or key their NPI.

Claim Status Hints
- If the telephone system is unable to match the date of service with the patient or provider’s NPI, you will receive a fax notification stating that your request for information could not be processed via phone. Please call again and opt to speak to a representative for assistance with this policy.
• Fax back information should be received within 15 minutes of your request.
• Status information for contracts that begin with prefixes other than XU is not currently available.
• Claims must be paid or rejected in order to receive a claim status fax back.
• Claim Status Summaries are formatted to resemble your provider register.
• The summary will include the actual register date of your payment if you were paid.
• If benefits were paid to your patient, your summary will not reflect a date in the "Date Paid" field.
• You may inquire on up to ten dates of service per member.
• FEP (identified with an "R" in the first position of the contract number) must be keyed with a "0" in the last position of the contract number.

Benefit Summary Hints
• Benefit information on BlueCard® is available by calling the BlueCard Eligibility Line® at 1-800-676-BLUE (1-800-676-2583).
• Groups with non-standard or “special” benefits are routed to a representative for benefit information.
• Provider Services is specifically designed to provide in-network benefits only.
• Organize your Benefit Summary requests by products (for example, HMO) prior to beginning your request for benefit summaries.

The Provider Services telephone system is available for your convenience 24 hours a day, seven days a week. For information not offered by Provider Services, you will need assistance from a provider inquiry representative.

Customer Care Center
If your patients have questions about their healthcare benefits, you should tell them to call the number on their ID card. If they don’t have their card, you may refer them to the Customer Care Center at 1-800-376-7741 or (225) 293-0625.

Preadmission Authorization
For admission authorization requests, please call our Authorization Unit at:

- Plan Approval 1-800-392-4085
- Federal Employee Program 1-800-334-9416
- Authorization Unit Fax: (225) 295-2532
- Behavioral Health 1-800-991-5638

Provider Network Administration
If you need assistance with any of the material contained in this manual, contact Provider Network Administration at

network.administration@bcbsla.com 1-800-716-2299, option 4
Provider Relations Services

Provider Relations Representatives assist providers and their office staff and provide information about Blue Cross and its programs and procedures. To determine who your Provider Relations Representative is, see the Provider Representatives map at www.bcbsla.com/providers >Provider Tools. Please do not call your Provider Relations Representative with routine claim or benefit questions. You may obtain immediate answers to those questions through iLinkBlue or by calling the Provider Services at 1-800-922-8866:

_provider.relations@bcbsla.com_  _1-800-716-2299, option 4_
Section 13

DEFINITIONS
THESE DEFINITIONS ARE DICTATED BY THE SUBSCRIBER/MEMBER BENEFITS

Allowable Charge/Professional Allowance
The lesser of the submitted charge or the amount established by Blue Cross, or negotiated based on
an analysis of providers’ charges, as the maximum amount allowed for physician services covered
under the terms of the member contract/certificate.

Allied Health Provider
A licensed and/or certified healthcare provider other than a physician or hospital, which may include
a clinical laboratory company, managed mental healthcare company, optometrist, chiropractor,
podiatrist, psychologist, therapist, licensed professional counselor (LPC), board certified substance
abuse counselor (BCSAC), licensed clinical social worker (LCSW), durable medical equipment
supplier, diagnostic center, and any other healthcare provider, organization, institution or such other
arrangement as recognized by Blue Cross provider allied health services and agrees to provide or
arrange for the provision of covered services to members.

Alpha Prefix
A three-digit prefix to the member’s identification number that identifies the Blue Cross Plan or the
national account in which the member is enrolled. FEP members ID numbers will start with “R.”

Authorization
A determination by Blue Cross regarding an admission, continued hospital stay, or other healthcare
service or supply which, based on the information provided, satisfies the clinical review criteria
requirement for medical necessity, appropriateness of the healthcare setting, or level of care and
effectiveness. An authorization is not a guarantee of payment. Additionally, an authorization is not a
determination about the member’s choice of provider.

Benefit(s)
The amount Blue Cross is obligated to the member to satisfy, under the terms of a member contract/
certificate, for Covered Services exclusive of applicable Deductible, Coinsurance, and Copayment
amounts.

Blue Advantage
Our Medicare Advantage network that is effective January 1, 2016, in the Baton Rouge, Lafayette and
New Orleans areas only.

Billed Charges
The total charges made by a provider for all services and supplies provided to the member.
Blue Cross

Refers to Blue Cross and Blue Shield of Louisiana.

Clean Claim

A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special or additional treatment that prevents timely payment from being made on the claim.

Coinsurance

The sharing of allowable charges for covered services. The sharing is expressed as a pair of percentages, a Plan percentage that we pay, and a member percentage that they pay. Once the member has met any applicable deductible amount, the member’s percentage will be applied to the allowable charges for covered services to determine the member’s financial responsibility. The Plan’s percentage will be applied to the allowable charges for covered services to determine the benefits provided.

Consumer Directed Health Care (CDHC)

A broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

As an umbrella term, CDHC encompasses multiple models and services including Consumer Directed Health Plans, high deductible health plans, member healthcare accounts, debit cards, member support tools, provider cost and profile information, Ebusiness services, and next generation networks.

Consumer Directed Health Plans (CDHP)

High deductible health plans (HDHPs) partnered with member personal savings accounts (PSAs), such as a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA), or a Flexible Spending Arrangement (FSA), thereby forming a CDHP. The type of account used in these arrangements has strong implications to the administration of the CDHP, as the IRS regulations governing these tax-favored PSAs vary significantly.

High deductible health plans vary in design (deductible thresholds, preventive coverage, and more), and are offered and administered by a health insurance company, such as a Blue Cross Plan.

Coordination of Benefits (COB)

Determining primary/secondary/tertiary liability between various healthcare benefit programs and paying benefits in accordance with established guidelines when members are eligible for benefits under more than one healthcare benefits program.
Copayment (Co-pay)
That portion of charges for covered services, usually expressed as a dollar amount that must be paid by the member and usually collected by a physician at the time of service.

Covered Services
Those medically necessary healthcare services and supplies for which benefits are specified under a member contract/certificate.

System of terminology and coding developed by the American Medical Association that is used for describing, coding and reporting medical services and procedures.

Deductible
A specific amount of Covered Services, usually expressed in dollars, that must be incurred by the member before Blue Cross is obligated to member to assume financial responsibility for all or part of the remaining Covered Services under a member contract/certificate.

Electronic Funds Transfer (EFT)
Allows payment to be sent directly to iLinkBlue enrolled providers’ checking or savings accounts. With EFT, providers can view their Weekly Provider Payment Registers in iLinkBlue and they will not receive a Payment Register by mail.

Emergency
A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: a) placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Experimental/Investigational
The use of any treatment, procedure, facility, equipment, drug, device or supply not yet recognized by the National Association of Blue Cross and Blue Shield Plans as accepted practice for treatment of the condition. Note: Blue Cross makes no payment for experimental/investigational services.

Explanation of Benefits (EOB)
A notice sent to the member after a claim has been processed by Blue Cross that explains the action taken on that claim.

Federal Employee Program (FEP)
A healthcare benefits plan designed for personnel employed by the Federal Government.
Flexible Spending Arrangement (FSA)

Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee’s share of insurance premiums or medical expenses not covered by the employer’s health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. FSAs can also be provided to cover childcare and transit expenses, but those accounts must be established separately from medical FSAs.

Grandfathered Plan

A health plan that an individual was enrolled in prior to March 23, 2010, and is still enrolled. Grandfathered plans are exempt from most changes required by PPACA. New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), otherwise known as HIPAA, was enacted as a broad congressional attempt at incremental healthcare reform. The “Administrative Simplification” section of that law requires the United States Department of Health and Human Services (DHHS) to develop standards and requirements for maintaining and transmitting health information.

Health Reimbursement Arrangement (HRA)

An employer-funded plan that reimburses employees for Qualified Medical Expenses (QMEs); an HRA is funded solely by the employer. Reimbursements for medical expenses, up to a maximum dollar amount for a coverage period, are not included in an employee’s income. Unused funds can be rolled over annually but are owned by the employer and thus are not portable when the employee leaves the employer’s company.

Health Savings Account (HSA)

A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified healthcare expenses of the account beneficiary who, for the months of which contributions are made to an HSA, is covered under a high-deductible plan. An HSA is employee-owned but can be funded by the employer and/or the employee. Unused funds are owned by the employee and thus are portable when the employee leaves the employer’s company.

High Deductible Health Plan (HDHP)

A descriptive term relating to a broad category of health plans that feature higher annual deductibles than other traditional health plans. Deductibles typically exceed $1000 for individual coverage and $2000 for family coverage. This term encompasses those CDHP plans that are HSA qualified.
HSA Qualified High Deductible Health Plan
An individual or family health plan with minimum annual deductible and maximum out-of-pocket amounts indexed annually for inflation according to Internal Revenue Code (IRC) § 223(c)(2) and IRC § 223(g)(1).

HMO Louisiana Select Network
A subset of HMO Louisiana providers who have signed a separate agreement with PLAN to provide services to Members with HMO Louisiana Select Network Contracts/Certificates.

HMO Louisiana Select Network Provider
Any physician or group of physicians, or any facility, including but not limited to, a hospital, clinical laboratory, free-standing ambulatory surgery facility, skilled nursing services who has entered into a HMO Louisiana Select Network contractual agreement with HMO Louisiana to provide Covered Services to Members.

iLinkBlue
A secure Web portal available at no cost for healthcare providers, designed to help you quickly complete important functions such as claims entry, authorizations and billing information.

Identification Card
The card issued to the member identifying him/her as entitled to receive benefits under a member contract/certificate for services rendered by healthcare providers and for such providers to use in reporting to Blue Cross those services rendered to the member.

Identification Number
The number assigned to the member and all of his/her Blue Cross records. This number is a unique number selected at random, has a three-letter alpha-prefix in the first three positions, and is noted on the Identification card.

International Classification of Diseases, 10th Revision (ICD-10-CM)
A numerical classification descriptive of diseases, injuries and causes of death.

Medically Necessary/Medical Necessity
Healthcare services, treatments, procedures, equipment, drugs, devices, items or supplies that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. In accordance with nationally accepted standards of medical practice;
b. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient’s illness, injury or disease; and

c. Not primarily for the personal comfort or convenience of the patient, physician or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member
A participant (employee or dependent) covered under a subscriber contract.

National Drug Code (NDC)
A unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

National Provider Identifier (NPI)
A 10-digit number unique to each provider that is issued by the Centers of Medicare and Medicaid Services (CMS). The NPI is required for providers to submit transactions to federal and state agencies, as well as file claims with private health plans.

Network/Participating Providers
A licensed physician who has met the minimum credentials verification requirements of Blue Cross and who as entered into an agreement with Blue Cross wherein the participating Physician, as a member provider, agrees to render healthcare services to Blue Cross members.

Noncovered Service
A service and/or supply (not a Covered Service) for which there is no provision for either partial or total Benefit/payment under the member contract/certificate.

Notification
A message sent to confirm, validate, acknowledge, or provide information from one entity to another.

Physician Advisory Committee (PAC)
A committee made up of participating physicians throughout the state that meets on a periodic basis with Blue Cross to discuss and make recommendations concerning policies and procedures affecting the Blue Cross and HMO Louisiana networks.

Plan
Blue Cross and Blue Shield of Louisiana also referred to as Blue Cross.

Plan Review
A determination by the Plan regarding a healthcare service for the purpose of applying benefit coverages and limitations and medical policies to determine medical necessity, if the service is cosmetic, investigational or experimental in nature or if the service is covered under the member’s benefit plan.
Participating Plan
A licensee participating in Blue Bank ownership and governance. Also means: A Licensee in whose service area a national account has employee and/or retiree locations, but in which the national account headquarters is not located unless otherwise agreed in accordance with National Account Program policies and provisions.

Patient Protection and Affordable Care Act (PPACA)
PPACA is legislation (Public Law 111-148) signed by President Obama on March 23, 2010. It is commonly referred to as the health care reform law.

Personal Savings Account (PSA)
A broad term used to represent the member’s portfolio of accounts: Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), Flexible Savings Account (FSA). This is also referred to as Health Care Accounts (HCA).

Professional Allowance/Allowable Charge
The lesser of the submitted charge or the amount established by the Plan as the maximum amount allowed for physician services covered under the terms of the member contract/certificate.

Provider
A licensed or accredited hospital, medical supply or service vendor, or individual that provides medical care to a member.

Provider Payment Register
A claims summary identifying all claims paid or denied, along with payment, is provided to the provider by electronic means when set up with EFT or by mail when not set up with EFT.

Qualified Medical Expenses (QME) Substantiation
Refers to the process of determining that expenses submitted to a PSA administrator to be paid from HRAs or FSAs meet the requirements defined by Internal Revenue Service (IRS) regulations. Eligible medical expenses are defined as those expenses paid for care as described in Section 213(d) of the Internal Revenue Code. Additionally, the IRS has allowed some over the counter drugs to qualify as eligible medical expenses. For more detailed information, please refer to IRS Publication 502. (See www.irs.gov/pub/irs-pdf/p502.pdf.)

Subscriber/Member
Employees or individuals and their enrolled dependents covered under a subscriber contract/certificate who are entitled to receive healthcare benefits as defined in and pursuant to a subscriber contract/certificate.
Subscriber Contract/Certificate

A contract/certificate or health benefit plan which provides for payment in accordance with the provider agreement and which is issued or administered by or through Blue Cross, its subsidiaries and affiliates and includes any national and regional group accounts of Blue Cross and Blue Shield of Louisiana or any other Blue Cross Plan, Blue Shield Plan, or the Blue Cross and Blue Shield Association having a Benefit provision for which Blue Cross acts as the control plan, a participating plan or service plan in providing those benefits. It also includes any health plans or programs sponsored, provided, indemnified, or administered by other entities or persons who have made arrangements with Blue Cross, such as network access-only agreements, to access and utilize the provider in connection with their managed care health plans or programs. Such entities or persons may avail themselves of the same access to service and related rights as Blue Cross, and such entities or persons shall be bound to the same payment responsibilities in regard to their members as Blue Cross is for their respective members under the provider agreement. The participating provider will provide these services and look only to each joined entity or person for the Professional Allowance/Allowable Charge in the manner it would look to Blue Cross. The member contract/certificate or health benefit plan entitles members/members to receive healthcare benefits as defined in and pursuant to a member contract/certificate or health benefit plan.

Unbundled

Filing claims with two (2) or more reimbursement/medical codes to describe a procedure performed when a single, more comprehensive reimbursement/medical code exists that accurately describes the entire procedure.
SUMMARY OF CHANGES

Below is a summary of changes to the Professional Provider Office Manual. Minor revisions not detailed in the summary include modifications to the text for clarity and uniformity, grammatical edits and updates to web links referenced in the document.

**December 2016**

**Section 2: Network Overview**
- Office of Group Benefit Plans - Updated section
- Blue Connect - Updated section

**Section 4-A: Electronic Claims Submission & Payment**
- Administrative Representative - Updated section

**Section 5: Reimbursement**
- **Not Separately Reimbursable Codes** - Added section

**Section 6: Billing Guidelines**
- Ambulance Transport Benefit - Updated section
- Behavioral Health - Updated section
- Chiropractic and Therapy Services - Added section
- Drug Screening Assays - Updated section
- Laboratory - Using Preferred Labs - Updated section

**Section 13: Definitions**
- iLinkBlue - Added definition