Are You Ready?
The Conversion to ICD-10

Do you believe you cannot afford to implement ICD-10? While moving to a new coding system after 35 years will certainly be an adjustment, it will not be as difficult as you may think. Implementing ICD-10 will have its cost for training, software upgrades and testing. However, most provider offices should be able to manage the ICD-10 transition successfully, in terms of coding and cost.

ICD-10 has approximately 70,000 diagnosis codes and 72,000 procedure codes compared to ICD-9 having 14,500 diagnosis codes and 3,900 procedure codes. When placed into context:

• Most providers will never use all 70,000 diagnosis codes and will continue to use a limited number of codes within their specialty, just as they do today.
• Most of the increase is associated with additional clinical detail that providers are currently documenting.

While the cost to convert to ICD-10 has such vast differences, most provider practices have determined that:

• Providers only need the ICD-10 diagnosis codes and can purchase a code book or download the code sets from the Centers for Disease Control and Prevention (CDC) website.
• Training in ICD-10 diagnosis coding is available for providers and their practices online at a reasonable cost from specialty societies, coding organizations and vendors.
• The Center for Medicare & Medicaid Services (CMS) and many payers are making end-to-end testing available at no cost. For offices relying on vendors, most testing responsibilities belong to the vendor and not the provider practice, however do not make any assumptions. Contact your vendor and confirm testing is in progress or has been completed.

Keep these key areas in mind, when converting your practice to ICD-10:

• Have a plan
• Get trained
• Update internal practice tools
• Work with vendors and payers
• Test the process

As a reminder, Blue Cross and Blue Shield of Louisiana has created a professional scenario-based testing portal to support ICD-10 readiness testing. To help you in this process, we created customized scenarios, based on provider type and specialty. Each professional medical scenario will present a unique combination of three narratives in a format that allows you to enter ICD-10 codes. Your responses will be submitted to Blue Cross for processing at the end of each testing scenario.

The ICD-10 “Go Live” date is October 1, 2015.
LA SB No. 710 Aids Physicians Applying for Network Participation

Louisiana Senate Bill 710 (Act No. 897) makes provisions for healthcare insurers to compensate non-participating physicians—who have applied for network participation—as though they are a participating network provider during the network application process, when all criteria are met. This bill benefits both the physician and the member during the waiting time between applying for network participation and the completion of the credentialing process.

In essence, Blue Cross will process claims for the applicant physician as though he/she were already in-network and apply the member’s in-network level benefits. The applicant physician agrees to accept Blue Cross’ allowables and the member’s costshare(s) as payment in full and not balance bill the member for any amounts above the Blue Cross allowable. The applicant physician; however, will not be listed in our provider directories until he/she is effective in our provider network(s).

To be eligible for this provision the following criteria must be met:

1. You must be a physician (MD) or osteopath (DO). This provision does not apply for ancillary and allied providers (e.g. nurse practitioners, therapists, chiropractors, etc.).

2. You must be applying for network participation to join a provider group that already has an executed group contract on file with Blue Cross. This provision does not apply for solo practitioners.

3. You must have hospital admitting privileges or an acceptable hospital arrangement to a network facility.

4. You must include, with your network application, a written letter of request asking Blue Cross to invoke Act 897 and reimburse you as a network physician during the credentialing process. Below is preferable sample language you may use for your Act 897 request.

[Date]

Dear BCBSLA:

In accordance with enactment of Act 897, please accept this written request to reimburse [physician’s name] for services provided as a new physician at [provider group name] at our group contract rate and with in-network benefits.

[Provider Group Name] agrees that all contract provisions, including holding covered members harmless for charges beyond the Blue Cross allowable amount and the member’s costshare amount (deductible, coinsurance and/or copayment, as applicable) will apply to the new physician.

[Signature of the physician]

If you have questions about this provision, you may contact our Network Operations department at network.administration@bcbsla.com or 1.800.716.2299, option 3.

Signature Required on LSCA

Blue Cross requires all providers to sign and date the Louisiana Standardized Credentialing Application (LSCA). The signature and date must be handwritten, as Blue Cross does not accept signature stamps or date stamps. The date must be within 180 days of the date of Credentialing Subcommittee approval. Any omission of the signature or date will delay the processing of the application.

In addition, Blue Cross will only accept the most current version of the LSCA. The updated LSCA (latest revision date is January 2012) is available online at www.bcbsla.com/providers >Forms for Providers.

For more information on the credentialing process, visit www.bcbsla.com/providers >Credentialing.

Imaging Authorizations

Blue Cross, including HMO Louisiana, Inc., is contracted with AIM Specialty Health (AIM), an independent company, to administer authorization services for elective outpatient high-tech imaging studies.

Ordering physicians must use AIM’s authorization portal (available through iLinkBLUE) for imaging authorizations for Blue Cross, HMOLA and Federal Employee Program (FEP) members. AIM conducts authorization services for the following outpatient, non-emergent imaging services:

- 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

An authorization requested by providers other than the ordering physician of the radiology service is prohibited. Ordering physicians (whether a primary care physician 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 if a specialist orders the test. Hospitals and freestanding facilities that perform the technical component of the imaging services should not obtain authorizations for ordering physicians; however, they may check the status of an authorization request through iLinkBLUE (www.bcbsla.com/ilinkblue/).
Request for Medical Records for Risk Adjustment Process

Blue Cross, including HMOLa, has partnered with Altegra* to perform risk adjustment chart reviews on our behalf.

We have a confidentiality agreement with Altegra. Any information shared with Altegra will be kept in the strictest of confidence, in accordance with all applicable state and federal laws and HIPAA requirements regarding the confidentiality of patient records.

Reviewing medical chart documentation is a key component of the risk adjustment process. For example, it enables us to identify conditions that you may have noted in the progress notes, but were:

- Not included on the claim at the time of the visit
- Not coded to the highest degree of specificity at the time of the visit.

You are required to provide us with medical records as outlined in your Blue Cross network agreement:

*Provider shall provide Blue Cross, upon request and without charge to Blue Cross or Member, information including medical records of a Member reasonably required by Blue Cross to determine benefits and verify services related to provider’s attendance, examination, and/or treatment and allow Blue Cross on-site audit of such records.*

For questions about your Blue Cross and HMOLa contract obligations, please contact Provider Relations at provider.relations@bcbsla.com or 1.800.716.2299, option 4.

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*Altegra Health Company, an independent company that serves as a risk adjustment research manager for Blue Cross and HMOLa.*

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To RSVP, please send an email to provider.relations@bcbsla.com. Include a list of those from your office who will be attending along with your office name, a contact name and phone number. Please also include the date and session* you plan to attend.

*Each session is a repeat so only one session is required.

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Tired of waiting for the mailman to deliver your Blue Cross provider newsletter?

Send an email with your name, provider name, correspondence email address and NPI or Tax ID number to provider.communications@bcbsla.com and we will add you to our newsletter mailing list.
New OGB Benefits for 2015
Effective March 1, 2015, Office of Group Benefits (OGB) members have one of five new benefit plans:
• Pelican HRA 1000
• Pelican HSA 775
• Magnolia Local
• Magnolia Local Plus
• Magnolia Open Access
Full details on these new benefit plans are in the OGBnews newsletter, available online at www.bcbsla.com/providers >News.

Well-child Visit Billing Guidelines
Childhood is a vital time for growth and development and well-care visits are necessary for healthcare providers to evaluate the physical, emotional and social development of the child and decrease the risk for serious and long term health conditions. A well-child visit (preventive medicine evaluation) is a critical step in maintaining health. It is important that providers are reimbursed appropriately for services being provided to our members.

Proper coding for well-child visits:
• 99382 - New Patient, Age 1-4 years
• 99383 - New Patient, Age 5-11 years
• 99392 - Established Patient, Age 1-4 years
• 99393 - Established Patient, Age 5-11 years

Use these ICD-9 Codes for these visits (as appropriate):
• V20.2 - Routine Infant or Child Health Exam
• V70.0 - Routine Medical Exam
• V70.8 - General Medical Exam NEC
• V70.9 - General Medical Exam NOS

Billing a well-child visit and sick-child visit on same visit:
Providers may bill for a preventative evaluation and management (E&M) service (well-child visit) and a problem-oriented E&M service (sick visit) on the same day and be reimbursed for both by filing the well-child CPT® code and the sick-visit CPT code with modifier 25.

CPT guidelines state, “The abnormality or pre-existing problem found during the preventative exam must be significant enough to require additional work to perform all the components of the problem-oriented E&M service.”

The well-child visit must occur with a PCP or pediatrician. Medical records must have documentation to justify both services.

In addition, please file all the appropriate diagnosis codes as applicable for all services performed during the well/sick child visit.

How are the member’s benefits applied?
The well-child exam will apply to the members’ preventive benefits and the sick visit will apply to the regular medical benefits. Please communicate this to your patients at the time of service. Any questions regarding specific member benefits may be viewed on iLinkBLUE (www.bcbsla.com/ilinkblue/) or by calling the customer service number on the member’s ID card.

Newborn Billing Guidelines
Blue Cross would like to remind our providers of newborn coding guidelines. When a newborn is seen in the hospital the first time, please code the appropriate code from categories V30-V39, live born infants, according to type of birth. It should be sequenced as the principal diagnosis, followed by any congenital anomaly codes (740-759) and any other conditions from the perinatal period (760-779), as well as any birth weight status codes (V21.3X).
Modifier 25

Did you know that you can bill both wellness and sick visit charges on the same day? The wellness services should be reported on the claim using a wellness evaluation and management code along with the appropriate diagnosis code. Then, the non-wellness service code should be reported on the same claim along with modifier 25. Services other than wellness done on the same day as a well visit are subject to the member’s costshare amount (copayment, deductible or coinsurance, as applicable). To avoid confusion, please communicate this with your patients at the time of service.

Modifiers XE, XP, XS and XU

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.

- According to the Centers for Medicare & Medicaid Services (CMS), “The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter.”
- Modifier 59 should not be used to bypass an edit unless the proper criteria for its use are met and the documentation in the patient’s medical record clearly supports this criteria and the use of modifier 59.

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.

Note: 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.

Specificity of Codes

It is important to file ALL applicable diagnosis codes (supported by the patient’s medical records) 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.

Administrative Appeals

We recognize that disputes may arise between members and Blue Cross regarding covered services. Here at Blue Cross, appeals are distinguished as either administrative appeal or a medical necessity appeal.

**Administrative appeals** involve member contractual issues other than medical necessity or investigational denials. Remember these tips to ensure a fair administrative appeals process:

- A claim requesting additional information (medical records, other carrier’s explanation of payment, etc.) is not an appeal. No adverse benefit determination has been made at the time of the request.
- A request for an appeal without the member's permission will be returned for the member's written authorization
- Provide detailed and thorough information in your submission for a full and fair review.
- An appeal is not a contractual dispute between Blue Cross and your office. This is considered a "provider dispute.”
- All laboratory tests ordered during a wellness visit are not payable under the first dollar wellness/preventive benefit. Please refer to the United States Preventive Services Task Force (USPSTF) website at [www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org) for an updated listing of all first dollar requirements.

**Provider disputes** involve provider contractual issues. Examples include authorization penalties and contractual allowable disputes. Bundling and claim check issues must be submitted on a Reimbursement Review Form (available online at [www.bcbsla.com/providers >Forms for Providers]) for an initial review for bundling, claim check issues or reimbursement reviews. As a reminder, a claim denied or assessed a penalty for failure to obtain authorization is not a decision based on medical necessity criteria. The denial/penalty is strictly based on your signed provider agreement, which indicated that you agreed to follow our medical management process, including obtaining authorizations when required.

Finally, there is no need to submit a duplicate copy of a claim when filing an appeal or dispute, unless you are submitting a corrected claim.

For more information on appeals, view the provider manuals, available online at [www.bcbsla.com/providers >Education on Demand or on iLinkBLUE (www.bcbsla.com/ilinkblue)](http://www.bcbsla.com/ilinkblue) under the “Manuals” section.
Billing and Coding

Appropriate National Drug Code on Claims

As we prepare for the conversion to ICD-10, we have made enhancements to our claims processing system to require all appropriate NDCs (National Drug Codes) for prescription drugs billed through the member’s medical benefits.

For Hardcopy Claims:
- On the CMS-1500 Form, report the NDC in the shaded area of Box 24 A.
- On the UB-04 Form, report the NDC in Box 43 (description field)

For Electronic Claims:
Report the NDC in loop 2410, Segment LIN03. The code should consist of the Centers for Medicare and Medicaid Services (CMS) 11-digit NDC derivative with a leading zero resulting in a fixed length 5-4-2 (no hyphens) configuration. The proper format is validated during the processing period. The drug pricing information along with the corresponding unit(s) of measure should be reported in loop 2410 CTP03-05. Available measures of units include the international unit, gram, milliliter and unit.

Reporting the NDC on claims improves accuracy, especially for claims filed using miscellaneous HCPCS code J3490. It will also improve claims adjudication and provide us with better data for our members.

ICD-10 Coding Book Winners!

Blue Cross would like to announce the winners of the ICD-10 coding book giveaway for December, January and February. Thank you for completing the ICD-10 professional scenario-based testing.

December 2014
- Kristy Koch- WK Robotic and Laparoscopic Surgery Clinic
- Ashley Falcon- Gastroenterology Associates
- Lucille Hanafy- Avoyelles Physical Therapy Clinic
- Kelly Middlebrooks- Avoyelles Physical Therapy Clinic
- Tammy Graf- Summers Neurosurgery

January 2015
- Paula Gremillion- Gastroenterology Associates
- Jennifer Erikson, RHIA- The Surgical Specialty Center of Baton Rouge
- Debi Sharp- JCT Medical Consulting
- Cynthia Wilmoth- Neuro Associates
- Jami Pyle- Lewy Physical Therapy Inc.

February 2015
- Angel Rieger- The Allergy & Asthma Clinic
- Amy Bennett- Internal Medicine Associates
- Vicky Morales- De La Ronde Medical Center
- Andon Morgan- Family Practice Associates
- L.A. “Butch” Gomez- Daughters of Charity Services New Orleans

Blue Cross values your efforts in participating in the ICD-10 professional scenario-based testing. Each month, Blue Cross will hold a drawing for the providers who have completed and submitted test scenarios in the testing portal. If you have already completed scenarios in the testing portal, you will automatically be entered into the drawing. Each provider will only be eligible to win one coding book. The coding book will be delivered to the winner’s office.

For more information on this promotion or any of your Blue Cross-related ICD-10 questions, email us at ICD-10providercommunications@bcbsla.com.

The ICD-10 "Go Live" date is October 1, 2015.

ARE YOU READY?

Have an ICD-10 question, send us an email: ICD-10providercommunications@bcbsla.com.

The ICD-10 professional scenario-based testing link is available at: www.bcbsla.com/providers >ICD-10 Conversion.
Premera and Anthem Cyberattacks

In March, Premera Blue Cross, one of 37 independent licensees of the national Blue Cross and Blue Shield Association (BCBSA), confirmed a cyberattack on its data systems. Premera operates in the Pacific Northwest and provides healthcare coverage in Alaska and Washington.

Premera representatives say that while their customers’ stored personal identifying information was possibly exposed in the cyberattack, there is no evidence at this time that hackers have used the information. Premera discovered the cyberattack recently, but its representatives believe it took place last spring, and that hackers accessed data stored in their systems dating back to 2002. Premera is working with the FBI and other appropriate law enforcement agencies to find out how the cyberattack happened.

Because of this, a small number of our customers may be affected by these companies’ cyberattacks, if they received care, resulting in a claim being filed, in one of the states that Premera or Anthem covers. For example, if a customer was on vacation or traveling for work to one of these states and received medical treatment there, that customer could have a claim and stored data in the other plans’ systems.

How Your Patients Can Get Help:
Anthem and Premera are sending written notifications to everyone affected, including BCBSLA members. Both plans are offering two free years of credit monitoring and identity theft protection services to those affected. Any of your patients who got medical treatment in one of the states these plans cover and is concerned should:

- Anthem: Visit www.AnthemFacts.com or call 1.877.263.7995
- Premera: Visit www.premeraupdate.com or call 1.800.768.5817

Although BCBSLA, Anthem and Premera are all part of the national Blue Cross and Blue Shield Association, they are independent, locally managed plans, and their data systems are not connected. These cyberattacks did not occur here and did not affect BCBSLA’s data storage operations.

We take extensive steps to protect our customers’ personal and health information. With the recent media reports of cyber security events, we have stepped up our efforts and are implementing more aggressive measures to do what we can to prevent data breaches from occurring here. With the sophistication of today’s cyberattacks, detecting and stopping them is a never-ending undertaking that we evaluate and update continuously. We will continue to use inside and outside experts and industry best practices and tools to ensure we have the appropriate security for our members.

Medical Management

HEDIS Chart Review- It’s that time again!

We review HEDIS (Healthcare Effectiveness Data and Information Set) measures annually, identifying opportunities for improvement as well as noting the areas where Blue Cross is at or above the national benchmarks. HEDIS measures focus on effectiveness of care, access to care and use of services. To obtain the best values for HEDIS measures, a combination of claims data and chart review data is needed. Blue Cross is currently collecting data in the form of chart reviews. This means that your office may be contacted by representatives from Blue Cross or a contracted vendor acting on our behalf for record reviews.

Earlier this year our vendor, Outcomes Health, joined Altegra Health. Please extend Altegra Health your professional courtesy and assistance in providing these records. There are several factors involved in this process and while it is designed to be minimally disruptive to your offices, we appreciate your cooperation in the timely scheduling and disclosure of the chart reviews.
Medical Policy Update

Blue Cross regularly develops and revises medical policies in response to rapidly changing medical technology. Our commitment is to update the provider community as medical policies are adopted and/or revised. Benefit determinations are made based on the medical policy in effect at the time of the provision of services. Please view the following updated medical policies, all of which can be found on iLinkBLUE at www.bcbsla.com/ilinkblue/.

New Medical Policies

Policy No.   Policy Name
Effective January 1, 2015
00440   itraconazole (OnmelTM)
00451   Phosphate Binders (Branded)
00453   interferon beta 1-b (Betaseron)

Effective January 5, 2015
00447   Functional Magnetic Resonance Imaging

Effective January 21, 2015
00432   BRAF Gene Mutation Testing to Select Melanoma Patients for BRAF Inhibitor Targeted Therapy
00448   alemtuzumab (Lemtrada™)
00459   Genetic Testing for FLT3 and NPM1 Mutations in Acute Myeloid Leukemia
00461   Microarray-Based Gene Expression Profile Testing for Multiple Myeloma Risk Stratification
00467   Pharmacotherapy for Idiopathic Pulmonary Fibrosis

Effective February 18, 2015
00462   Treatment of Hepatitis C with ombitasvir, paritaprevir, ritonavir, and dasabuvir (Viekira Pak™)
00463   Intravenous Anesthetics for the Treatment of Chronic Pain

Updated Medical Policies

Policy No.   Policy Name
Change Effective December 17, 2014
00008   Automatic Implantable Cardioverter Defibrillator (AICD)
00098   Dermatologic Applications of Photodynamic Therapy
00379   Genetic Testing for Hereditary Hearing Loss
00389   Whole Exome and Whole Genome Sequencing for Diagnosis of Genetic Disorders

Change Effective January 1, 2015
00242   ustekinumab (Stelara®)
00306   Dipeptidyl Peptidase-4 (DPP-4) Inhibitors, DPP-4 Inhibitor Combination Drugs, Cycloset® (bromocriptine)
00322   Diabetic Test Strips
00335   Topical Testosterone Products
00336   Omega-3 Fatty Acid Products
00334   PathFinderTG® Molecular Testing

Change Effective January 21, 2015
00440   itraconazole (OnmelTM)
00451   Phosphate Binders (Branded)
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Medical Policy Coverage Legend

These symbols are referenced next to medical policies listed on this page and indicate Blue Cross’ coverage as follows:

I Investigational
C Eligible for coverage with medical criteria
N Not medically necessary
R Retired

Provider inquiries for reconsideration of medical policy coverage, eligibility guidelines or investigational status determinations will be reviewed upon written request. Requests for reconsideration must be accompanied by peer-reviewed, scientific evidence-based literature that substantiates why a technology referenced in an established medical policy should be reviewed. Supporting data will be reviewed in accordance with medical policy assessment criteria. If you have questions about our medical policies or if you would like to receive a copy of a specific policy, log on to iLinkBLUE at www.bcbsla.com/ilinkblue/ or call Provider Services at 1.800.922.8866.
Finding Solutions Together for a Better Patient Experience

For many of our members, navigating the healthcare system can be an overwhelming experience. This is especially true for those who have recently purchased health insurance for the first time.

Our Consumer Experience team regularly surveys members and conducts research so we can understand their healthcare concerns. Then, working together with you, our network providers, we can alleviate anxiety for our mutual customers —our members, your Blue Cross patients.

Fortunately, the top concerns our members have expressed about seeking healthcare are all ones that can be addressed and discussed during office visits with your patients. Talking about concerns with your patients is a good way to get them more engaged in their healthcare. It also makes them feel more confident about accessing the treatment they need and sticking to the care plans you give them.

The top five healthcare concerns members have mentioned to us are:

1. Out-of-Pocket Costs: Members have a lot of uncertainty around their out-of-pocket costs for treatment, tests, specialists, etc. Fear of getting an unexpected bill is a major source of anxiety for members.

We are developing cost estimator tools that will be available later this year. In the meantime, you and your office staff can use information available in iLinkBLUE to address members’ common out-of-pocket cost concerns such as:

- Member eligibility, including who is covered on the contract and the applicable provider network (including eligibility for BlueCard® members seeking treatment in Louisiana)
- Benefits and prior authorization requirements
- Allowable charges
- The member’s deductible and out-of-pocket threshold status
- Imaging authorization statuses

You can also encourage your patients to call the Customer Service number on their ID cards if they have questions about their benefits and what’s covered, or you can have them work with your staff to make sure any referrals, lab work, etc., are to another provider in their network.

2. Pharmacy Coverage: Members have a lot of uncertainty about what their pharmacy benefits cover and their out-of-pocket costs. One way you can help the member in this area is to prescribe generic drugs when possible. These are considered first-line drugs, and the out-of-pocket costs are lower than brand-name drugs. Drugs that work and cost less also make it more likely your patients will remain adherent. Visit www.bcbsla.com/pharmacy to find formulary information regarding preferred brand drugs.

In addition, ask your patients if they have any concerns or issues about taking a particular type of drug when giving them a prescription. It can help alleviate their anxiety and increase their adherence to talk with you about potential side effects or any challenges they foresee in taking a medication.

3. Coordination of Care: Members are concerned about their doctors seeming informed and up-to-date about care they received from other providers. Through our Quality Blue Primary Care program and other programs, Blue Cross is able to share more information—based on our claims data—to help you have a fuller picture of your patients’ health and needs. Contact Provider Relations at provider.relations@bcbsla.com for more information about what we can share with your practice.

4. Wellness Visits: Some patients avoid annual wellness visits because they do not understand there is little to no out-of-pocket cost for these visits. They only go to the doctor if they are sick or injured and need care. You can remind your patients that for most health plans, an annual wellness visit is covered with a reduced or zero member costshare. You can also discuss the benefits regular screenings and wellness visits contribute to their overall health.

5. Preventive Care: Members have more than 50 preventive care benefits available at no additional cost to them when coded as a wellness visit by their physicians. You can refer to www.bcbsla.com/Docs/Preventive_Care_Services.pdf for the comprehensive list.

Other opportunities to improve the patient’s experience center around wellness or preventive care interventions. For example, members reported that they were unclear about when to receive an annual flu vaccine, smoking cessation opportunities available to them and aspirin therapy options. Blue Cross can provide your office with materials that describe these and other wellness interventions, which you can distribute to patients.

Members can also visit www.bcbsla.com/wellness to take their personal health assessment and sign up for their online member accounts if they have not done so already—this gives them real-time access to information about the wellness benefits and preventive services available through their health plans. This is also a fast, easy way for them to see their health benefits, claims and other important information about their Blue Cross plan.

Members can download our BCBSLA mobile app for Android or iPhone, to have their healthcare coverage information available at their fingertips.

We are continually working to provide our members with a better experience, and will continue sharing research insights and updates about our available resources throughout the year. Thank you for all that you do for our members!
In 2014, Blue Cross and HMOLA began sending Specialty Care Insight reports to network providers in cardiology, orthopedics, otolaryngology (ENT), gastroenterology and urology. These reports mark the first time Blue Cross shared data—based on our claims—with providers in these specialties to show how they compare with similar practices on efficiency (cost of care) and effectiveness (outcomes for medical conditions that physicians in that specialty commonly treat) measures.

Blue Cross will send the practices in these specialties a Specialty Care Insight Report twice a year. And beginning this year, Blue Cross is sharing data from these reports with primary care physicians in our networks.

As primary care physicians are accountable to coordinate care, ensure improved health outcomes and manage costs for their attributed Blue Cross and HMO Louisiana members, they need information that helps them make more informed referrals. Primary care physicians often share patients and co-manage episodes with specialists, and collaboration such as this allows the greatest value for our members.

Blue Cross aims to share this information twice a year by sending network primary care practices enrolled in our QBPC program a Shared Care Report. Blue Cross anticipates that the report will include specialty data for cardiology, orthopedics, otolaryngology, gastroenterology and urology specialties. The overall effectiveness and efficiency data in those specialties for the five practices to which that practice most often refers patients will be shared.

The specialty practice names are blinded in the first round of the Shared Care Reports, but Blue Cross plans to list each practice by name in future versions of this Shared Care report.

Blue Cross is continuing to meet with the Louisiana societies and professional chapters for the specialties currently included in the Specialty Care Insight program to get ongoing feedback on the measures included in these reports.

For more information on the Specialty Care Insight initiative, visit www.bcbsla.com/SCI.

QBPC White Paper Available Online

Blue Cross has published a white paper on the development, implementation and first year of QBPC. The white paper is available online at www.bcbsla.com/QBPC. This document contains statistics on the disease management improvements, enrollments and other successes the program has seen after only one year.

Learn more about our QB Programs...

We offer more information on our QB programs at www.bcbsla.com/providers >Quality Blue.
More Members to Benefit from QBPC-waived Copayment in 2015

We have implemented a new cost-savings incentive for members when services are performed by a QBPC provider. Blue Cross, including HMOLA, will waive or reduce a member’s office copayment for office visits with a QBPC-enrolled primary care doctor (this benefit also applies for office visits with a nurse practitioner who works with the enrolled primary care doctor). This means that Blue Cross will pay 100 percent of the Blue Cross allowable charge.

The reduced or waived copayment is for the office visit only – if other services, such as x-rays or lab work, are performed during the office visit, the member will be subject to his/her usual copayment for those services.

For office staff, the most accurate way to determine a member’s appropriate QBPC cost share is by referring to iLinkBLUE (www.bcbsla.com/ilinkblue/). These copayment waivers and reductions will be reflected on QBPC provider’s remittance advices.

<table>
<thead>
<tr>
<th>Product</th>
<th>Copayment Incentive</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>BlueConnect</td>
<td>Copayment waived for QBPC PCP office copayment services</td>
<td>January 1, 2015, and as policies renew</td>
</tr>
<tr>
<td>Community Blue</td>
<td>Copayment waived for QBPC PCP office copayment services</td>
<td>January 1, 2015, and as policies renew</td>
</tr>
<tr>
<td>Preferred Care PPO and HMO products with office copayment services</td>
<td>Copayment reduced by $15 for regular QBPC PCP office copayment services</td>
<td>January 1, 2015, and as policies renew</td>
</tr>
<tr>
<td>Preferred Care PPO products without office copayment services (e.g. deductible products such as BlueSaver)</td>
<td>No change to the QBPC PCP office cost shares. The deductible for office services is not waived or reduced.</td>
<td>No Change</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of Louisiana employee group policies (ID cards with the group number beginning with 46210)</td>
<td>Copayment waived for QBPC PCP office copayment services</td>
<td>July 15, 2014</td>
</tr>
</tbody>
</table>

For more information on this benefit or if you have questions, contact your Blue Cross Provider Relations Representative. To locate your Provider Relations representative, view the Provider Representative Map, located at www.bcbsla.com/providers >Provider Tools.
Our Mission: "To improve the health and lives of Louisianians."

What’s New on the Web

www.bcbsla.com > I’m a Provider

- UPDATED provider manuals (also available on iLinkBLUE)
- New OGB newsletter (see Page 4 for details)

Get This Newsletter Electronically:
Your correspondence email address allows us to electronically keep you abreast of the latest Blue Cross news and some communications that are sent via email only.

Email provider.communications@bcbsla.com and please include a contact name, phone number and your provider number in your email.

Have an Idea?
NetworkNews is your newsletter, designed to serve you, our valued network providers. The views of our readership are important to us. If you have ideas for articles or suggestions about how we can improve this newsletter, please email us at provider.communications@bcbsla.com.

Network News

Network News is a quarterly newsletter for Blue Cross and Blue Shield of Louisiana network providers. We encourage you to share this newsletter with your staff.

The content in this newsletter is for informational purposes only. Diagnosis, treatment recommendations and the provision of medical care services for Blue Cross members are the responsibilities of healthcare professionals and facility providers.

If you would like to receive this newsletter by email, please contact us at provider.communications@bcbsla.com.

View this newsletter online at www.bcbsla.com > I’m a Provider > News

Important Contact Information

Authorization
See member’s ID card

BlueCard® Eligibility
1.800.676.BLUE(2583)

Claims Filing
P.O. Box 98029
Baton Rouge, LA 70898

EDI Clearinghouse
1.225.291.4334
EDICH@bcbsla.com

FEP
1.800.272.3029

Network Administration
1.800.716.2299 Fax: 225.297.2750
Network.Administration@bcbsla.com

Provider Services Call Center
1.800.922.8866

Fraud & Abuse
1.800.392.9249
Fraud@bcbsla.com

iLinkBLUE & EFT
1.800.216.BLUE(2583)
iLinkBLUE.ProviderInfo@bcbsla.com

Please share this newsletter with your insurance and billing staff!