The Time Has Come for ICD-10

October 1 is right around the corner and it is time to transition to ICD-10 codes. Based on ICD-10 webinars we held in August and September, the most common question is how to correctly code claims using ICD-10 codes. The information below shows you different situations and how you should properly code in those situations.

Blue Cross will NOT accept claims filed with ICD-9 codes for dates of services on and after Oct. 1, 2015. Below are the rules for filing claims:

For professional claims:
- If the dates of services are before Oct. 1, 2015, the claim should be filed with ICD-9 codes.
- If the dates of service span Oct. 1, 2015, the claim must be:
  - For professional services (excluding durable medical equipment and anesthesia claims), split into two claims. All services prior to Oct. 1, 2015, should be filed on one claim with ICD-9 codes. All services on or after Oct. 1, 2015, should be filed on one claim with ICD-10 codes.
  - For durable medical equipment (DME) services, the claim should be coded as a single claim with ICD-9 codes. No splitting is needed.
  - For anesthesia services, the claim should be coded as a single claim with ICD-9 codes. The beginning and ending dates of service should be coded as Sept. 30, 2015. No splitting is needed.
- If the dates of services are on or after Oct. 1, 2015, the claim must be filed with ICD-10 codes.

For inpatient facility claims:
- If the discharge date is prior to Oct. 1, 2015, the claim should be filed with ICD-9 codes.
- If the discharge date is on or after Oct. 1, 2015, the claim should be filed with ICD-10 codes.

For outpatient facility claims:
- If the statement from and through dates are before Oct. 1, 2015, the claim should be filed with ICD-9 codes.
- If the statement from and through dates span Oct. 1, 2015, the claim must be split into two claims: all services prior to Oct. 1, 2015, filed on one claim with ICD-9 codes and all services on or after Oct. 1, 2015, filed on a separate claim using ICD-10 codes.
- If the statement from and through dates are on or after Oct. 1, 2015, the claim should be filed with ICD-10 codes.
Our New Provider Relations Manager

We are pleased to announce Kim Gassie as the new Blue Cross provider relations manager as of July 2015.

Kim brings much familiarity to this role with more than 27 years of Medicare/Medicaid provider relations and education experience. Most recently, Kim has been our plan’s liaison with the Blue Cross Blue Shield Association on many different forefronts and also the Blue Distinction® program administrator for the various Blue Distinction designations. Prior to that role, Kim was the network innovations administrator, managing and implementing divisional and corporate projects.

Kim has had healthcare experience in the areas of provider education and training from her roles as senior education coordinator for Pinnacle Medicare Services and senior provider relations analyst for Unisys, Louisiana Medicaid Intermediary. She is also active with many of the professional healthcare organizations and medical societies in Louisiana.

In-network Labs

Participating providers in our networks 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 participating reference laboratory providers.

Through data analysis, we continue to identify providers who are out of compliance with our laboratory referral policy. Once identified, notification reminders of our policy are being mailed to physicians of record who ordered the lab services.

Please refer to your Professional Provider Office Manual, which states that all providers participating in the network should refer members to participating reference lab vendors when lab services are needed and are not performed in the provider’s office. Providers who consistently do not refer members to network reference labs may be subjected to lower allowable charges.

Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by Preferred Care PPO or HMO Louisiana participating hospitals. Otherwise, send all lab orders to one of our participating reference labs.

Our reference lab guidelines are available online in our provider manuals and speed guides.

- www.bcbsla.com/providers >Education on Demand
- iLinkBLUE under the “Manuals” section (www.bcbsla.com/iLinkBLUE)

HMO Expanding Statewide

As you have probably noticed, the PPO-model, large-scale network is no longer a one-size-fits-all solution for healthcare coverage. With the Affordable Care Act, millions more customers are shopping for health insurance, many of whom are doing so for the first time. More and more, they are looking to us and other insurers to give them different plans to choose from that feature different premium costs and network makeup.

We continue to offer our customers a variety of choices so they can pick the healthcare plan that best meets their family needs and budget.

In offering new products, we rely on the vast amount of healthcare data at our disposal to identify providers who are delivering the highest-quality, most cost-efficient care among their peers. These are the providers we are contracting with to evolve our HMO Louisiana network, which we will offer statewide in 2016.

While we are expanding our HMO Louisiana network to be a statewide network of doctors and hospitals, it will not be as broad as our PPO network, and not every provider in our PPO network will be included.

Our Statewide Network Reference Labs

| Clinical Pathology Labs | 1.800.595.1275 | www.cpllabs.com |
| Labcorp | 1.800.621.8037 | www.labcorp.com |
| Omega Diagnostics | 1.866.875.0415 | www.omegadiagnosticslab.com |
| Quest Diagnostics Clinical Laboratories | 1.800.MYQUEST | www.questdiagnostics.com |
Behavioral Health Network Changes

Today, Magellan Health manages the behavioral health network for our HMO Louisiana, BlueConnect, Community Blue and Federal Employee Program (FEP) members. Effective Jan. 1, 2016, we will no longer use Magellan as the behavioral health network for these members.

Respectively, the HMO Louisiana, BlueConnect and Community Blue provider networks will include behavioral health providers on Jan. 1, 2016. These members will utilize the behavioral health providers in their own network. FEP members will access the behavioral health providers in our Preferred Care PPO network.

Magellan providers who choose not to join our provider networks will be considered out-of-network for our members effective Jan. 1, 2016.

If you are a behavioral health provider and you would like to participate in our networks, please contact our Network Development department at network.development@bcbsla.com or (800) 716-2299, option 1.

Administrative Representative

Today, Blue Cross offers network providers the option to request inpatient and outpatient authorizations electronically through our iLinkBLUE Provider Suite. Then in 2016, network providers will be required to manage their behavioral health and/or Blue Advantage* from HMO Louisiana, Inc. services electronically.

The designation of an administrative representative ensures you have access to our Authorization Portal tool. This tool allows you to request and manage inpatient and outpatient authorizations, upload discharge information, view request decisions and many other items.

In the near future, Authorization Portal users will be able to check pre-service reviews for out-of-area members. Users will be able to view pre-service authorizations and notifications for these members.

Without the designation of an administrative representative, Blue Advantage network providers will not be able to access their online resources (eligibility, benefits, claims and more) for Blue Advantage members. Behavioral health facilities will not be able to access and manage authorizations.

If your facility does not have a designated administrative representative, please contact our Provider Relations department at provider.relations@bcbsla.com or (800) 716-2299, option 4.

*Blue Advantage is our Medicare Advantage network that will be effective Jan. 1, 2016, in the Baton Rouge, Acadiana, Northshore and Greater New Orleans areas only.
**Remind Patients to Get Their Flu Shot**

Each year, millions of people suffer from the flu, a highly contagious infection. It spreads easily from person to person and can be life threatening in older adults and in people of any age who have a chronic illness such as heart, kidney or lung disease.

The Centers for Disease Control (CDC) recommends that everyone six months and older get a flu shot each year. Vaccines are safe and the most effective flu prevention.

Blue Cross would like to remind providers to encourage their patients to get their annual flu shot. We will cover the flu shot at 100 percent when members receive their flu vaccine from a network provider or participating retail pharmacies. This means that our members will pay no cost share for their flu shots.

**Note:** If you file the flu shot with a sick or regular visit, members must pay their copayment or deductable as applicable for the sick services.

Please use the following HCPCS or CPT codes when billing for the flu vaccine:
- Administration of vaccine: G0008
- Vaccine: 90655-90660, 90662

**Blue Cross Updates Code Ranges**

Blue Cross recently completed a review of new 2015 CPT and HCPCS codes. As a result, we have made minor updates to the Outpatient Procedure Services and the Diagnostic and Therapeutic Services code ranges.

The following CPT code(s) have been added to the Outpatient Procedure Services code range **effective July 1, 2015:**

- 0392T
- 0393T

The following HCPCS codes were added to the Diagnostic and Therapeutic Services code range **effective July 1, 2015:**

- C2613
- C9453-C9455
- Q5101
- Q9976-Q9978

These changes do not affect existing codes and allowable charges on the Outpatient Procedure Services and Diagnostic and Therapeutic Services schedule. They simply allow our system to accept these codes appropriately for claims adjudication. The above changes also apply to the HMO Louisiana Diagnostic and Therapeutic Services schedule.

The complete lists of the Outpatient Procedure Services and Diagnostic and Therapeutic Services are in the Member Provider Policy & Procedures Manual, available on iLinkBLUE (www.bcbsla.com/ilinkblue) under the Manuals section.

**Multiple Diagnosis Codes on Claim Form**

The CMS-1500 claim form version 02/12 allows 12 possible ICD-9 or ICD-10 diagnosis codes instead of the four diagnosis codes allowed on the old version 08/05 claim form. The newer form includes an "ICD Indicator" field to report whether filing with ICD-9 or ICD-10 codes. You must file ICD-9 codes and ICD-10 codes on separate claim forms. They cannot be filed on the same claim form.

Providers should include all applicable diagnosis codes including chronic conditions that exist at the time of encounter.

**Claims Submission Reminders**

Blue Cross strives to process your claims in a timely manner. To help expedite the processing time, claims must be filed with valid Blue Cross NPI numbers for both billing and rendering providers. Claims must also include the corresponding tax identification number and the current member identification number including the 3-digit alpha prefix. Neither member nor provider Social Security numbers are accepted.

**Modifier 33 for Preventive Services Under PPACA**

PPACA (Patient Protection and Affordable Care Act) mandates coverage for certain preventive or screening services with a U.S. Preventive Services Task Force (USPSTF) A or B rating and prohibits patient cost share for non-grandfathered contracts.

The American Medical Association (AMA) created Modifier 33, preventive service, to aid both providers and payors in compliance with PPACA.

Modifier PT is more specialized. CMS created Modifier PT to be used when a screening colonoscopy becomes diagnostic or therapeutic. For Blue Cross claims, providers can append Modifier 33 or PT to indicate that the screening colonoscopy (45378) was converted to a polypectomy (45383). In this scenario Modifier 33 or PT 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 or PT should not be applied to non-preventive colonoscopies (done to evaluate signs, symptoms, follow-up or existing conditions).

CPT codes identified as inherently preventive (e.g., a screening mammography) or services not mandated by PPACA should not be appended with Modifier 33.

**Check out our online manuals, speed guides, tidbits and more!**

www.bcbsla.com/providers

>Education on Demand
As we prepare for the conversion to ICD-10, we are also making enhancements to our claims processing system to require all appropriate NDCs (National Drug Codes) for all drug claims or medical drug claims billed through our members’ medical benefits. Providers must file NDCs on claims.

**For Hardcopy Claims**
- On the CMS-1500 claim form, report the NDC in the shaded area of Box 24A.
- On the UB-04 claim 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 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 the miscellaneous HCPCS code J3490. Having the NDC improves claims adjudication and provides us with better data for our members.

As part of our ICD-10 transition, we have developed a scenario-based testing portal to support professional providers with ICD-10 readiness testing. This portal will allow you to practice coding clinical scenarios applicable to your specialty using ICD-10 codes. Each specialty will have up to nine frequently encountered clinical narratives for coding. Upon completion, you will have access to view peer reports which compare your coding results with other providers who tested the same scenario with us. You can find the testing link online at [www.bcbsla.com/providers>ICD-10 Conversion]. This testing portal will close on October 30.

If you missed our ICD-10 webinars, you may view the presentation along with FAQs and other resources online at [www.bcbsla.com/providers>ICD-10 Conversion]. You may email questions to ICD10ProviderCommunications@bcbsla.com.

The implementation of ICD-10 codes is a big change for our providers. We are here to help you with any questions you may have during this process. In October, we will host an open forum to give you the opportunity to ask our panel of experts questions about ICD-10. The dates for the open forum are:
- October 16     11:30 a.m. – 12:30 p.m.
- October 23     11:30 a.m. – 12:30 p.m.
- October 30     11:30 a.m. – 12:30 p.m.

The link to access the Open Forum will be online at [www.bcbsla.com/providers>ICD-10 Conversion].

**Coding for Insulin Pumps**
In an effort to appropriately align reimbursement to the types and costs of equipment provided, modifier(s) are required on insulin pump code E0784 for dates of service on or after July 1, 2015.

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

**Coding Examples for Insulin Pumps**
E0784NU – Omnipod insulin pump purchase
E0784RR – Omnipod insulin pump rental
E0784SCNU – Medtronic insulin pump purchase
E0784SCRR – Medtronic insulin pump rental
E0784KDNU – Insulin pump purchase other than Omnipod or Medtronic brand/model
E0784KDRR – Insulin pump rental other than Omnipod or Medtronic brand/model

**Off-campus Services**
Effective Jan. 1, 2016, for off-campus facility claims, Modifier PO should be reported for each service, procedure and/or surgery performed at off-campus provider-based outpatient departments.

For professional claims, there will be separate place of service codes for on-campus and off-campus services that should be reported beginning Jan. 1, 2016.

- 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.

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E0784KDRR – Insulin pump rental other than Omnipod or Medtronic brand/model

**More On ICD-10**

**Missed Our ICD-10 Webinars?**
If you missed our ICD-10 webinars, you may view the presentation along with FAQs and other resources online at [www.bcbsla.com/providers>ICD-10 Conversion]. You may email questions to ICD10ProviderCommunications@bcbsla.com.

**Post Implementation ICD-10 Open Forums**
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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

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<th>Policy Name</th>
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<tr>
<td><strong>Effective June 17, 2015</strong></td>
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<tr>
<td>00454</td>
<td>tesamorelin (Egrifta®)</td>
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<tr>
<td>00466</td>
<td>Endovascular Therapies for Extracranial Vertebral Artery Disease</td>
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<tr>
<td>00470</td>
<td>Ingestible pH and Pressure Capsule</td>
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<tr>
<td><strong>Effective July 15, 2015</strong></td>
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<tr>
<td>00471</td>
<td>Genetic Testing for Duchenne and Becker Muscular Dystrophy</td>
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<td>00473</td>
<td>Peripheral Subcutaneous Field Stimulation</td>
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<td>00475</td>
<td>Auditory Brainstem Implant</td>
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<td><strong>Effective Aug. 19, 2015</strong></td>
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<tr>
<td>00456</td>
<td>lumacaftor/ivacaftor (Orkambi™)</td>
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<td>00458</td>
<td>Amniotic Membrane and Amniotic Fluid Injections</td>
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<td>00465</td>
<td>Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension</td>
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<td>00477</td>
<td>Electronic Brachytherapy for Nonmelanoma Skin Cancer</td>
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Recently Updated Medical Policies

<table>
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<th>Policy No.</th>
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<td><strong>Changes Effective June 17, 2015</strong></td>
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<td>00045</td>
<td>Stereotactic Radiosurgery and Stereotactic Body Radiotherapy</td>
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<td>Nasal Allergy Medications</td>
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<td>00350</td>
<td>Allergy Tests of Uncertain Efficacy</td>
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<td>00395</td>
<td>Insulins (Non-Long Acting Products)</td>
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<tr>
<td><strong>Changes Effective July 7, 2015</strong></td>
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<tr>
<td>00353</td>
<td>Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)</td>
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<td>00356</td>
<td>Proton Pump Inhibitors (PPIs) and Proton Pump Inhibitor/Non-Steroidal Anti-Inflammatory (NSAID) Combination Products</td>
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<td><strong>Changes Effective July 15, 2015</strong></td>
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<tr>
<td>00357</td>
<td>Overactive Bladder Medications (Branded)</td>
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<tr>
<td><strong>Change Effective Aug. 19, 2015</strong></td>
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<tr>
<td>00272</td>
<td>Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer</td>
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<td>00328</td>
<td>Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome</td>
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<tr>
<td>00359</td>
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<td>Genetic Testing for Mental Health Conditions</td>
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<td>00439</td>
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<td>Treatment of Hepatitis C with sofosbuvir/ledipasvir (Harvoni®)</td>
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<td><strong>Change Effective Sept. 8, 2015</strong></td>
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<tr>
<td>00105</td>
<td>Positron Emission Tomography (PET) Oncologic Applications</td>
</tr>
</tbody>
</table>

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

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 (800) 922-8866.
What Is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an “apples-to-apples” basis. Health plans also use HEDIS results to see where they need to focus their improvement efforts.

Many health plans report HEDIS data to employers or use their results to make improvements in their quality of care and service. Employers, consultants and consumers use HEDIS data, along with accreditation information, to help them select the best health plan for their needs. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by the National Committee for Quality Assurance (NCQA).

What Does HEDIS Measure?

HEDIS measures address a broad range of important health issues. Among them are the following:

- Advising smokers to quit
- Antidepressant medication management
- Breast cancer screening
- Cervical cancer screening
- Children and adolescent access to primary care physician
- Children and adolescent immunization status
- Comprehensive diabetes care
- Controlling high blood pressure
- Prenatal and postpartum care

Why Is HEDIS Important?

- Private and public purchasers use HEDIS data to compare health plan performance.
- Health plans use HEDIS data to identify opportunities for improvement and to monitor the success of their efforts to improve.
- State and federal regulators may use HEDIS data as part of their oversight processes.
- Consumers use HEDIS data to assist them when they make choices about health plans.
- Ensures health plans are offering quality preventive care and service to members.
- Allows for a true comparison of the performance of health plans by consumers and employers.

Why Is HEDIS Important to You, Our Providers?

HEDIS can help you to identify noncompliant members to ensure they receive preventive screenings. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. Medical record documentation is required to record pertinent facts, findings and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments and outcomes.

What Is the Value of HEDIS to Your Patients, Our Members?

HEDIS ensures that members will receive optimal preventive and quality care. It gives members the ability to review and compare health plans’ scores, helping them to make informed healthcare choices.

What Can You Do?

- Encourage your patients to schedule preventive exams
- Remind your patients to follow up with ordered tests
- Complete outreach calls to noncompliant members

This article is the first in a series of articles pertaining to HEDIS that will be published in Provider Network News. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Sources: www.ncqa.org
www.qualitycompass.com
Changes to Inpatient Authorizations Process

The authorization process ensures that members receive the highest level of benefits they are entitled to and that the most appropriate setting and level of care for a given medical condition are provided. Recently, Blue Cross reviewed the process and procedural steps for obtaining an inpatient authorization and concurrent review of inpatient stays and made the following revisions:

Inpatient Authorizations:
- Clinical information is necessary for all non-elective medical inpatient admissions. Effective July 1, 2015, Blue Cross discontinued issuing authorizations and initial length of stay for medical admissions without clinical information.
- The process for elective-scheduled inpatient services has not changed.

Concurrent Review of Inpatient Stays:
- We are reducing our concurrent review for diagnosis related groups (DRG) facilities. Blue Cross will authorize an initial 10-day length of stay once clinical information is provided and inpatient criteria are met for the initial authorization of medical admissions.
- It is very important to provide the correct discharge date to Blue Cross. This ensures accuracy of your facility’s utilization management data. If we are unable to collect accurate discharge dates, we may reduce the initial 10-day application.
- If your patient requires a length of stay beyond the 10 days, your facility must request a concurrent review and provide updated clinical information.
- If you require concurrent review or if your patient is discharged before the initial 10-day authorization, then we require you to notify us in one of three ways:
  1. Upload new clinical information and/or enter the discharge date and diagnosis in the online authorization portal, available through iLinkBLUE (if you currently use this option).
  2. Fax updated clinical/discharge information to (800) 267-6547.
  3. Call your designated concurrent review nurse.

Remind Patients to Get an Annual Wellness Visit

Blue Cross encourages all members to have a checkup each year with a primary care doctor—a general practice, family medicine or internal medicine doctor for adults, or a pediatrician for children.

Yearly checkups are important for our members to:
- Get any health screenings or shots they should have
- Ask you any questions they have about their health
- Get help finding specialty care if they need it
- Set personal health and wellness goals
- Catch any issues early, when they are easier to treat
- Check physical, emotional and social development of children to make sure they are meeting the right age milestones

Most Blue Cross plans cover an annual wellness visit with low or no member cost share, so the members do not have additional out-of-pocket costs for this service. And, if members see a primary care doctor enrolled in our Quality Blue Primary Care program, they could have no cost share for office visits (depending on their benefits and plan type).

How Can You Help?
If you have patients who have not had a wellness visit in more than a year, you can do outreach and encourage them to schedule one before the end of the year.

In addition, if you have patients in your healthcare system who do not have a relationship with one of your primary care doctors, you can talk to them about why it is important to have a primary care doctor who will work with specialists to coordinate their care, and encourage them to begin seeing one. Share our website about why everyone should have a primary care doctor with your patients: www.bcbsla.com/PCP.

Your patients can find network doctors/clinics in our online directory at www.bcbsla.com/FindCare.

Oncology Management Program Ends

Cardinal Health Specialty Solutions (CHSS) has notified us that they are discontinuing their Oncology Management Pathways program on Sept. 30, 2015. The Oncology Management Program was implemented in 2012 to help identify and promote the best clinical practices in treatment methods for select types of cancer. We partnered with CHSS to provide support in treatment pathways development and clinical expertise. This program has been a collaborative effort between our program participants, CHSS and our organization.

If you are a program participant and have any questions, please email Network Development at network.development@bcbsla.com or call (800) 716-2299, option 1.

We help Louisianians protect every day.
Help Your Patients Quit for a Day with the Great American Smokeout, Nov. 19

The American Cancer Society (ACS) marks the Great American Smokeout on the third Thursday of November each year by encouraging smokers to use the date to make a plan to quit, or to plan in advance and quit smoking that day. Providers may wish to use this event to help your patients who use tobacco try quitting—even for one day—and take an important step towards a healthier life.

Tobacco use remains the single largest preventable cause of disease and premature death in the United States, yet about 42 million Americans still smoke cigarettes—a bit under one in every five adults. As of 2012, there were also millions of Americans smoking cigars or smoking tobacco in pipes—other dangerous and addictive forms of tobacco.

Louisiana providers have several free resources to offer your patients who smoke and/or use tobacco products. Any Louisiana resident who wants to quit can call (800) QUIT-NOW, a free, confidential, 24-hour toll-free helpline that will link them to a trained Quit Coach®. Learn more at www.quitwithusla.org.

Long-time tobacco users who are ready to quit can get help from the Smoking Cessation Trust (www.smokingcessationtrust.org). The trust pays for stop-smoking programs for Louisianans who have been smoking cigarettes since before Sept. 1, 1988. Encourage your patients to call (855) 259-6346 for more information—you could change their lives!

The ACS also has quitting resources and information at www.cancer.org/healthy/stayawayfromtobacco/.

Updates to AIM Specialty Health ProviderPortal℠

On Aug. 7, 2015, enhancements to the AIM Specialty Health ProviderPortal were implemented. Providers are now able to review and edit requests before submission. If your requested procedure does not meet clinical criteria after the initial review, you will receive quick feedback. The data entry process and collection is more streamlined and tailored to your patient’s diagnosis. This makes peer-to-peer review more useful.

Registration Open for QBPC Statewide Collaborative

Registration is now open for the 2015 QBPC Statewide Collaborative, which will take place from 11 a.m. until 3 p.m. on Thursday, Oct. 29, at the Hilton Capitol Center in downtown Baton Rouge. You can register for this event online at www.bcbsla.com/QBPCCollaborative.

2015 QBPC Statewide Collaborative Agenda:

- 10:30 a.m. – Registration
- 11 - 11:45 a.m. – QBPC overview and awards ceremony, in which Blue Cross and Blue Shield of Louisiana staff will recognize the top-performing clinics and doctors participating in the program.
- 11:45 a.m. - 12:45 p.m. – Keynote speaker Dr. Janet Wright, Executive Director of the Million Hearts Initiative.
- 1 - 3 p.m. – Afternoon breakout sessions for practice staff on motivational interviewing and a QBPC roundtable discussion.

Continuing medical education credit will be available for the Statewide Collaborative sessions.

There is no cost to attend the Statewide Collaborative, but you must register in advance to guarantee your spot. Please R.S.V.P. by Friday, Oct. 2, if you plan to attend. Each attendee must individually register.

Please share this information with your billing office and those at your office who work with Blue Cross reimbursement.
Electronic BlueCard® Authorizations

Today, our providers are encouraged to designate an administrative representative* to manage the process of granting office level user security access to use our Authorization Portal (available through iLinkBLUE) for the purpose of obtaining electronic authorization for our members.

In the very near future, you will have the option to electronically request, review and sometimes receive authorizations for BlueCard® members using the new Pre-Service Review for Out of Area Members application. This new tool will work like an access gate that routes you to the member’s Blue Plan landing page based on the three character alpha prefix associated with the member identification number. Without an administrative representative, your office cannot grant user access to this new tool.

You will access the Pre-Service Review for Out of Area Members tool by clicking on the "Authorizations and Medical Policy" iLinkBLUE menu selection, then looking under the Authorizations Portal section.

Because this authorization access tool is new, it may not be available for all Blue Plans. The member’s Blue Plan’s landing page will include information about the services that can be authorized electronically. Each Blue Plan’s landing page will include authorization requirements and medical policy access.

We will offer more information, including provider training, on this new tool as we get closer to implementation. If you need more information on how to designate an administrative representative, you may contact our Provider Relations department at provider.relations@bcbsla.com or (800) 716-2299, option 4.

*See article on Page 3 for more information on designating an administrative representative.

Adding Benefits for Same Sex Marriages

The U.S. Supreme Court ruled on June 26, 2015, that same-sex marriages are legal nationwide. This means fully insured Blue Cross and Blue Shield of Louisiana and HMO Louisiana Inc. customers in a same-sex marriage are eligible for spousal/dependent health plan benefits. (Self-insured benefit plans may provide their own definitions of "spouse," although most such plans administered by Blue Cross use the same definition as we do.) Providers may be interested in this information for patients with questions as well as for themselves and their family members.

Groups that offer coverage to an employee’s opposite-sex spouse must now offer that same coverage to same-sex spouses. There are no religious or other exemptions—if a group covers spouses as dependents, the group must cover all spouses. Fully insured benefit plans and most self-funded benefit plans say spousal coverage is offered to a "legal spouse." Same-sex spouses are legal spouses.

Prior to the Supreme Court ruling, Louisiana did not recognize same-sex marriages that took place in other states.

Domestic Partner Coverage

In the past, Blue Cross implemented a process to allow same-sex domestic partners (non-married couples) to be added to large insured group (100+) and self-insured benefit plans. We allowed these "spouse equivalents" to be added because until the Supreme Court ruling, there was no legal way to add a same-sex partner to coverage under Louisiana law.

Going forward, domestic partnership will not be an option on any fully insured Blue Cross or HMO Louisiana policy or plan. We will not be removing existing domestic partners from coverage, but we will not add partners unless they enroll as a legally married spouse. This accommodation can also be made for self-funded groups upon request.
Past President Howard Reitz Dies at Age 96

Howard Reitz, past president and CEO of Blue Cross and Blue Shield of Louisiana and father of current President and CEO Mike Reitz, died Aug. 4, 2015, at home surrounded by his family.

A Korean war veteran, the elder Reitz was president of Cincinnati Blue Cross in Ohio from 1946 to 1953. He joined Blue Cross of Louisiana as head of its marketing department and was appointed president and CEO in 1967. During his tenure, the company grew from 50,000 members to nearly one million.

Also during his 17-year stint as CEO, Blue Cross of Baton Rouge and Blue Cross of Greater New Orleans consolidated to form a statewide plan—Louisiana Health Service & Indemnity Co., doing business as Blue Cross of Louisiana. The merger more than doubled the company’s business and brought it national accounts. On Jan. 1, 1985, the company began doing business as Blue Cross and Blue Shield of Louisiana to reflect the fact that both hospital and physician coverage were provided by one plan.

Blue Cross soon outgrew its small building on Florida Street in Baton Rouge, and Reitz began a search for suitable property to build on. In 1978, Blue Cross purchased 102 acres near Bluebonnet Boulevard and Interstate 10. The company’s new headquarters was completed in 1987, but Reitz had retired as president and CEO in 1983. The project was completed under his successor, Jerry Johnson.

Your Healthcare Dollar at Work

We are here to help our members protect themselves from the unexpected every day. So, we thought you and your patients might like to know how much of each dollar paid for health insurance is spent on each type of care.

The picture below shows how much we spend on covering claims for hospital care, doctors’ care and medicines. This is a picture of what we spend combined on our members, both individuals and those who get coverage through work.

This is a great way to understand what parts of healthcare cost more. The cost of this care affects how much it costs us to cover it—and how much members pay in premiums.

This picture also shows how much of each dollar we must pay in taxes and how much we spend to keep the company going to serve our members.

After we pay healthcare claims, taxes and other costs, we place one cent of every dollar collected from our members into a reserve fund to protect their coverage in case of emergency. For us, keeping strong reserves isn’t just our responsibility as a healthcare company, it’s our duty as citizens of Louisiana.
What's New on the Web

www.bcbsla.com/providers

- UPDATED ICD-10 Conversion: Updated ICD-10 webinar presentation, FAQ’s, and other information.

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
(800) 676-BLUE (2583)

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

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

FEP
(800) 272-3029

Fraud & Abuse
(800) 392-9249
Fraud@bcbsla.com

iLinkBLUE & EFT
(800) 216-BLUE (2583)
iLinkBLUE.ProviderInfo@bcbsla.com

Network Administration
(800) 716-2299 Fax: (225) 297-2750
Network.Administration@bcbsla.com

Provider Services Call Center
(800) 922-8866

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.

Please share this newsletter with your insurance and billing staff!

King vs. Burwell Decision

King vs. Burwell

On June 25, 2015, the Supreme Court upheld a provision in the Affordable Care Act. This provision states the federal government can continue to provide subsidies to residents of states (like Louisiana) that have not established their own health insurance marketplaces. As always, please continue to verify member eligibility through iLinkBLUE to confirm coverage is available when services are rendered.

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.

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