QBPC Statewide Collaborative Success Stories

Blue Cross and Blue Shield of Louisiana held the first Quality Blue Primary Care (QBPC) Statewide Collaborative in November 2014 in Baton Rouge. This was the first time that clinics from around Louisiana (enrolled in or considering joining QBPC) had a chance to come together, discuss best practices and learn how to get the most out of the program. More than 200 guests attended. QBPC is our population health and quality improvement program that we launched in 2013. Blue Cross’ Executive Vice President for External Operations and Chief Medical Officer Dr. David Carmouche and Medical Director of Quality and Informatics Dr. Paul Murphree kicked off the collaborative by sharing some updated statistics about where QBPC is after one year.

More than 450 primary care physicians are enrolled in the program, coordinating care for nearly 137,000 Blue Cross members, including more than 50,000 of whom have one or more chronic conditions. One of four hypertensive and one of six diabetic Blue Cross members are seeing doctors enrolled in QBPC. And, early data on the QBPC health quality measures shows the program is making a difference – from January to October 2014, there was a 12 percent improvement on diabetes quality measures, a 28 percent improvement on hypertension quality measures, a 32 percent improvement on vascular disease quality measures and a 69 percent improvement on chronic kidney disease measures. *

*Based on QBPC clinics that had been in the program at least three months as of October and were active throughout 2014.

Blue Cross and Blue Shield Association Chief Medical Officer Dr. Trent Haywood also addressed the audience, saying he looks forward to hearing continued success stories from our efforts to improve healthcare quality and reverse Louisiana’s historically poor health outcomes.

Dr. Carmouche and Dr. Murphree also presented awards for the top-performing clinics in QBPC after the first year:

- **Highest Achievement in Diabetes Care 2014**: The Family Doctors – Shreveport
- **Highest Achievement in Hypertension Care 2014**: The Family Doctors – Shreveport
- **Highest Achievement in Kidney Care 2014 – East Jefferson Internal Medicine (Site 2)**
- **Highest Achievement in Vascular Care 2014**: The Family Doctors – Shreveport
- **Highest Overall Performance (on both quality and efficiency measures)**: The Baton Rouge Clinic

Following the awards presentation, the Collaborative featured three sessions for which attendees could earn three hours of CME or CEU credits. The keynote speaker was Dr. Peter Toth, Director of Preventative Cardiology at CGH Medical Center in Sterling, Illinois. Blue Cross Population Health staff also gave presentations on population health initiatives under way and interventions that have been effective for primary care practices treating patients with chronic conditions. For more information about the QBPC program and how to become a QBPC provider, visit www.bcbsla.com/qbpc.

Source: QBPC Quality Measures Data from January through October 2014
Changes for 2015 Blue Dental Policies

Blue Cross now offers new traditional dental policies for our members. In addition, many of our members with small group Blue Dental policies will now have traditional orthodontic coverage and some do not have a waiting period for traditional orthodontic services.

- Benefit waiting periods on some of our Blue Dental policies have changed
- Pediatric dental essential health benefits in stand-alone certified Blue Dental policies are now available for members up to age 21
- New small group traditional Blue Dental policies offer Preventative Care Benefits where diagnostic and preventative services do not count toward a member’s annual benefit maximum

Members with Blue Dental policies will continue to use the Advantage Plus PPO* network. Effective January 1, 2015, self-insured groups previously administered by Benefit Management Services (BMS), will now access the Advantage Plus Network. Services with dates of service of January 1, 2015, and after, should be filed with United Concordia. All self-insured business accessing the Advantage Plus Network will have the network indicated on the front of their ID Card.

More information on becoming a UCD network provider is available online at www.UnitedConcordia.com.

* The Advantage Plus PPO Network is maintained by United Concordia Companies, Inc., an independent company that administers dental benefits on behalf of Blue Cross.

AIM Is Closed for the Following 2015 Holidays:

- Mon., May 25 - Memorial Day
- Fri., July 3 - Independence Day
- Mon., Sept. 7 - Labor Day
- Thurs., Nov. 26 - Thanksgiving Day
- Fri., Nov. 27 - Day After Thanksgiving
- Fri., Dec. 25 - Christmas Day

Community Blue Out-of-Network Referrals

We continue to receive out-of-network claims for our Community Blue members. In order to ensure our Community Blue members receive the highest level of benefits, please refer these members to providers participating in the Community Blue Network.

Community Blue is available in the Baton Rouge and Shreveport areas in Ascension, Bossier, Caddo, East Baton Rouge and West Baton parishes.

Look For Updated Manuals

We are updating the following provider manuals:

- The BlueCard® Program Provider Manual
- Dental Network Office Manual
- HMOLA Provider Office Manual
- Member Provider Policy & Procedure Manual (available only on iLinkBLUE)
- Professional Provider Office Manual

By late January 2015, the newly revised manuals will be available online at www.bcbsla.com/providers >Education on Demand. They will also be available under the manual section of iLinkBLUE (www.bcbsla.com/ilinkblue/).

New Provider System of Records

Network Operations recently implemented a new provider system of records. Some of you may have experienced claims problems and issues with being able to access iLinkBLUE due to this implementation. Please know we are working diligently to resolve the issues and prevent future problems.

AIM’s Integrated Imaging Solution Program

AIM has an imaging management program called the Integrated Imaging Solution Program.* This program consists of two major components:

1) Clinical Review and Education: Reduces inappropriate use through full clinical review and scoring of radiology and cardiology requests submitted prospectively.

2) Member Engagement Including Provider Transparency: Operates in tandem with case review and education. When a physician goes through the review process for an imaging exam, AIM provides price and capability information for selecting an imaging facility. After the review process is completed, AIM compares the price and capability for the imaging facility selected during the review process with other facilities located in the same geographic area. If AIM finds another facility that offers comparable or better capabilities at a lower price, AIM will provide the member with information for choosing whether or not to switch to that facility. AIM will also provide assistance in scheduling the service.

While we are not currently utilizing this program for our Blue Cross and HMOLA members, it is important you understand that the program is utilized by other Blue Plans.

*This program does not impact, nor are there any changes to our current Imaging Authorizations Program at this time. The authorization requirements for elective outpatient high-tech imaging services established by Blue Cross and HMOLA are NOT optional.
Member Satisfaction Survey

Each year, Blue Cross conducts the Consumer Assessment to Healthcare Providers and Systems Survey (CAHPS). The 2014 CAHPS was conducted from January through May 2014. From this survey, we received more than 1,100 responses from Blue Cross members.

The survey asked members to rate their satisfaction in several different categories, including getting care quickly, doctor communication skills, shared decision-making, rating of personal doctor and rating of specialist. The results from the survey help us gauge how well we are meeting our members’ expectations and goals and identify areas of opportunity for improvement.

Overall, the health plan rating given to Blue Cross for our PPO and HMO networks has remained strong and our members are satisfied with how well YOU—our providers—communicate with them, and their personal experience with their physician remains higher than the national benchmark.

To ensure our members continue to remain satisfied, opportunities exist for them to have access to a specialist when needed. Please remember that our URAC (Utilization Review Accreditation Commission) accreditation for access and availability requires members to have access to a specialist within a reasonable time frame.

Thank you, once again, for your commitment to our members’ healthcare needs. We appreciate your partnership with Blue Cross in striving to provide the highest quality of care to our members—your patients.

96.7% of our network providers communicate well

90.4% of our members are satisfied with their personal doctor

Hospital Scorecards To Be Distributed To Facilities Participating In Hospital Quality Program

Blue Cross has begun to distribute hospital scorecards to facilities that are participating in the Hospital Quality and Value Improvement Program. The scorecards will be emailed to the quality contacts who have been in communication with the Blue Cross quality team and mailed to the CEO of the hospital.

The scorecard includes how the facility performed on mortality, potentially preventable complications and potentially preventable readmissions as compared to the risk-adjusted expected rate. These measures include only Blue Cross and Blue Shield of Louisiana claims data.

A "How to Read Your Hospital Scorecard" document will be available online at www.bcbsla.com/Providers >Quality Blue. For more information about your hospital scorecard or the hospital quality program, email us at QualityBlue@bcbsla.com.

Credentialing Policy Reminder

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: 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.

HDO Attachment G Form

Blue Cross constantly evaluates our processes and procedures, including what we require of our network providers. An update to the Health Delivery Organization (HDO) Information Form, Attachment G, will affect all new and existing reference laboratory providers participating in our networks.

We require that all reference laboratory providers in our networks (new and existing) must offer a full menu of diagnostic services to be eligible for network participation. These network requirements include the ability to provide a comprehensive list of services to members that includes routine testing such as basic blood counts and cholesterol tests, as well as highly complex methods that assist in diagnosing genetic conditions, cancers and other rare diseases.

We encourage our network reference laboratory providers to complete the new HDO Attachment G and submit it to Blue Cross’ credentialing department to ensure that you meet our credentialing requirements. The updated form is available online at www.bcbsla.com/providers >Forms for Providers.
Quality Blue Primary Care Cost-Savings Incentive

We are committed to improving healthcare quality and lowering overall medical costs for our members—your patients. To emphasize the importance of having quality primary care providers (PCPs) to treat our members’ medical needs, Blue Cross will expand a cost-savings incentive for members when services are performed by a Quality Blue Primary Care (QBPC) provider.

Effective January 1, 2015, and as policies renew, Blue Cross, including HMOLA, will waive or reduce the members’ out-of-pocket expenses for office copay services; when services are rendered by an approved QBPC provider. The most accurate way to determine the members’ appropriate cost share is by referring to iLinkBLUE (www.bcbsla.com/ilinkblue/). This benefit is optional for self-funded groups and not available for OGB members.

Updated Drug Allowables

As part of our routine biannual review of drug and drug administration code pricing, Blue Cross has updated the reimbursement schedule for drug codes, effective for claims with dates of service on and after March 1, 2015.

These allowables are available on iLinkBLUE (www.bcbsla.com/ilinkblue/) under the “Allowable Charge” section. Providers will need to enter “2015-03-01” to access the allowable charges. You may also access the allowable charges for drug and drug administration codes under the “Provider Manuals” section of iLinkBLUE. To register for iLinkBLUE, visit www.bcbsla.com/providers >Electronic Services >iLinkBLUE.

Remind Your 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 chronic illness such as heart, kidney and lung disease.

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

Please encourage your patients to get their annual flu shot. We will cover the flu shot at 100 percent when members receive their flu vaccine from network providers or participating retail pharmacies. This means that our members pay NO copayment, coinsurance or deductible for their flu shots.

Note: if providers file the flu shot with a sick or regular visit, members must pay their copayment or deductible as applicable for the sick services.

Medicare Crossover Duplicate Claims

All Blue Plans are required to process Medicare crossover claims for services covered under Medigap and Medicare supplemental products through the Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare claims to the Blue secondary payer to eliminate the need for the provider’s office or billing service to submit an additional claim to the secondary carrier. Additionally, this has allowed Medicare crossover claims to be processed in the same manner nationwide.

Since 2013, when a Medicare claim crosses over, providers are to wait 30 calendar days from the Medicare remittance date before submitting a claim to Blue Cross.

The claims you submit directly to Medicare immediately cross over to Blue Cross only after they have been processed by Medicare. This process usually takes approximately 14 business days to occur.

Upon receipt of the remittance advice from Medicare, Blue Cross requires an additional 30 calendar days to process the claim. Once the claim is processed, you will receive payment or instructions from Blue Cross.

Providers should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare benefits may exhaust or have exhausted, please continue to submit claims to Medicare to allow the crossover process to occur and for the member’s benefit policy to be applied.

Medicare primary plans, including those with Medicare exhausted services that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected.

Share this newsletter with your business office and those who work with Blue Cross reimbursement.
Unnecessary Medical Authorizations Causing Delays

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.

Authorization requirements may vary slightly by product. Providers should initiate the authorization process at least 48 hours prior to the service being rendered. You can research and view and even submit some authorization requests through iLinkBLUE using the Authorization menu option.

To that end, Blue Cross has experienced an increased number of unnecessary medical authorization requests. These requests are causing delays and extremely long wait times for those services that need authorizing in a timely and efficient manner. Providers are encouraged to refer to iLinkBLUE to verify benefits and confirm that a service truly needs an authorization request.

Complete listings of services that require authorization are in our online network speedguides and provider office manuals, available under the manual section of iLinkBLUE (www.bcbsla.com/ilinkblue/) and online at www.bcbsla.com/providers >Education on Demand.

Blue Cross Updates Code Ranges

We recently completed a review of new 2014 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 outpatient code changes listed below were effective July 1, 2014.

The following HCPCS code(s) have been added to the Outpatient Procedure Services code range:

- 0355T
- 0356T

The following HCPCS code have been added to the Diagnostic and Therapeutic Services code range:

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<td>0350T</td>
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<td>0351T</td>
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<td>0352T</td>
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<td>0353T</td>
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These changes do not affect existing codes and allowable charges on the Outpatient Procedure Services and Diagnostic and Therapeutic Services schedules. It simply allows our system to accept these codes appropriately for claims adjudication. The above changes also apply to the HMOLA schedules.

Blue Cross Coding Accuracy and Reassignment

The following code(s) have been reclassified from Diagnosis and Therapeutic Services to Outpatient Procedure Services code range:

- G0104
- G0105

These code changes allow Blue Cross to change reimbursement and/or coding for accuracy and internal consistency, resulting in the reassignment of reimbursement and/or medical codes for services that have been unbundled or incorrectly coded or to reject codes for mutually exclusive or incidental procedures.

Other codes previously reclassified:

- G0121
- 51701
- 51702

Please make this information available to your business office and those individuals who work with Blue Cross reimbursement.

If you have any questions about these changes, please call our Network Development Representatives at 1.800.716.2299, option 1 or email network.development@bcbsla.com.
Member Benefits

Product Enhancements Effective January 1, 2015
(And as policies renew)

• **Bariatric Surgery** – Coverage is available for obesity surgery with strict eligibility requirements. This benefit is only available for grandfathered and non-grandfathered fully-insured large groups of 200-plus employees. It is optional for self-funded groups.
  - Benefit is once per lifetime
  - Requires prior authorization and must be performed at Blue Cross-approved Blue Distinction facility. For more information on the Blue Distinction program, including a complete listing of Blue Distinction Centers in Louisiana, visit [www.bcbsla.com/providers](http://www.bcbsla.com/providers) Quality Blue.
  - Member must be 18 years or older
  - Six-month participation in supervised weight loss program
  - Psychiatric evaluation and clearance
  - Nutritional counseling
  - BMI of 40 or higher, or 35 and higher with any one of the following: type 2 diabetes, cardiovascular disease, severe obstructive sleep apnea or poorly controlled hypertension
  - Covered procedures include: Sleeve, Band and Gastric Bypass

• **Diabetes Prevention Program** – As members renew in 2015, a Diabetes Prevention Program is available to members age 18 years of older, covered at 100 percent. If this coverage is elected, this insurance policy will be the primary payer for these claims. There is no coordination of benefits. This is optional for grandfathered and non-grandfathered self-funded plans upon their renewal.

• **Hearing Aid Dealer Network Participation** – Blue Cross now offers network participation to hearing aid dealers. Hearing aid benefits may not be available for out-of-network situations.

• **Hospital Penalty Removed for Non-participating Providers** – The 30 percent penalty that was enforced when services were received from a non-participating hospital has been removed for all grandfathered and non-grandfathered fully-insured small and large groups. This is optional for grandfathered and non-grandfathered self-funded groups.

• **Life Vest Wearable Defibrillator (addition of coverage)** – Implantable defibrillators and wearable defibrillators are now covered when authorized by Blue Cross, as outlined in our medical policies. Portable defibrillators are not covered. This benefit applies to grandfathered and non-grandfathered fully-insured individual and group policies, and self-funded group policies.

• **Preventive Care at Zero Dollar - Safe Harbor Generic Drug Program** – Some pharmacy plans that offer a coinsurance-based drug benefit design offer coverage of generic preventive care (safe harbor) drugs at no cost to the member when purchased in-network. There will be changes to the drug categories eligible for first dollar preventive coverage. This benefit applies to grandfathered and non-grandfathered fully-insured individual and group policies, and self-funded group policies.

• **Rural Health Clinics Reorganized** – Blue Cross will list both the rural health clinic and its individual providers by specialty for each rural health clinic in our provider directories. Member cost shares will remain at the primary care provider (PCP) level for grandfathered and non-grandfathered fully-insured individual, and group policies. Rural health clinics will be removed as a PCP option for self-funded group policies.

• **Skilled Nursing Facility Coverage for Nursing Homes** – Benefit plans will allow coverage for skilled nursing services provided in a nursing home specifically approved by Blue Cross and Blue Shield of Louisiana. This benefit is available for grandfathered and non-grandfathered fully-insured individual and group policies. It is optional for grandfathered and non-grandfathered self-funded group policies.

• **Vision Benefits Expanded** – Out-of-network benefits have been added to self-funded vision plans.

• **Wellness Visit Limits Removed** – Visit limits on routine physical exams and Obstetricians and Gynecologist (OB/GYN) exams for preventive and wellness care have been removed from grandfathered fully-insured individual and group policies. It is optional for grandfathered self-funded group policies.
Lymphedema Coverage Mandate (Senate Bill 57)

Senate Bill 57 passed during the 2014 regular session of the Louisiana legislature mandates coverage for lymphedema treatment. Blue Cross currently covers lymphedema on all product lines (except Blue Value and Blue Select) for individuals at standard contract benefits. These products will be expanded to include lymphedema coverage.

Policy Year Reminder

January 1, 2015, is the effective date of individual qualified health plans. The new policy year will be a 12-month calendar year beginning at 12 a.m. on January 1 and ending at 11:59 p.m. on December 31 of each year.

Updated FEP MAC Schedule Available

The new Federal Employee Program (FEP) Maximum Allowable Charge (MAC) dental listings, effective January 1, 2015, are now available under the "Manuals" section of iLinkBLUE (www.bcbsla.com/ilinkblue/).

Now Is The Time To Prepare for ICD-10

With less than a year before the October 1, 2015, compliance date for the implementation of ICD-10, providers are focusing on several key areas to ensure a successful transition and reduce the challenges associated with moving toward ICD-10 implementation. Blue Cross has identified three key areas of ICD-10 preparedness for providers to focus on prior to the ICD-10 compliance date. These areas include documentation, education, and training and transition planning.

• Documentation: Detailed clinical documentation is important for the ICD-10 transition. There are many vendors providing documentation training by specialty to prepare providers for producing the documentation necessary for ICD-10 preparedness.

• Education and Training: The better educated and trained your practice is for ICD-10, the less your practice will suffer with productivity challenges of ICD-10 transition. It is important to identify training options in your area of specialty. Plan for training at least four to five months prior to the advent of ICD-10.

• Transition Planning: Providers should develop an implementation strategy that includes an assessment of the impact on your practice, a detailed timeline and budget. Remember to review payment policies since the transition to ICD-10 will involve new coding rules. Continue to review documentation to ensure that specificity supports the ICD-10 requirements.

For more information on ICD-10, visit www.bcbsla.com/providers >ICD-10. Email your Blue Cross-related ICD-10 questions to ICD10providercommunications@bcbsla.com. ICD-10 resources and training materials are also available through CMS at www.cms.gov/ICD10.

ICD-10 Coding Book Giveaway

Blue Cross values your efforts in participating in the ICD-10 Professional Scenario-based Testing. We now want to provide you with a chance to win an ICD-10 Coding book.

Blue Cross will hold a monthly 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.

As a reminder, Blue Cross has created a 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 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.

For more information on this promotion or any of your Blue Cross-related ICD-10 questions, email us at ICD10providercommunications@bcbsla.com.
### New Medical Policies

**Policy No.** | **Policy Name**  
--- | ---  
00416 | Confocal Laser Endomicroscopy  
00425 | Semi-Implantable and Fully Implantable Middle Ear Hearing Aids  
00431 | tasimelteon (Hetlioz™)  
00438 | Scintimammography and Gamma Imaging of the Breast and Axilla  
00443 | Myoelectric Prosthetic Components for the Upper Limb  
00445 | Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids  

**Effective October 15, 2014**  
00430 | Genetic Testing for Hereditary Hemochromatosis  
00433 | Serum Biomarker Tests for Multiple Sclerosis  
00434 | Intracavitary Balloon Catheter Brain Brachytherapy for Malignant Gliomas or Metastasis to the Brain  
00449 | Chromosomal Microarray Testing for the Evaluation of Early Pregnancy Loss  

**Effective November 21, 2014**  
00427 | C1 esterase inhibitor [recombinant] (Ruconest®)  
00429 | Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease  
00455 | Treatment of Hepatitis C with sofosbuvir/ledipasvir (Harvoni®)  
00457 | Treatment of Hepatitis C with simeprevir (Olysio®) PLUS sofosbuvir (Sovaldi®)  

### Updated Medical Policies

**Policy No.** | **Policy Name**  
--- | ---  
00050 | Hematopoietic Stem-Cell Transplantation for Autoimmune Diseases  
00268 | Use of Common Genetic Variants (single nucleotide polymorphisms) to Predict Risk of Nonfamilial Breast Cancer  
00289 | Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Patients with Non-Small Cell Lung Cancer (NSCLC)  

**Change Effective October 15, 2014**  
00070 | Hyperbaric Oxygen Pressurization (HBO)  
00137 | Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon  
00263 | Sublingual Immunotherapy as a Technique of Allergen-Specific Therapy  
00364 | Bisphosphonates (Oral)  
00387 | Urinary Drug Testing  

**Change Effective November 21, 2014**  
00110 | Radioembolization for Primary and Metastatic Tumors of the Liver  
00134 | Vagus Nerve Stimulation  
00148 | Laboratory Tests for Heart Transplant Rejection  
00180 | Magnetic Resonance Imaging-Guided Focused Ultrasound  
00181 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta  
00199 | Radiofrequency Denervation  
00214 | abatacept (Orencia®)  
00225 | adalimumab (Humira®)  
00324 | GLP-1 Agonist for Diabetes: Byetta® (exenatide), Bydureon® (exenatide ER), Victoza® (liraglutide), and Tanzeum® (albiglutide)  
00436 | apremilast (Otezla®)  

### Medical Policy Coverage Legend

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

- **I** Investigational
- **E** 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.
HEDIS® Measures Benefit Members

Blue Cross strives to improve healthcare quality, and we are striving to educate our members about the excellent care our provider networks offer. With an increased emphasis on HEDIS (Healthcare Effectiveness Data and Information Set) performance, we are enlisting your help in improving our HEDIS rates. As both state and federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual providers as well. In 2015, we will be increasing our efforts for onsite medical record reviews.

HEDIS measures focus on effectiveness of care, access to care and use of services. Provider documentation is critical to improving HEDIS rates. Submitting complete encounter data, correct coding of office visits and keeping comprehensive chart records will help to improve our providers’ HEDIS rates.

Most HEDIS measurements use claims information for evaluating HEDIS performance. Diagnoses and/or procedure codes are often used. If a service is not billed or submitted correctly, the service may not be captured for HEDIS nor reflected in performance scores.

Blue Cross asks our providers to follow these guidelines to ensure good HEDIS rates:

- Providers should keep accurate, legible and complete medical records for their patients.
- Providers should encourage patients to receive appropriate preventive services to ensure their health and well-being.

As a result of measuring healthcare services, Blue Cross is able to develop initiatives to improve the health of members based on their healthcare needs. Our quality initiatives serve to increase member awareness and understanding of preventive healthcare, healthcare screenings and appropriate care for various disease states. Our goal is to empower our members to take an active role in their health.

Understanding Value-driven Healthcare

Both healthcare plans and providers find themselves in the midst of a massive transformation of our entire healthcare delivery system. It is a change that is necessary because although the United States healthcare system is the most expensive in the world, its people are not significantly healthier as a result. Indeed, data from the Dartmouth Atlas of Care reveals that regions that spend more on healthcare do not experience improved survival or better quality of care if they live in regions with more care. In fact, the care they received appears to be worse.

There is considerable debate about why this disparity between cost of healthcare and quality of health outcomes exists, but in the coming months I will attempt to explain much of it. This understanding will be especially relevant to the people of Louisiana; because data shows that our state has some of the highest healthcare-related costs in the country and yet lags behind many other states in the quality of health outcomes achieved.

The relationship of quality, appropriateness and cost of care are correlated in a relationship that denotes value, and that in essence is the transformation that is currently underway, from a volume-driven, transaction-based system to a value-driven, outcomes-based system. It will not be easy, but is necessary.
Blue Cross Welcomes Kevin Egge as VP of Provider Contracting and Relations

Kevin Egge has joined Blue Cross and Blue Shield of Louisiana as vice president of provider contracting and relations. In this role, he will further the state’s largest health insurer’s efforts to improve the healthcare delivery system.

Egge has eight years of experience in healthcare system payment. He most recently was director of contracting, Central North Region, for Humana, Inc., where he directed the implementation of incentive and risk deals for healthcare groups and systems in 11 states. Previously, he worked in the development of transplant Centers of Excellence around the country.

Egge holds a Master of Health Administration degree from the University of Iowa and a Bachelor of Arts degree from Gustavus Adolphus College in St. Peter, Minnesota.

Medication Substitution (Act 396)

Effective January 1, 2015, network providers will be reimbursed when there is a need to substitute a specific medication as outlined in Senate Bill 545 of Act 396, R.S. 22: 1007 (J).

This only applies to brand drug to brand drug substitutions required by Blue Cross for which the provider executes the substitution. This does not apply to generic substitutions or Step Therapy Programs.

To receive reimbursement, the provider should submit the CPT® code 99499 with the modifier TS appended. The use of this code must be supported in the member’s medical records and is payable once per date of service to include all substitutions made. This new fee is not applicable to non-participating providers. Claims submitted for this fee from providers who are non-participating will be rejected. There is no member cost share associated with this fee. The fee is subject to a routine audit.

Blue Cross Launches Specialty Care Insight Program to Share Data with Specialists

Blue Cross has completed the first round of the Specialty Care Insight program, in which we share information about cost and quality with specialty physician practices in our network based on 2013 claims data.

Specialty Care Insight reports, that Blue Cross developed in partnership with CCGroup, Inc., were produced for five specialty types: cardiology, orthopedics, otolaryngology, urology and gastroenterology. The reports show analytical data that lets practices see how they compare to peers on cost of care and utilization of certain services or procedures to treat medical conditions commonly treated in that specialty. The reports also revealed med markers that signify drivers of higher cost of care.

Blue Cross mailed reports to these five specialty practices beginning in August 2014, and held a series of webinars for each specialty to explain why this program was implemented, how to read the Specialty Care Insight report, and how practices can use the information in these reports to improve patterns and reduce overutilization of high-cost, unnecessary services where appropriate.

In 2015, Blue Cross will use refreshed data to produce updated Specialty Care Insight reports for the practices in these five specialties, giving them an updated look at how they are comparing to their peers. The refreshed data will be based on a two-year timeframe (July 1, 2012, through June 30, 2014).

Please visit www.bcbsla.com/SCI to learn more about this program and access valuable resources including methodology videos and recorded webinars.
Pharmacy

Drug Formulary Updates for 2015

To ensure that we are offering a responsible and cost-effective drug benefit and keeping up with the changes in the market, Blue Cross is updating our formulary beginning January 1, 2015. Due to Louisiana state law, for some members, these changes will not go into effect until their respective 2015 contract renewal date.

Throughout 2014, our Pharmacy and Therapeutics Committee, a group of Louisiana doctors and pharmacists, review published literature about the safety, efficacy and cost of prescription medicines. Although many drugs were added to the formulary throughout the year, the Committee also advised us to move some drugs from a lower Tier 2 copayment level to a higher Tier 3 copayment level.

Drugs that will require a 3rd Tier copayment effective January 1, 2015 along with lower 2nd Tier and 1st Tier copayment alternatives, are listed below:

For members on BlueConnect transitional plans, the Tier 3 drugs listed below will no longer be covered, but the alternatives will remain on the formulary.

<table>
<thead>
<tr>
<th>Drug Formulary Changes Effective January 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3 Medications</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Fosrenol*, Renagel*, Renvela* powder packet</td>
</tr>
<tr>
<td>Premarin* vaginal cream</td>
</tr>
<tr>
<td>Accu-Chek* test strips</td>
</tr>
</tbody>
</table>

The drug formulary change below will only affect those members on a 3-Tier pharmacy product with the exception of BlueConnect transitional plans in which this drug will not be covered:

<table>
<thead>
<tr>
<th>Drug Formulary Changes Effective January 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable to 4 -Tier and 5-Tier Pharmacy Benefit Plans</td>
</tr>
<tr>
<td>Tier 3 Medications</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Betaseron*</td>
</tr>
</tbody>
</table>

Members who are taking prescription drugs that are affected by the drug formulary changes have received a notification containing information regarding the lower copayment brand and generic alternatives.

Specialty Pharmacy Changes

Our specialty pharmacy program helps our members using specialty drugs. On January 1, 2015, we added the drugs listed in this chart to the specialty program:

<table>
<thead>
<tr>
<th>2015 Specialty Drug Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-MOP</td>
</tr>
<tr>
<td>Crixivan*</td>
</tr>
<tr>
<td>Epivir-HBV*</td>
</tr>
<tr>
<td>lamivudine/zidovudine</td>
</tr>
<tr>
<td>OxoRalen-Ultra®</td>
</tr>
<tr>
<td>riluzole</td>
</tr>
<tr>
<td>Tivicay*</td>
</tr>
<tr>
<td>Zerit®</td>
</tr>
</tbody>
</table>

After the 2015 contract renewal, if members take the drugs listed in the chart:

- They must get these drugs from a specialty pharmacy in their network (only applicable to individual members and self-insured groups that opted into this benefit).
- They can only get a 30-day supply at one time.
- They will pay a higher copayment/coinsurance (applicable to benefit plans that have a specialty tier).

Not all of the drugs listed in the chart at left are covered under BlueConnect. Thus, BlueConnect members will only be affected by the applicable changes for covered drugs.
Have an Idea?

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