Is an Authorization Required?

We have noticed an increase in provider disputes where providers have failed to obtain prior authorization.

Most member policies apply a penalty on network providers for failing to obtain an authorization when required. For our Office of Group Benefits (OGB) members, claims are denied when a provider fails to obtain a required prior authorization.

Failure to obtain a prior authorization can result in:

- A 30 percent penalty imposed on PPO and HMO network providers for failing to obtain authorization prior to performing an outpatient service that requires authorization.
- A $1,000 penalty applied to inpatient hospital claims if the patient's policy requires an inpatient stay to be authorized. Note: some policies contain a different inpatient penalty provision.
- The denial of payment for services for OGB members.

Authorization penalty amounts or services that are denied for no authorization are not billable to the member.

Services that require prior authorization can be found in our provider manuals and network speed guides. Both are available online at www.bcbsla.com/providers.

Tips to Know

It is important that the place and dates of service as well as the diagnosis and procedure codes match the authorization.
Provider Network

Professional Providers Must Designate Admin Reps
Today, facilities can use our BCBSLA Authorizations application (available through iLinkBLUE) to submit and manage authorization requests electronically for Blue Cross and Blue Shield of Louisiana members.

We are excited to announce that soon professional providers will be able to use the BCBSLA Authorizations application. To prepare for using this tool, we ask professional providers to begin the process of setting up an administrative representative now. Administrative representatives are a requirement for accessing our Authorizations Portal, which includes our online BCBSLA Authorizations application.

Refer Members to Network Providers
Members pay significant costs when using a non-participating provider. In the interest of affordable, quality care for your patients, please always refer your Blue Cross patients to participating providers. This is especially important when referring to a specialist or to an independent provider for services like lab work, medical equipment and specialty pharmacy.

To verify that a provider is participating, please consult our online directories at www.bcbsla.com.

Impact of referring members to non-participating providers:
• The amounts that some non-participating providers charge are higher than Blue Cross’ allowable charges. Non-participating providers can balance bill the member for all amounts not paid by Blue Cross.
• Out-of-network member benefits often include higher copayments, coinsurances and deductibles.
• Some members may have no benefits for services provided by non-participating providers.

Security Changes Coming to iLinkBLUE
We created the Provider Identity Management Team to help providers establish and manage system access through our new Security Setup Tool, which today allows access to our Authorizations Portal and in 2017 access to iLinkBLUE. One of the roles of this team is to set up, educate and assist administrative representatives.

The Provider Identity Management Team will soon begin contacting providers without administrative representatives to begin the setup process. They will also work with existing administrative representatives to transition users through future security changes coming to iLinkBLUE.

In early 2017, the iLinkBLUE Provider Suite will be moved under a higher level of security to meet additional compliance requirements. iLinkBLUE offers online access to benefits, eligibility, claims information, electronic fund transfers and more.

To access the new iLinkBLUE, providers must have an administrative representative. This makes it critical for providers to designate an administrative representative by the end of 2016.

More details about enhancements coming to iLinkBLUE in 2017 will be in future issues of this newsletter.

Administrative Representative Role:
• The key person who delegates electronic access to appropriate users
• Adheres to Blue Cross’ guidelines
• Only grants access to employees who legitimately must have access in order to fulfill their job responsibilities
• Promptly terminates employee access at such time as an employee changes roles or terminates employment

To begin the process of designating an administrative representative, contact our Provider Identity Management team at ProviderIdentMgmt@bcbsla.com. Put "Admin Rep" in the subject line.
Physician Assistants, Midwives & Behavior Analysts Invited to Join Our Networks

Beginning January 1, 2017, physician assistants, certified nurse midwives and applied behavior analysts have the option to participate in our provider networks. These providers must be credentialed, which generally takes up to 90 days. Interested providers must complete a Louisiana Standardized Credentialing Application (available online at www.bcbsla.com/providers > Forms for Providers) and submit their completed information to us by September 1, 2016, to ensure you are in our networks beginning January 1, 2017.

If you are a provider group that has an existing delegated agreement with Blue Cross, there is no additional credentialing action required to add these provider types to our networks if they already have a Blue Cross record. On January 1, 2017, we will automatically convert them to participate in the networks included in your group’s allied health agreement.

For questions regarding network participation, please contact Network Development at network.development@bcbsla.com or 1-800-716-2299, option 1.

Behavioral Health Rainmakers Wanted

We are actively seeking behavioral health professionals who can schedule appointments for patients within seven days of discharge from an acute inpatient setting. We refer to such providers as “Rainmakers” as they are willing to open access to care for newly discharged patients and to help keep them engaged in care post-discharge. Research shows that patients seen by an outpatient behavioral health professional within seven days of discharge are less likely to be readmitted. Rainmakers are beneficial to our discharge planners, clinical teams and members.

If you work within a group of three or more providers and are interested in being a Rainmaker, please send an email to New Directions at LouisianaPR@ndbh.com.

New Directions is an independent company that serves as the behavioral health manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

Newsletter Fully Digital in 2017

Beginning with the 2017 second quarter issue of Provider Network News, it will be delivered via email only. It will continue to be available online at www.bcbsla.com/providers > News. The first quarter 2017 issue of our provider newsletter will be the final printed issue to be mailed hardcopy.

If you currently do not get this newsletter via email, please use the Provider Update Request Form found on Page 5 to send us your current email information.

The form is also available online at www.bcbsla.com/providers > Forms for Providers.

Save the Date for Our Upcoming Facility Workshops

Free Facility Workshops are coming to cities near you in September 2016. These workshops offer training and educational materials on a wide range of topics. Each location will have only one session.

Workshop Schedule:
- Sept. 13 - Baton Rouge
- Sept. 14 - Lafayette
- Sept. 15 - Lake Charles
- Sept. 21 - Bossier City
- Sept. 22 - West Monroe
- Sept. 27 - Houma
- Sept. 28 - Metairie

How to RSVP

We will soon email invitations to the correspondence email address we have on file for facility providers, and the invitation will be the only way to RSVP your attendance.

If you currently do not get communications via email or need to update your correspondence email address, please use the Provider Update Request Form on Page 5 or find the form online at www.bcbsla.com/providers > Forms for Providers.
Provider Availability Standards
We are committed to providing access to high-quality healthcare for all members, promoting healthier lifestyles and ensuring member satisfaction with the delivery of care. To support these commitments, network providers are responsible for meeting the following availability standards:

**Emergency:** Immediate access, 24 hours a day, 7 days a week. These are medical situations in which a member would reasonably believe his/her life to be in danger, or that permanent disability might result if the condition is not treated. Examples are loss of consciousness, seizures, chest pain, severe bleeding or trauma, etc.

**Urgent:** 30 hours or less. These are medical conditions that could result in serious injury or disability if medical attention is not received. Examples are severe or acute pain, high fever in relation to age and condition, etc.

**Routine Primary Care:** 5 to 14 days. These are problems that could develop if untreated but do not substantially restrict a member’s normal activity. Examples are backache, suspicious mole, etc.

**Preventive Care:** 6 weeks or less. These are routine exams. Examples are routine physical, well baby exam, annual Pap smear, etc.

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

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

Patient Coverage Arrangements
We ask that you share your patient coverage arrangements with Blue Cross for vacationing or extended leave periods.

If you are going to be away from your patients for three or more weeks, please send an email to network.development@bcbsla.com with the subject line “Patient Coverage Arrangements.” Include a brief summary of your preparations.

Provider Update Request Form
Help Blue Cross keep your information accurate and current with the Provider Update Request Form. Use the form to submit updates or corrections to your practice information.

The form is available online at [www.bcbsla.com/providers](http://www.bcbsla.com/providers >Forms for Providers or you may cut out the form located on the next two pages.

Identifying OGB Member Coverage
It is important that you verify Office of Group Benefits (OGB) members’ benefits prior to rendering services. There are five benefit plan types currently available for OGB members.

There are two ways to identify the OGB plan type:

1. The contract type listed on the Health Care Benefits Summary page on iLinkBLUE (www.bcbsla.com/ilinkblue)
2. The three-letter alpha prefix on the member’s contract ID number

- Magnolia Local uses prefixes: LZB – BlueConnect
  LXS – Community Blue
- Magnolia Local Plus, Magnolia Open Access, Pelican HRA 1000 and Pelican HSA 775 all use prefix OGS.
Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include tax identification number changes, address changes, hours of operation or changes if you are closing your practice. Please type or print legibly in black ink.

## GENERAL INFORMATION

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## BILLING ADDRESS CHANGE (address for payment registers, reimbursement checks, etc.)

**Former** Billing Address

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**New** Billing Address

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## MEDICAL RECORDS ADDRESS CHANGE (address for medical records request)

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## CORRESPONDENCE ADDRESS CHANGE (address for manuals, newsletters, billing guidelines, medical policies, etc.)

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23XX7231 R05/16  Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.
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Accepting New Patients
Closing panel to new patients (No longer accepting new patients):

- Yes
- No

Opening panel to accept new patients (My panel is currently closed and I would like to begin accepting new patients):

- Yes
- No

### TAX IDENTIFICATION NUMBER CHANGE (please attach the REQUIRED copies of your new IRS Employer Identification Number Letter and a copy of your W-9)

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### CONTACT INFORMATION

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<tr>
<td>mail: Blue Cross and Blue Shield of Louisiana</td>
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<tr>
<td>Attn: Network Operations</td>
</tr>
<tr>
<td>P.O. Box 98029</td>
</tr>
<tr>
<td>Baton Rouge, LA 70898-9029</td>
</tr>
<tr>
<td>fax: 225-297-2750</td>
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<tr>
<td>email: <a href="mailto:network.administration@bcbsla.com">network.administration@bcbsla.com</a></td>
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<tr>
<td>phone: 1-800-716-2299, Option 3</td>
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<tr>
<td>225-297-2758 (Baton Rouge Area)</td>
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### Notification Request

- If you wish to terminate your network participation, please contact Network Development at network.development@bcbsla.com or 1-800-716-2299, option 1
- Please submit documentation for closing your practice (Provider decided to close location, deceased, retired, etc.) on letterhead or contact Network Operations at network.administration@bcbsla.com or 1-800-716-2299, Option 3
Updated Drug Allowables
We updated the reimbursement schedule for drug and drug administration codes, effective for claims with dates of service on and after September 1, 2016.

These allowables are available on iLinkBLUE (www.bcbsla.com/ilinkblue) under the “Allowable Charge” section. Enter “2016-09-01” in the “Please select a date” field to access the new allowable charges. Printable PDF listings of these drug allowable charges are also available under the “Manuals” section of iLinkBLUE.

Sleep Study Policy Change
Effective July 1, 2016, the following changes apply for sleep study services:

Facility Sleep Studies
- We will not cover facility-based sleep studies when performed by a facility that is not specifically accredited to perform sleep studies by either The Joint Commission (TJC) or the American Academy of Sleep Medicine (AASM).
- We will not cover facility-based sleep studies when the member meets the criteria to have a home sleep study instead.
- An authorization is required for facility-based sleep studies.

InterQual (IQ) criteria are used in the authorization process to determine medical necessity. Medical records such as progress notes and Epworth Sleepiness Scale may be required in reviewing authorization requests*.

Home Sleep Studies
- We cover home sleep studies for members age 18 and older.
- An authorization is not required** for home sleep studies.
- Home sleep study claims should be billed with HCPCS code G0398 or G0399. We will not accept HCPCS code G0400 (3 channels or less).
- CPT codes 95800, 95801 and 95806 are not appropriate codes for billing home sleep study services.
- Always refer members to network providers that perform home sleep studies.

Consult the Professional Provider Office Manual (available online under the “Manuals” section of iLinkBLUE at www.bcbsla.com/ilinkblue and at www.bcbsla.com/providers >Education on Demand) for complete billing guidelines on facility and home sleep study services.

**Note: Authorization may be required for some self-funded groups. An authorization is not a guarantee of payment. Always verify the member’s benefits prior to rendering services.

Transplant, Amputation & Ostomy Status Codes
For patients who have had a transplant, amputation or ostomy procedure, there are status and encounter codes that should be included to ensure accurate claims processing and medical records documentation. Please use these codes when applicable.

Many of the status and encounter codes fall within the following ICD-10-CM code ranges*:

- **Transplant:** Z4821-Z48290; Z930-Z944; Z9481-Z9484; Z95811-Z95812
- **Amputation:** Z44101-Z44129; Z89411-Z89619
- **Ostomy:** Z430-Z439; Z930-Z939
- **Respirator Status:** Z9911-Z9912
- **Insulin Long Term:** Z794
- **Postpartum:** Z390-Z392

*This is not an all-inclusive list.

Admissions through the ER/Observations
When a patient is treated in an emergency room affiliated with an acute care facility and is subsequently admitted to the facility, the emergency room record should become part of the admission record and the associated emergency room charges should be included on the inpatient claim.

The admission date indicated on the UB-04 claim form should reflect the date when services were first provided in the emergency room, rather than the date when the patient was admitted. Multiple emergency room visits on the same day with a subsequent admission for a clinically associated diagnosis should be filed with the inpatient hospital claim.

These rules apply regardless of whether the emergency room is physically located on the same campus as the affiliated acute facility or off campus.

If ambulance services are furnished by the hospital, or by others under arrangements with the hospital, to transport the patient from a free-standing emergency room to the acute facility, the ambulance service is not separately reimbursed.
Reporting National Drug Code (NDC) on Claims
Effective July 23, 2016, we require all clinician administered drugs billed on professional and outpatient hospital claims to be processed through the member’s medical benefits to include the NDCs for the drugs. Providers are required to report NDCs on claims with any associated HCPCS or CPT codes, including immunizations. (HCPCS codes beginning with the letter “A” are excluded from this requirement). Failure to report an NDC on these claims will result in automatic rejections.

Providers should use the following billing guidelines to report NDCs on professional CMS-1500 claims and outpatient facility UB-04 claims:

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

For complete NDC reporting guidelines on professional and facility claims, consult our provider manuals available under the "Manuals" section of iLinkBLUE (www.bcbsla.com/ilinkblue) and at www.bcbsla.com/providers >Education on Demand.

Diagnosis Codes for Newborns
Professional claims for initial newborn evaluation and management (E&M) services performed by the provider while the newborn is in the hospital should report the correct diagnosis codes.

We have found multiple instances where twins (Z383X) or multiples (Z386X) were incorrectly coded as a single liveborn (Z380X) on the professional initial newborn claims. Correct identification of newborns in terms of single, twin or multiple liveborn is very important to accurately process claims and ensure coding that can be substantiated in medical record audits. Please refer to the ICD-10-CM code range Z38.00-Z38.8 to identify the appropriate code.

Increased Medical Record Chart Audits
From time to time, we enlist vendors to perform medical record chart audits on our behalf. Per your Blue Cross network agreement, providers are not to charge a fee for providing medical records to Blue Cross or agencies acting on our behalf.

Refunds Involving Workers' Compensation Claims
When a provider receives a claims payment from both workers' compensation and Blue Cross, the provider must refund Blue Cross. In most circumstances, workers' compensation is excluded under the terms of a member contract/certificate and Blue Cross is not responsible for the claim.

As a reminder, while most services that fall under workers’ compensation are considered contract exclusions, we encourage providers to file claims with us. If the service is determined not to be covered by workers’ compensation or the contract does not exclude these services, you risk future consideration.
HEDIS® Measure for Low Back Pain
The Low Back Pain HEDIS measure is the percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (X-ray, MRI, CT scan) within 28 days of the diagnosis. A higher score indicates appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur with 28 days of the diagnosis).

Per the Choose Wisely Initiative, 80 percent of people in the United States will have had low back pain in their lifetime. Overuse of imaging for low back pain is common and costly. Medicare reports that 14 to 23 percent of low back pain patients receive imaging studies within the first six weeks of diagnosis at a cost of $82 million to $226 million per year.

The American Academy of Family Physicians, The American Association of Neurological Surgeons and Congress of Neurological Surgeons, The American College of Occupational and Environmental Medicine, The American College of Physicians, and the North American Spine Society’s stance on imaging for low back pain is that imaging such as X-ray, CT scans and MRI should not be ordered within the first six weeks of diagnosis unless red flags are present because low back pain is generally resolved within the first four weeks of conservative treatment.

HEDIS uses 28 days rather than six weeks because it is the normal resolution period with conservative treatment. This may allow providers flexible timeframes to manage low back pain. Physicians can recommend conservative treatment in the first four to six weeks of complaints of low back-pain when no red flags appear. These treatments include initial over the counter pain medication as needed, heat, physical therapy and exercise. The likelihood that something severe will not be detected early if waiting until after four to six weeks to perform imaging if symptoms are still there is low. In the primary care setting, .01 percent of low-back pain patients are found to have an infection and .7 percent are found to have cancer.

Below are educational resources for more information on treating patients with low back pain:

- American College of Physicians - Click on "Supplements" http://annals.org/article.aspx?articleID=746803

Approval Letters Now Sent by Fax
Our Care Management team has begun sending all approval of service notification letters via fax. Approval letters will no longer be mailed.

Professional providers and facilities may receive up to three separate batches of faxes—inpatient, outpatient and recertification—daily Monday-Saturday beginning at 4 a.m.

Each batch will include all of the members who were approved for services from the previous business day. For example, if there were 15 outpatient services authorized for your facility, the outpatient batch fax will include all 15 approval letters.

Medical Policy Update for Outpatient Facility Claims
Blue Cross has made system enhancements to apply our medical policies to outpatient facility claims more efficiently and effectively.

If you would like to review a specific medical policy, go to iLinkBLUE (www.bcbsla.com/ilinkblue) and click on the "Authorizations and Medical Policy" menu option, then click on the "Medical Policy Guidelines" link. Our medical policy index allows you to search for medical policies alphabetically or by the medical policy number.

InterQual for Spine Fusion
Effective July 1, 2016, Blue Cross will apply InterQual (IQ) criteria when reviewing spine fusion surgeries. These services will be peer-reviewed by a board certified-like specialist when the case does not clearly meet IQ criteria. Services that do not meet criteria will be deemed as not medically necessary and are not billable to the member.

All inpatient services require prior authorization. While most benefit plans do not require an authorization for outpatient spine fusion services, preservice reviews are highly recommended for all outpatient spinal fusion surgeries.

Please share the information in this newsletter with your billing staff and those at your office who work with Blue Cross reimbursement.
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 March 16, 2016**  
00492  
Magnetic Resonance Imaging  
Targeted Biopsy of the Prostate  
00495  
Computed Tomography Perfusion Imaging of the Brain  
**Effective April 20, 2016**  
00496  
Dopamine Transporter Imaging With Single-Photon Emission Computed Tomography  
00502  
Genetic Testing for Neurofibromatosis  
**Effective May 18, 2016**  
00503  
Radiofrequency Ablation of Peripheral Nerves to Treat Pain  
00506  
dichlorphenamide (Keveyis™)  
00507  
uridine triacetate (Xuriden™)  
00508  
sebelipase alfa (Kanuma™)  
00509  
Treatment of Hepatitis C with elbasvir and grazoprevir (Zepatier™)

Recently Updated Medical Policies

**Policy No.**  
**Policy Name**  
**Changes Effective March 16, 2016**  
00011  
Bone Growth Stimulation  
00194  
Low-Level Laser Therapy  
00257  
Multigene Expression Assays for Predicting Recurrence in Colon Cancer  
00343  
Topical Acne Products  
00432  
secukinumab (Cosentyx™)  
00502  
Genetic Testing for Neurofibromatosis  
**Changes Effective April 20, 2016**  
00003  
Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening  
00009  
Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure  
00186  
Neurodiagnostics  
00198  
Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)  
00296  
Percutaneous Left-Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation  
00449  
Chromosomal Microarray Analysis for the Evaluation of Pregnancy Loss  
**Changes Effective April 23, 2016**  
00103  
Positron Emission Tomography (PET) Cardiac Applications

**Changes Effective May 14, 2016**  
00153  
Contrast-Enhanced Computed Tomography Angiography (CTA) for Coronary Artery Evaluation

**Changes Effective May 18, 2016**  
00094  
Percutaneous Vertebroplasty, Kyphoplasty, Mechanical Vertebal Augmentation and Sacroplasty  
00258  
Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used With Autologous Bone Marrow)  
00288  
In Vitro Chemoresistance and Chemosensitivity Assays  
00337  
Migraine Medications (Oral, Injectable, and Transdermal)  
00388  
Cialis® (tadalafil)  
00450  
Keratoprosthesis
BlueCard® Medicaid Programs
While some Blue Plans administer Medicaid programs, we currently do not. Because Medicaid is a state-run program, requirements vary for each state and among Blue Plans.

When you see a Medicaid member from another state, you must accept the Medicaid fee schedule that applies in the member’s home state. Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations.

If you provide services that are not covered by Medicaid, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for Medicaid billing requirements.

Some states require that out-of-state providers enroll in their Medicaid program in order to be reimbursed. Some states may accept a provider’s Medicaid enrollment in the state where they practice to fulfill this requirement.

Where to Send Members for Lab Services
Hospital-based physicians can help keep Blue Cross member costs down by referring them to a Blue Cross preferred reference laboratory.

Some member benefit plans cover laboratory services at 100 percent of the allowable charge when a member receives services in the physician’s office or at one of our preferred reference laboratories.

When members have laboratory services done in a hospital-based setting, benefits are often applied to the member’s deductible and/or coinsurance. Only preoperative lab services rendered before an inpatient stay or outpatient procedure should be performed by a network hospital.

Providers can find a list of our statewide and regional preferred reference laboratories, as well as more information that can help you better educate your Blue Cross patients about our laboratory guidelines, in our Preferred Reference Laboratory speed guides, available online at www.bcbsla.com/providers > Education on Demand.

To view the most current list of preferred labs, visit our website at www.bcbsla.com/providers > Doctor & Hospital Search and enter the member’s ID number or network, type "Laboratory" in the "Specialty or Keyword" field, then enter a city or zip, and click "search."

Verify Member Eligibility as Louisiana Medicaid Expansion Begins
In January, Louisiana adopted the Medicaid expansion with coverage set to start on July 1, 2016.

Enrollment began on June 1 and the state anticipates more than 300,000 individuals will enroll under the Medicaid expansion. This will include consumers who previously purchased Blue Cross and Blue Shield of Louisiana coverage through the Healthcare Marketplace.

Enrollment in Medicaid will require a two-step process. First, consumers must apply and be accepted by Medicaid. Then, they must actively disenroll within the Healthcare Marketplace from their commercial coverage. They can complete both steps through www.healthcare.gov.

What does this mean for Providers?
As a result of the Medicaid expansion’s potential shift in coverage, it is more important than ever for you to check eligibility prior to rendering services.

Always verify:
- Whom their coverage is with;
- What benefits are available; and
- Where to file claims.

For Blue Cross and Blue Shield of Louisiana members, eligibility and benefit information can be verified anytime on iLinkBLUE (www.bcbsla.com/ilinkblue).

Learn more about the Medicaid expansion and its impact on Louisiana by visiting the Straight Talk blog (http://straighttalkla.com) by Blue Cross healthcare economist Michael Bertaut.
What's New on the Web

www.bcbsla.com/providers

- UPDATED provider manuals are available under the Education on Demand section
- UPDATED Provider Update Request Form is available under the Forms for Providers section

Important Contact Information

Authorization
See member’s ID card

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

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

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

Provider Services Call Center
(800) 922-8866

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

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.

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.

View this newsletter online at www.bcbsla.com/providers, then click on News.

The content in this newsletter may not be applicable for Blue Advantage (HMO), our Medicare Advantage product and provider network. For Blue Advantage, we follow CMS guidelines, which are outlined in the Blue Advantage (HMO) Provider Administration Manual, available on the Blue Advantage Provider Portal through iLinkBLUE (www.bcbsla.com/iLinkBLUE).

Please share this newsletter with your insurance and billing staff!