



Louisiana

Member Provider Policy & Procedure Manual



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Blue Cross and Blue Shield of Louisiana MEMBER PROVIDER (FACILITY) POLICY & PROCEDURE MANUAL

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

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

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

If you have questions about the information in your manual or your participation as a Member Hospital, please call Network Administration at 1-800-716-2299, option 3 or (225) 297-2758.



Please note:

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

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

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Member Provider Policy and Procedure Manual

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Quick Reference Guide to **IMPORTANT ADDRESSES AND PHONE NUMBERS**



Provider Services

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

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

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



Provider Network Administration

network.administration@bcbsla.com

Participation/Contracting/Credentialing/Provider Relations Questions: 1-800-716-2299 or (225) 297-2758.

Claims Addresses

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

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

FEP claims should be mailed to:

Blue Cross and Blue Shield of Louisiana - FEP Claims
P.O. Box 98028
Baton Rouge, LA 70809-9029



Electronic Services

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

EDI Clearinghouse

EDICH@bcbsla.com
(225) 291-4334

BlueCard® Eligibility Line

1-800-676-BLUE (1-800-676-2583)

Member Benefits

Call the number on the member's ID card.

Fraud & Abuse Hotline

1-800-392-9249

Appeals and Grievances/Provider Dispute Resolution

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Department
P.O. Box 98045
Baton Rouge, LA 70898-9045
1-800-376-7741

Section 1

NETWORK PARTICIPATION

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

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

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

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

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

Participating Provider Agreements

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

- **Submitting claims for Blue Cross Members.**

This includes claims for inpatient, outpatient and professional services if applicable. To ensure prompt and accurate payment, it is important that you provide all patient information on the required claim form including appropriate HCPCS, CPT® codes and ICD-10-CM diagnosis and procedure codes. Also, remember to include your national provider identifier (NPI) on the claim form.

The Claims Submission section of this manual will give you specific information about completing the claim form as well as HCPCS, CPT and ICD-10-CM coding information.

- **Accepting the Blue Cross and Blue Shield of Louisiana payment as indicated by the Member Contract/Certificate and the Reimbursement Appendix.**

You may bill the member for any deductible, coinsurance, copayment and/or noncovered service according to the terms of the Member Contract/Certificate and the Reimbursement Appendix.

If you are a Preferred Care Provider (PPO) but are not an HMO Louisiana or HMO Louisiana Select Network Provider the reimbursement will be based upon the Blue Cross PPO Allowable Charge as outlined in your provider agreement when treating members with HMO or HMO Louisiana Select Network Contracts/Certificates subject to applicable deductible, non-covered services, copayment and coinsurance as defined by the Member Contract/Certificate.

The Provider Payment Register/Remittance Advice summarizes each claim and itemizes patient liability, the amount above the Reimbursement Amount/Allowable Charge and payment information. Additional information concerning the Payment Register/Remittance Advice is included in this manual.

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

Certain Plan Member Contracts/Certificates include cost containment programs such as preadmission authorization, concurrent review and case management.

- **Providing financial and medical information necessary to carry out the terms of the Member Provider Agreement.**

Blue Cross may require this information in a format designated by the Plan, at no charge to the Plan or its members, including but not limited to:

- 1) Financial statements, ledgers, billings, itemized statements, price lists and patient ledgers.
- 2) Medical records and medical record abstract information. When requested, the Member Provider shall make available complete medical records or medical record abstracts in a format that Plan personnel can utilize.
- 3) Notify Blue Cross of advance notice changes and updates to hospital's services charge master.

Amendments to Provider Agreements

Blue Cross has the right to amend provider agreements by making a good faith effort to notify the provider at least 60 days prior to the effective date of the change.

Member Provider Benefits

Member Providers are those hospitals and affiliated units that have entered into a Member Provider Agreement with Blue Cross. As a Member Provider, a hospital enjoys a close working relationship with the largest health insurer in Louisiana. As a result, the hospital shares in many advantages:

- All Member Providers receive recognition in Blue Cross' marketing programs. Blue Cross Members have benefit incentives in the Member Contracts/Certificates to choose Member Providers over non-member providers.
- For Member Providers, the member's benefits are paid directly to the hospital.
- Blue Cross provides coverage for large groups, small groups and individuals. Consequently, a higher percentage of premium receipts are paid in Benefits as compared to other health insurers in Louisiana. Both of these factors reduce hospitals' uncompensated care levels. As a Member Provider, a hospital works with Blue Cross to benefit the overall healthcare industry in Louisiana.

Allied Health Providers

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

Non-participating Providers

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

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

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

PPO and HMO Point of Service Members

When a member receives covered services from a non-participating hospital, the benefits that Blue Cross will pay under the member's benefit plan will be reduced by 30 percent. This penalty is the member's responsibility.

The member may also be responsible for higher copayments, coinsurances and deductibles when receiving services from non-participating providers.

HMO Louisiana Members

HMO Louisiana members enrolled in an HMO product have no benefits for services provided by non-participating providers without obtaining prior approval. When the plan (1) issues an authorization that the services are medically necessary and (2) approves a member to receive the medically necessary covered services from a non-participating provider, benefits will be at the highest level possible to limit the member's out-of-pocket expenses.

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

Credentialing Program

Blue Cross has been credentialing providers since 1996. Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC) for our PPO and HMO networks.

Blue Cross and Blue Shield of Louisiana reviews providers with which we contract as required by regulatory agencies. Participating providers are expected to cooperate with quality-of-care policies and procedures. An integral component of quality of care is the credentialing of Participating Providers. This process consists of two parts: credentialing and recredentialing.

Credentialing Process

The credentialing process consists of an initial full review of the provider's credentials at the time of application to join our networks. This policy applies to hospitals, skilled nursing facilities, ambulatory surgical centers, home health agencies, independent laboratories, durable medical equipment suppliers, rehabilitation centers, ambulance companies, radiology centers, home infusion centers, hospice centers, urgent care centers, renal dialysis centers (free-standing), psychiatric hospitals, alcohol/drug rehabilitation centers, lithotripsy/orthotripsy facilities, radiation centers, long-term acute care centers, orthotics and prosthetics facilities, comprehensive outpatient rehabilitation facilities, federally qualified rural health clinics, state-owned psychiatric hospitals and laboratory and diagnostic centers.

Prior to initial participation in a Blue Cross network, credentialing criteria includes, but is not limited to, the following:

- Current, valid state or occupational license
- In good standing with state and federal regulatory agencies
- Current Medical Malpractice Liability Insurance and/or LPCF participation and
- One of the following, depending on the facility type:
 - 1) Accredited by a recognized accrediting body (i.e., JCAHO, AAAHC, CHAP); or
 - 2) Acceptable organization on-site assessment

Based upon compliance with the criteria, Blue Cross' medical director will recommend to the Credentialing Committee that a provider be approved or denied participation in our networks. The Credentialing Committee, comprised of network practitioners, will make a final recommendation of approval or denial of a provider's application.

Recredentialing Process

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

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

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

Status Changes

Providers are required to report changes in their credentialing criteria to Blue Cross within 30 days from the date of occurrence. Failure to do so may result in immediate termination.

CLIA Certification Required

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



BCBSLA - Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029



Fax: (225) 297-2750
Attn: Network Operations

Credentialing Process and Network Provider Directory

As a network provider, you may only participate in the Blue Cross networks and be listed in the network provider directory as the specialty you actually practice. For example, providers may not participate in our networks as one of the following specialties of general practice, family practice, internal medicine or pediatrics unless they practice in a full primary care provider (PCP) capacity. For more information on our credentialing process, visit www.bcbsla.com/providers >Credentialing.

Credentialing Requirements for Freestanding Diagnostic Imaging Facilities

Blue Cross and Blue Shield of Louisiana requires that all freestanding diagnostic imaging centers and the equipment used for the modalities listed below be accredited by either the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC) as a condition for network participation. If a center performs any or all of the modalities below and is not accredited or fails to remain accredited, they will be removed from all Blue Cross and/or HMO Louisiana networks in which they participate.

Accreditation is required to perform the following modalities:

- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Positron emission tomography (PET)
- Nuclear Cardiology

Blue Cross will review each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Blue Cross every three years in accordance with URAC standards. Providers who do not maintain their accreditation or do not abide by Blue Cross' credentialing guidelines will be subject to termination from any of our networks in which they participate. The only exception to this rule would be when a diagnostic imaging center no longer performs a modality that requires accreditation or performs another modality that does not require accreditation.

Please note: This policy only applies to "freestanding" and not "hospital-based" diagnostic imaging centers at this time.

Freestanding diagnostic imaging facilities may send proof of accreditation through one of the following methods:



network.administration@bcbsla.com



(225) 297-2750 (fax)

Locum Tenens

A locum tenens is a physician who is hired to temporarily replace another physician. The usual physician may be absent for reasons such as illness, pregnancy, vacation or continuing medical education. The usual physician identifies the reported services as locum tenens physician services by entering code Modifier Q6 (service furnished by a locum tenens physician) after the procedure code on the CMS-1500 claim form. Blue Cross follows the CMS locum tenens billing requirements, which can be found at www.cms.gov.

Medical Staff

Only providers who are a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP) or Psychologist are set up as a medical staff provider under the hospital agreement and file claims independently. All other providers are considered part of the hospital per diem and/or DRG case rates and will not be set up independently under the hospital agreement.

Urgent Care Center Hours of Operation

In order to participate in the Blue Cross networks, an urgent care center must be open at least until 8 p.m., Monday through Friday and open for a minimum of eight hours on either Saturday or Sunday. Additionally, the center must have at least one Medical Doctor (MD) on staff full-time during all business operating hours of the clinic.

If a facility does not meet these requirements, please contact the Network Development Representative for the area to discuss further. To find the appropriate area representative, see our interactive map on the Provider page of www.bcbsla.com/providers > Provider Tools.

Provider Directories

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

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



**Online
Provider Update Form**
www.bcbsla.com/providers
> Forms for Providers

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

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

A Provider Update Request Form is provided in this manual and can be used to notify us of changes or additions to provider directories. You may also complete the update form online at www.bcbsla.com/providers >Forms for Providers. Select the "Provider Update Form" from the list and fill in the blanks. You may notify us of a change by contacting us through the following ways as well:

1-800-716-2299, option 3

provider.update@bcbsla.com

(225) 297-2750 (fax)

Louisiana		Provider Update Request Form	
<p>Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.</p>			
GENERAL INFORMATION			
Provider Last Name	First Name	Middle Initial	
Tax ID Number	Provider National Provider Identifier (NPI)		
Clinic Name	Clinic National Provider Identifier (NPI)		
Languages Spoken	<input type="checkbox"/> Adding Language Spoken (please specify)		
Name of Person Completing Form			
Contact Phone Number	Contact Email Address		
BILLING ADDRESS CHANGE (address for payment registers, reimbursement checks, etc.)			
Former Billing Address			
City, State and ZIP Code	Phone Number		
New Billing Address			
City, State and ZIP Code	Phone Number	Fax Number	
Email Address	Effective Date of Address Change		
MEDICAL RECORDS ADDRESS CHANGE (for medical records request)			
Former Medical Records Address			
City, State and ZIP Code	Phone Number		
New Medical Records Address			
City, State and ZIP Code	Phone Number	Fax Number	
Email Address	Effective Date of Address Change		
Page 1 of 2			
<p>23XX7211 R1/16 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.</p>			

CORRESPONDENCE ADDRESS CHANGE (for manuals, newsletters, billing guidelines, medical policies, etc.)			
Former Correspondence Address			
City, State and ZIP Code	Phone Number		
New Correspondence Address			
City, State and ZIP Code	Phone Number	Fax Number	
Email Address	Effective Date of Address Change		
PHYSICAL ADDRESS CHANGE (must include a copy of your liability insurance showing the new address)			
Former Physical Address			
City, State and ZIP Code	Phone Number		
New Physical Address			
City, State and ZIP Code	Phone Number	Fax Number	
Email Address	Effective Date of Address Change		
Office Hours	Age Range (if applicable, indicate age range)		
Accepting New Patients Closing panel to new patients (No longer accepting new patients) <input type="checkbox"/> Yes <input type="checkbox"/> No Opening panel to accept new patients (My panel is currently closed and I would like to begin accepting new patients) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Return Form To:	Email: provider.update@bcbsla.com	Fax: 225-297-2750	
	Mail: BCBSLA – Network Operations P.O. Box 98029 Baton Rouge, LA 70898-9029	Phone: 1-800-716-2299, option 3	
Page 2 of 2			

Please note: Blue Cross cannot guarantee the continuing participation of providers listed in the online directories. Providers with multiple locations may not participate at all locations. Facility-based physicians may not be contracted healthcare providers.

Health Care Consumer Billing and Disclosure Act

In order to receive maximum benefits, members of any health plan should choose providers who participate in their plan's network. However, when choosing a facility, a member may not be aware that some of the physicians who provide services at that facility may not be in their plan network. To ensure this information is available to all Louisiana patients when choosing a facility, in the summer of 2009, the Louisiana State Senate passed the "Health Care Consumer Billing and Disclosure Protection Act."*

This legislation requires that facilities provide health plans with a listing of the physicians or groups who provide hospital-based services at their facility in the following specialties: **anesthesiology, pathology, radiology, emergency medicine** and **neonatology**. The legislation also requires that we, as a health plan, provide our members with an online listing of physicians or groups providing hospital-based services at each facility and the Blue Cross networks in which those physicians or groups participate.

As stated in the legislation, health insurers must be notified of any changes within 30 days of the change. When your facility has a change in this list of providers, please send the following information to us:

Facility

- Facility Name
- Physical Address
- Phone Number
- Facility Tax ID
- Facility NPI Number



Hospital-Based Physicians at the Facility

- Physician or Group Name
- Physical Address
- Phone Number
- Physician or Group Tax ID
- Physician or Group NPI Number



network.development@bcbsla.com



Fax to (225) 297-2750,
Attn. Network Development

To view the charts for each area and more information, go to our web page at www.bcbsla.com/providers > Doctor and Hospital Search > Find Hospital-based Physician.

*View the complete text of the act: www.legis.la.gov/legis/ViewDocument.aspx?d=668373.

Section 2 NETWORK OVERVIEW

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

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



Online Network Speed Guides
www.bcbsla.com/providers
> Education on Demand

Preferred Care PPO

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

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

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



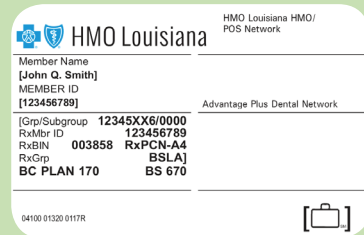
HMO Louisiana

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

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

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

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



Blue Connect

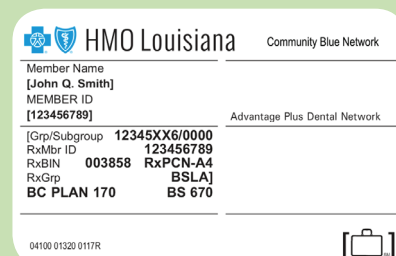
Blue Connect is an HMO Point of Service product available to groups and individuals in (Lafayette Area) - Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes and (New Orleans Area) Jefferson, Orleans and St. Tammany parishes. Members with Blue Connect may choose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

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



Community Blue

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



Federal Employee Program

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

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

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

	BlueCross BlueShield	Government-Wide Service Benefit Plan	
Federal Employee Program			
Member Name TEST I M SAMPLE	www.fepblue.org		
Member ID R94665017			
Enrollment Code Effective Date	112 01/01/2008	RxBIN RxCPCN RxGrp	610415 PCS 65006500

	BlueCross BlueShield	Government-Wide Service Benefit Plan	
Federal Employee Program			
Member Name TEST I M SAMPLE	www.fepblue.org		
Member ID R94665207			
Enrollment Code Effective Date	105 01/01/2008	RxBIN RxCPCN RxGrp	610415 PCS 65006500

Office of Group Benefits Benefit Plans

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

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

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

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

 Blue Cross Blue Shield of Louisiana <small>An Independent Member of the Blue Cross and Blue Shield Association.</small> <small>Blue Cross and Blue Shield of Louisiana is licensed as a Louisiana Health Service & Insurance Company.</small>		
Member Name	OFFICE OF GROUP BENEFITS	
Member ID	PELICAN HRA 1000	
Grp/Subgroup	ST222ERC/000	Deductible:
RxMbr ID	123456789	Employee only
RxBIN	003585 PCN ASPROD1	Family
RxGrp	OGB	Coinurance: Preferred
BC PLAN 170 BS PLAN 670		All Other Providers
048A0039 10/08		

Pelican HRA 1000

 Blue Cross Blue Shield of Louisiana <small>An Independent Member of the Blue Cross and Blue Shield Association.</small> <small>Blue Cross and Blue Shield of Louisiana is licensed as a Louisiana Health Service & Insurance Company.</small>		
Member Name	OFFICE OF GROUP BENEFITS	
Member ID	PELICAN HSA 775	
Grp/Subgroup	ST222ERC/000	Deductible:
RxMbr ID	123456789	Employee only
RxBIN	003888 PCN A-4	Family
RxGrp	BSLA	Coinurance: Preferred
BC PLAN 170 BS PLAN 670		All Other Providers
048A0039 10/08		

Pelican HSA 775

 HMO Louisiana, Inc. <small>A subsidiary of Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross and Blue Shield Association.</small>		
Member Name	OFFICE OF GROUP BENEFITS	
Member ID	MAGNOLIA LOCAL	
Grp/Subgroup	ST222ERC/000	Deductible:
RxMbr ID	123456789	Employee Only
RxBIN	003585 PCN ASPROD1	Family
RxGrp	OGB	Physician/Office Co-Pay
BC PLAN 170 BS PLAN 670		Specialty Co-Pay
04100 01320 0114		

Magnolia Local Blue Connect

 HMO Louisiana, Inc. <small>A subsidiary of Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross and Blue Shield Association.</small>		
Member Name	OFFICE OF GROUP BENEFITS	
Member ID	MAGNOLIA LOCAL	
Grp/Subgroup	ST222ERC/000	Deductible:
RxMbr ID	123456789	Employee Only
RxBIN	003585 PCN ASPROD1	Family
RxGrp	OGB	Physician/Office Co-Pay
BC PLAN 170 BS PLAN 670		Specialty Co-Pay
04100 01320 0114		

Magnolia Local Community Blue

Magnolia Local Plus (Active Employees & Retirees with and without Medicare) This benefit plan has an HMO benefit design but through a PPO network. Members with this benefit plan are not limited to a local-area only network. Members who choose the Magnolia Local Plus benefit plan will instead have access to the OGB Preferred Care network, which is Blue Cross' statewide Preferred Care PPO network of doctors and hospitals. With this benefit plan, there is no coverage for services performed by non-network providers.

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

BlueChoice 65

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

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

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

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

BlueCard® Program

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

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

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

How to Identify BlueCard Members

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

Alpha Prefix

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

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

1. Plan-specific alpha prefixes are assigned to every BCBS Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.
2. Account-specific prefixes are assigned to centrally-processed national accounts. National accounts are employer groups with offices or branches in more than one area, but offer uniform coverage benefits to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.
3. Occasionally, you may see ID cards from foreign BCBS members. These ID cards will also contain three-character alpha prefixes. For example, "JIS" indicates a Blue Cross and Blue Shield of Israel member. The BlueCard claims process for international members is the same as that for domestic BCBS members.

ID cards with no Alpha Prefix

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

"Suitcase" Logo



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



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

HMO patients serviced through the BlueCard® Program

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

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

How the Program Works

1. You may verify the patient's coverage on iLinkBlue at www.bcbsla.com/ilinkblue under BlueCard-Out of Area, then Coverage Information Request or by calling BlueCard Eligibility® Line at 1-800-676-BLUE (1-800-676-2583). An operator will ask you for the alpha prefix on the member's ID card and will connect you to the appropriate membership and coverage unit at the member's plan. If you are unable to locate an alpha prefix on the member's ID card, check for a phone number on the back of the ID card and if that's not available, call Provider Services at 1-800-922-8866.
2. After you render services to a BCBS member, you should file the claim (according to your contractual arrangements) with Blue Cross and Blue Shield of Louisiana. **Reminder: The claim must be filed using the three-character alpha prefix and identification number located on the patient's ID card.**

3. Once the claim is received, Blue Cross and Blue Shield of Louisiana electronically routes it to the member's own independent BCBS Plan.
4. The member's plan applies benefits, adjudicates the claim and transmits it to Blue Cross and Blue Shield of Louisiana, either approving or denying payment. The processing time of the claim may take longer than most Blue Cross processes.
5. Blue Cross and Blue Shield of Louisiana reconciles payment and forwards it to you according to your payment cycle.
6. The member's local Blue Plan sends a detailed Explanation of Benefits (EOB) report to the member.

Types of claims filed through the program

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

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

BlueCard Claims Submission

Hardcopy Claims



BCBSLA -Claims Department
P.O. Box 98029
Baton Rouge, LA 70898-9029.

Electronic Claims



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

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

Contract directly with the member's Blue Plan? File the claim directly to that Plan. For authorizations, see the member's ID card.

Ancillary Providers

Ancillary providers are independent clinical laboratories, durable/home medical equipment and supply providers, and specialty pharmacies located within BCBSLA's service area. An ancillary provider located outside BCBSLA's service area is considered a remote provider.

A remote provider is an independent clinical laboratory, durable/home medical equipment and supply or specialty pharmacy provider located outside of BCBSLA's service area that are contracted with BCBSLA under a license agreement to act as a local provider solely for services rendered in our service area.

Ancillary Claims Filing Instructions

Ancillary claims for independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy are filed to the local plan. The local plan is determined as the plan where the ancillary services were rendered.

- If a remote provider contract is in place with the local plan, the claim must be filed to the local plan, and it would be considered a participating provider claim.
- If a remote provider contract is not in place with the local plan, the claim must be filed to the local plan, and it would be considered a nonparticipating provider claim.

Definition of Local Plan for Ancillary Services

Independent Clinical Laboratory (Lab)



The plan in whose service area the specimen is drawn. This is determined by the state where the referring physician is located.

Durable/Home Medical Equipment (DME/HME)



The plan in whose service area the equipment was shipped to or purchased at a retail store.

Specialty Pharmacy



The plan in whose service area the ordering physician is located.

- Specialty Pharmacy is characterized as non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the plan's Specialty Pharmacy formulary.
- Specialty Pharmacy generally includes injectables and infusion therapies that require complex care. Examples of major conditions these drugs treat include, but are not limited to, cancer, HIV/AIDS and hemophilia.

Ancillary Claims Filing: Independent Clinical Laboratory (Lab) Claims

Lab claims must be filed to the Blue Plan where the specimen was drawn. Where specimen was drawn will be determined by which state the referring provider is located. The referring physician NPI number must be filed on all ancillary claims. If the referring physician NPI is not listed, the claim will be returned.

- CMS-1500 Health Insurance Claim Form:
 - The NPI of the referring provider is identified in field 17B - NPI of Referring Provider or Other Source
- 837 Professional Electronic Submission:
 - The NPI of the referring provider is populated in loop 2310A

Consumer Directed Health Care

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

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

When the Consumer is Paying More of the Bill			
Sales/ Marketing Fulfillment	Pre-Service	At Point of Service	Post-Service
<ul style="list-style-type: none"> • Seeks education about choices • Selects health plan • Selects network/ providers 	<ul style="list-style-type: none"> • Seeks information • Estimates costs to compare providers and treatment options • Seeks quality information about providers 	<ul style="list-style-type: none"> • Knows what they owe • Can apply payment from a variety of sources, including access to credit 	<ul style="list-style-type: none"> • Seeks help with next steps of treatment plan <ul style="list-style-type: none"> - Health information/ coaching - Efficient sources
<ul style="list-style-type: none"> • Promotion to consumers • Performance information for consumers 	<ul style="list-style-type: none"> • Determines member eligibility and benefits • May estimate member responsibility for upcoming service • May inform member of estimate in advance 	<ul style="list-style-type: none"> • Determines eligibility, benefits and specific member responsibility • Collects correct amount from the source selected by the member 	<ul style="list-style-type: none"> • Provides feedback on performance • Seeks improvements <ul style="list-style-type: none"> - Administrative - Clinical

Consumer Directed Health Plans

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

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

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

Examples of what to collect from members:														
1)	<table> <tr> <td>Member's Total Deductible</td> <td>\$2000</td> </tr> <tr> <td>Member's Deductible Applied</td> <td>\$2000</td> </tr> <tr> <td>Allowable Charge</td> <td>\$ 100</td> </tr> <tr> <td>Amount to be collected from member</td> <td>\$ 0</td> </tr> <tr> <td>Blue Cross Pays</td> <td>\$ 100</td> </tr> </table>	Member's Total Deductible	\$2000	Member's Deductible Applied	\$2000	Allowable Charge	\$ 100	Amount to be collected from member	\$ 0	Blue Cross Pays	\$ 100	Member Has Met Deductible		
Member's Total Deductible	\$2000													
Member's Deductible Applied	\$2000													
Allowable Charge	\$ 100													
Amount to be collected from member	\$ 0													
Blue Cross Pays	\$ 100													
2)	<table> <tr> <td>Member's Total Deductible</td> <td>\$2000</td> </tr> <tr> <td>Member's Deductible Applied</td> <td>\$1000</td> </tr> <tr> <td>Allowable Charge</td> <td>\$ 100</td> </tr> <tr> <td>Amount to be collected from member</td> <td>\$ 100</td> </tr> </table>	Member's Total Deductible	\$2000	Member's Deductible Applied	\$1000	Allowable Charge	\$ 100	Amount to be collected from member	\$ 100	Member Has NOT Met Deductible				
Member's Total Deductible	\$2000													
Member's Deductible Applied	\$1000													
Allowable Charge	\$ 100													
Amount to be collected from member	\$ 100													
3)	<table> <tr> <td>Member's Total Deductible</td> <td>\$2000</td> </tr> <tr> <td>Member's Deductible Applied</td> <td>\$2000</td> </tr> <tr> <td>Allowable Charge</td> <td>\$ 100</td> </tr> <tr> <td>Member's Coinsurance (20%)</td> <td>\$ 20</td> </tr> <tr> <td>Amount to be collected from member</td> <td>\$ 20</td> </tr> <tr> <td>Blue Cross Pays</td> <td>\$ 80</td> </tr> </table>	Member's Total Deductible	\$2000	Member's Deductible Applied	\$2000	Allowable Charge	\$ 100	Member's Coinsurance (20%)	\$ 20	Amount to be collected from member	\$ 20	Blue Cross Pays	\$ 80	Member with Coinsurance
Member's Total Deductible	\$2000													
Member's Deductible Applied	\$2000													
Allowable Charge	\$ 100													
Member's Coinsurance (20%)	\$ 20													
Amount to be collected from member	\$ 20													
Blue Cross Pays	\$ 80													

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

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their debit cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.

BlueSaver Claims Filing Tips

Below are some helpful tips that will guide you when processing claims for and payments from Blue members with a consumer directed health plan like BlueSaver:

- Commit to pre-service work with patients. Contact to confirm appointment and ask them to bring a copy of their current member card. Offer to discuss out of pocket expenses prior to their visit.
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Verify the member's eligibility or benefits through iLinkBlue or by calling BlueCard Eligibility® Line at 1-800-676-BLUE (1-800-676-2583) and provide the alpha prefix, or use electronic capabilities.
- Carefully determine the member's financial responsibility before processing payment.
- If the member presents an HSA or HRA debit card or debit/ID card, be sure to verify the member's cost sharing or out-of- pockets amount before processing payment.
- Please do not use the card to process full payment up front.
- File Claims for all members with CDHPs (including those with BlueCard) to Blue Cross.

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

Members with Consumer Directed Health Plans Like BlueSaver

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

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

Members can use their cards to pay outstanding balances on billing statements. If your facility currently accepts credit card payments, there is no additional equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit cards.

If the member presents a debit card (stand-alone or combined), be sure to verify the member's cost sharing amount before processing payment. Do not use the card to process full payment up front.

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



HMO of Louisiana Inc.'s Blue Advantage (HMO) Plan

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

Medicare Advantage Members From Other Blue Plans

For information to aid you in servicing Medicare Advantage members from other Blue plans, please refer to the *Blue Cross and Blue Shield of Louisiana BlueCard® Program Provider Manual*.

Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Enrollment in HMO Louisiana, Inc. depends on contract renewal. HMO Louisiana is a subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

Section 3

MEMBER ENGAGEMENT TOOLS

Overview

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

Estimated Treatment Cost Tool

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

Cost Estimates

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

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

Viewing Cost Estimates

A report of cost estimates is available to providers on iLinkBlue. Log into your existing login ID and click the new menu item named "Estimated Treatment Costs." You must have access to iLinkBlue in order to view your cost data, as this information will not be mailed. The report contains the cost ranges calculated for the facility or practicing location, as well as, an overview of the methodology used to develop these cost ranges.

Providers who log into iLinkBlue to view PPO cost data should be aware that no data will be displayed for providers with:

Applicable for facility procedures

- less than three episodes
- episodes less than \$100
- episodes that do not contain facility charges

Applicable for office procedures

- less than three episodes

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

Reconsideration Process

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

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

Member Reviews

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

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

Section 4

INPATIENT ACUTE CARE REIMBURSEMENT

Overview

Inpatient acute care hospital reimbursement is based on either prospective per diem rates consisting of three separate per diem categories, or case rates for specific diagnosis-related groups (DRGs) as defined in the Member Provider Agreement Reimbursement Appendix. A separate per diem is calculated for each category, whereas the case rate is determined by Medical Severity-DRG (MS-DRG) as applicable. Inpatient acute care hospital charges are assigned to one of the following categories:

- Medical admissions
- Surgical admissions
- Maternity admissions

The Reimbursement Amount for inpatient Hospital Services is based on the lesser of the prospective per diem rates (or case rate if applicable for specific MS-DRGs as defined in the Member Provider Agreement) or the Member Provider's Billed Charge or the case management rates agreed to by the Member Provider and Plan.

Inpatient acute care hospital charges are classified as either a medical, surgical or maternity admission. The Centers for Medicare and Medicaid Services (CMS) MS-DRG definitions and a CMS-approved grouper system are utilized to group each claim to a specific MS-DRG. Each MS-DRG is assigned to a reimbursement category. The MS-DRGs and the corresponding reimbursement categories are listed in the MS-DRG Type of Service Listing section of this manual. Blue Cross will notify the Member Provider of any changes in MS-DRG type of service classifications.

Blue Cross uses the current version of the MS-DRG grouper system that recognizes the differences in patient severity. It is updated annually on October 1 or as soon as it is available. The updated grouper is effective October 1 and applies to claims incurred on or after that date. Starting on July 1, 2014, the grouper system will use Discharge date or Statement "Through" date to group rather than Admission date. Inpatient discharges on or after October 1, 2015, will be processed under the DRG grouper system compliant with ICD-10 diagnosis and procedure code.

Reduced Reimbursement for Delayed Services

The per diem reimbursement amount for inpatient hospital services will be reduced by 50 percent for inpatient days during which the Member is awaiting surgical, specialized diagnostic and/or specialized radiological services but such services are not being rendered. Specialized diagnostic and/or specialized radiological services include but are not limited to: thallium stress test, MRI, CAT scan, GI endoscopy and cardiac catheterization.

Charge Master Increase

Blue Cross requires facility providers to provide advance notice of changes and updates to all services charge master. Failure to furnish timely charge master changes may result in delays to agreed-upon reimbursement adjustments.

Facility providers billed charges should be provided in the format referenced in the sample Charge Increase Worksheet below:

Exhibit Z1

Illustrative Aggregate Charge Increase Calculation

Inpatient

A	B	C	D	E	F	G	H	I	J	K
Chg #	Description	Comment	Annual Blue Cross Frequency	Rev Code	CPT (where Applicable)	Old Charge	Weighted Old Charges (D x G)	New Charges	Weighted New Charge (D x I)	Weighted Increase
Code 1			11	Rev Code 1	CPT 1	\$ 72.00	\$ 792.00	\$ 72.00	\$ 792.00	0%
Code 2			49	Rev Code 2	CPT 2	\$ 70.00	\$ 3,430.00	\$ 70.00	\$ 3,430.00	0%
Code 3			95	Rev Code 3	CPT 3	\$ 81.00	\$ 7,695.00	\$ 81.00	\$ 7,695.00	0%
Code 4			2	Rev Code 4	CPT 4	\$ 102.00	\$ 204.00	\$ 102.00	\$ 204.00	0%
Code 5			--	Rev Code 5	--	--	--	--	--	--
Code 6			--	Rev Code 6	--	--	--	--	--	--
Code 7		NEW	NA	Rev Code 7	CPT 7	NA	NA	\$ 98.00	NA	NA
Code 8			15	Rev Code 8	CPT 8	\$ 88.00	\$ 1,320.00	\$ 88.00	\$ 1,320.00	0%
Code 9			50	Rev Code 9	CPT 9	\$ 93.00	\$ 4,650.00	\$ 93.00	\$ 4,650.00	0%
Code 10			65	Rev Code 10	CPT 10	\$ 61.00	\$ 3,965.00	\$ 61.00	\$ 3,965.00	0%
Code 11			14	Rev Code 11	CPT 11	\$ 91.00	\$ 1,274.00	\$ 91.00	\$ 1,274.00	0%
Code 12			29	Rev Code 12	CPT 12	\$ 90.00	\$ 26,400.00	\$ 300.00	\$ 26,400.00	10%
Code 13			43	Rev Code 13	CPT 13	\$ 87.00	\$ 3,741.00	\$ 87.00	\$ 3,741.00	0%
Code 14		DELETED	NA	Rev Code 14	CPT 14	\$ 52.00	NA	NA	NA	NA
Code 15			64	Rev Code 15	CPT 15	\$ 68.00	\$ 4,352.00	\$ 68.00	\$ 4,352.00	0%
Total							\$ 55,359.00		\$ 57,823.00	4.5%

INPATIENT AND OUTPATIENT FREQUENCY MUST BE SEPARATED!

Outpatient

A	B	C	D	E	F	G	H	I	J	K
Chg #	Description	Comment	Annual Blue Cross Frequency	Rev Code	CPT (where Applicable)	Old Charge	Weighted Old Charges (D x G)	New Charges	Weighted New Charge (D x I)	Weighted Increase
Code 1			12	Rev Code 1	CPT 1	\$ 72.00	\$ 864.00	\$ 72.00	\$ 864.00	0%
Code 2			55	Rev Code 2	CPT 2	\$ 70.00	\$ 3,850.00	\$ 70.00	\$ 3,850.00	0%
Code 3			43	Rev Code 3	CPT 3	\$ 81.00	\$ 3,483.00	\$ 81.00	\$ 3,483.00	0%
Code 4			0	Rev Code 4	CPT 4	\$ 102.00	\$ -	\$ 102.00	\$ -	#DIV/0!
Code 5			--	Rev Code 5	--	--	--	--	--	--
Code 6			--	Rev Code 6	--	--	--	--	--	--
Code 7		NEW	NA	Rev Code 7	CPT 7	NA	NA	\$ 98.00	NA	NA
Code 8			32	Rev Code 8	CPT 8	\$ 88.00	\$ 2,816.00	\$ 88.00	\$ 2,816.00	0%
Code 9			27	Rev Code 9	CPT 9	\$ 93.00	\$ 2,604.00	\$ 93.00	\$ 2,604.00	0%
Code 10			86	Rev Code 10	CPT 10	\$ 61.00	\$ 5,246.00	\$ 61.00	\$ 5,246.00	0%
Code 11			12	Rev Code 11	CPT 11	\$ 91.00	\$ 1,092.00	\$ 91.00	\$ 1,092.00	0%
Code 12			34	Rev Code 12	CPT 12	\$ 70.00	\$ 24,300.00	\$ 300.00	\$ 24,300.00	10%
Code 13			7	Rev Code 13	CPT 13	\$ 87.00	\$ 609.00	\$ 87.00	\$ 609.00	0%
Code 14		DELETED	NA	Rev Code 14	CPT 14	\$ 52.00	NA	NA	NA	NA
Code 15			70	Rev Code 15	CPT 15	\$ 68.00	\$ 4,760.00	\$ 68.00	\$ 4,760.00	0%
Total							\$ 47,356.00		\$ 49,624.00	4.8%

Notices should be mailed to:

Net Dev - BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

Charge Increase Worksheet.xls



Blue Cross and Blue Shield of Louisiana
Member Provider Policy & Procedures Manual
December 2016

Subcontracted Providers

Subcontracted services are those services furnished to patients by providers other than the Member Provider while the patient is inpatient or outpatient. These services include, but are not limited to, EKG services, CAT scans, MRI, PET imaging, DME, technical components of clinical and anatomical lab, technical component of diagnostic services, etc.

The reimbursement outlined in the Member Provider Agreement is intended to cover all Hospital Services rendered to a patient, including those services that are performed by subcontracted providers. Subcontracted providers should seek payment solely from the Member Provider. Subcontracted providers should not bill Blue Cross or the Member for such services.

For those instances when Member Providers may need to send a Member to another facility when the Member is an inpatient, Member Provider should bill Blue Cross for that service. The other facility should not bill Blue Cross for the services rendered. For example, a Member, who is an inpatient at Main Street Hospital, needs hyperbaric oxygen therapy, but Main Street Hospital does not have the necessary equipment. Therefore, Main Street Hospital sends the Member to Metropolitan Medical Center. Once the procedure is completed, the Member returns to Main Street Hospital. In this case, Main Street Hospital should bill Blue Cross for the hyperbaric oxygen therapy and reimburse Metropolitan Medical Center accordingly. Metropolitan Medical Center should not bill Blue Cross or the Member.

At least annually, Member Providers should furnish Blue Cross with a listing of any subcontracted providers with whom the Member Provider has contracted to perform the Member Provider's duties and obligations under the Member Provider Agreement. This listing should be sent to the following address:



Blue Cross and Blue Shield of Louisiana
Attn: Network Development, Subcontracted Providers
P.O. Box 98029
Baton Rouge, LA 70898-9029



(225) 297-2750 (fax)

Medical Staff

Only providers that are a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Anesthetist (CRNA) or Psychologist may be set up with a Medical Staff specialty code in our system. All other provider types/specialty services are to be part of the hospital per diem and/or DRG case rates and should not be filed as a medical staff provider under the hospital record.

General Information

- Inpatient billings should include any charges for inpatient Hospital Services obtained from another organization while the Member is an inpatient at your hospital. A patient cannot be considered both an inpatient and an outpatient at the same time. Physician charges of these services should be billed separately on the CMS-1500 claim form.

- In computing the number of inpatient days of care provided to a Member, the date of admission and the date of discharge are counted as one day. No charge will be allowed for a fractional part of a day, except that a charge may be made directly to a Member who elects to remain beyond the hour of discharge designated by the attending physician or Member Provider. This charge is considered a Noncovered Service under the Member Contract/Certificate.
- Blue Cross will use the contracted rate, the current grouper, the payment processing methodology and other provisions in effect at the time of the patient admission as the basis for payment.
- Blue Cross will notify the hospital of any rate or reimbursement methodology changes no later than sixty (60) days prior to the effective date of the contract renewal.

Diagnosis Code Specificity

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

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

Example of specific ICD-10 coding:

not billable	M86.44 Chronic osteomyelitis with draining sinus, hand	header
preferred	M86.441 Chronic osteomyelitis with draining sinus, right hand	specified
preferred	M86.442 Chronic osteomyelitis with draining sinus, left hand	specified
not preferred	M86.449 Chronic osteomyelitis with draining sinus, unspecified hand	unspecified

Commercial Risk Adjustment

Blue Cross is using the Commercial Risk Adjustment (CRA) model that the Affordable Care Act (ACA) has adopted to predict healthcare costs based on enrollees in risk-adjustment-covered plans. The model incorporates organized diagnosis codes also known as HCCs (hierarchical condition categories) that correlate or link to corresponding diagnosis categories. It is critical that Blue Cross receive complete and accurately coded claims to properly indicate our members' health status.

Payment Methodology Examples

Please be aware that some of these examples may vary depending on whether they are processed in Legacy or our new operating system, Facets.

1) Payment to Member Hospital is Based on Billed Charges:

Per Diem	\$1,100
Length of Stay	5 days
Billed Charges	\$5,250
Total Per Diem	\$5,500 = \$1,100 x 5 days

Member Liability:

Noncovered Charges (NC)	\$ 50
Deductible (Ded)	\$ 200
Coinsurance (20%)	\$ 1,000 = [(\$5,250 - \$200 Ded - \$50 NC) x 20%]

Payment Based on the Lesser of Billed Charges

or Total Per Diem	\$5,250
Member Liability	(\$1,250)
Blue Cross Payment	\$4,000

Member liability and the Blue Cross payment is payment in full for Hospital Services. The hospital does not bill the Member for the \$250 difference between total per diem and Billed Charges (\$5,500 - \$5,250).

2) Payment to Member Hospital is Based on the Per Diem:

Per Diem	\$1,100
Length of Stay	5 days
Billed Charges	\$6,250
Total Per Diem	\$5,500 = \$1,100 x 5 days

Member Liability:

Noncovered Charges (NC)	\$ 50
Deductible (Ded)	\$ 200
Coinsurance (20%)	\$ 1,050 = [(\$5,500 - \$ 200 Ded - \$ 50 NC) x 20%]

Payment is Based on the Lesser of Billed

Charges or Total Per Diem	\$5,500
Member Liability	(\$1,300)
Blue Cross Payment	\$4,200

Member liability and the Blue Cross payment is payment in full for Hospital Services. The hospital does not bill the Member for the \$750 difference between Billed Charges and total per diem (\$6,250 - \$5,500).

3) Payment to Member Hospital is Based on an Outlier Provision (Per Diem):

In this example, the Reimbursement Amount is based on the per diem amount plus 60 percent of Billed Charges in excess of the Charge Outlier Threshold (three times per diem amount) when Billed Charges for a surgical, medical or maternity admission exceed \$50,000 and there are multiple primary diagnoses. Providers should refer to their Member Provider Agreement Reimbursement Appendix for the exact details of their outlier provision.

Per Diem	\$ 1,100
Length of Stay	6 days
Billed Charges	\$51,000
Total Per Diem	\$ 6,600 = \$1,100 x 6 days
Charge Outlier Threshold	\$19,800 = 3 x \$6,600
Outlier Payment Percentage	60%
Outlier Amount	\$18,720 = [(\$51,000 - \$19,800) x 60%]
Member Liability:	
Noncovered Charges	\$ 50
Deductible	\$ 200
Coinsurance	\$ 0

FORMULA:

Outlier Payment = [Total Per Diem + [(Outlier Payment Percentage) (Billed Charges – Charge Outlier Threshold)] – Member Liability]

Payment Based on the Lesser of Billed Charges or Total Per Diem	\$ 6,600
Outlier Amount	\$18,720
Member Liability	(\$ 250)
Blue Cross Payment	\$25,070

Member liability and the Blue Cross payment is payment in full for Hospital Services. The hospital does not bill the Member for the \$25,680 difference between Billed Charges and Member liability plus Blue Cross Payment (\$51,000 - \$25,320).

4) Payment to Member Hospital is Based on the Case Rate:

Case Rate	\$5,500
Length of Stay	5 days
Billed Charges	\$6,250

Member Liability:

Noncovered Charges (NC)	\$ 50
Deductible (Ded)	\$ 200
Coinsurance (20%)	\$ 1,050 = [(\$5,500 - \$ 200 Ded - \$ 50 NC) x 20%]

Payment Based on the Lesser of Billed Charges or the Case Rate	\$5,500
Member Liability	(\$1,300)
Blue Cross Payment	\$4,200

Member liability and the Blue Cross payment is payment in full for Hospital Services. The hospital does not bill the Member for the \$750 difference between Billed Charges and total case rate (\$6,250 - \$5,500).

Note: The per diem outlier provision does not apply to Case Rate reimbursement.

5) Payment to Member Hospital is Based on the Base Rate:

Base Rate	\$4,400
DRG Weight	1.25
Length of Stay	3 days
Billed Charges	\$6,250
Total Base Rate Allowable	\$5,500

Member Liability:

Noncovered Charges (NC)	\$ 50
Deductible (Ded)	\$ 200
Coinsurance (20%)	\$ 1,050 = [(\$5,500 - \$200 Ded - \$50 NC) x 20%]

Payment Based on the Lesser of Billed Charges or the Base Rate Allowable (Base Rate x Weight)	\$5,500
Member Liability	(\$1,300)
Blue Cross Payment	\$4,200

Member liability and the Blue Cross payment is payment in full for Hospital Services. The hospital does not bill the Member for the \$750 difference between Billed Charges and total Base Rate allowable(\$6,250 - \$5,500).

Note: The per diem outlier provision does not apply to Base Rate reimbursement.

MS-DRG or Base Rate Outlier Payment Examples

Payment to Member Hospital is Based on the Case Rate Outlier Provision:

Case Rate/Base Rate	\$10,500
Length of Stay	10 days
Billed Charges	\$41,500
Outlier (3X/55%)	\$ 5,500*

Member Liability:	
Deductible	\$ 600

Payment Based on Lesser of Billed Charges or Total Case Rate and Outlier:

BCBSLA	\$15,400**
Member	\$ 600
Total	\$16,000

*This amount is calculated as follows: $[(\text{Billed Charges}) - (\text{Case Rate} \times 3)] \times .55$

**This amount is calculated as follows: $[(\text{Case Rate}) + (\text{Outlier})] - (\text{Member Liability})$

Member liability and the Blue Cross payment represent payment in full for Hospital Services. The hospital does not bill the Member for the \$25,500 difference between Billed Charges and total payment (\$41,500 - \$16,000).

Payment Provision Worksheet (Per Diem)

Step 1 – Determine the base price amount for the claim.

MS-DRG Type of Service = _____ Total Charges = _____

Base Per Diem Amount = Per Diem _____ times _____ Days
 = \$ _____ times _____ = \$ _____

Lesser of Total Charges or Base Per Diem Amount = _____

Step 2 – Determine if the payment provision applies.

Are total charges greater than the facility contracted dollar amount for outlier to apply? YES or NO

If NO, then:

TOTAL REIMBURSEMENT AMOUNT* = Lesser of Total Charges or Base Per Diem Amount = \$ _____

If YES, then:

Are total charges greater than three times the Base Per Diem Amount (Threshold)?

Threshold = 3 times Base Per Diem Amount
 = 3 times \$ _____
 = \$ _____ YES or NO

If NO, then:

TOTAL REIMBURSEMENT AMOUNT* = Lesser of Total Charges or Base Per Diem Amount = \$ _____

If YES, then:

Additional Payment = The facility contracted percentage times (Total Charges less Threshold)
 = The facility contracted percentage times (\$ _____ less \$ _____)

Additional Payment = The facility contracted percentage times \$ _____

TOTAL REIMBURSEMENT AMOUNT* = Base Per Diem Amount + Additional Payment
 = \$ _____ + \$ _____
 = \$ _____ (Total Reimbursement Amount*)

* TOTAL REIMBURSEMENT AMOUNT represents the total provider receipt (Blue Cross payment + Member liability).

Inpatient Billing Guidelines

Admissions Through the Emergency Room/Observations

When a patient is treated in the emergency room affiliated with the acute care facility and is subsequently admitted to the affiliated acute facility, the emergency room record should become part of the affiliated acute facility admission record and the associated emergency room charges should be included when billing 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 to the acute facility. 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 of the affiliated acute facility. If an ambulance is used to transport the patient from a free-standing emergency room to the affiliated acute facility the ambulance service furnished by the hospital, or by others under arrangements with the hospital, are not separately reimbursed.

MS-DRG Validation/ICD-10-CM Code Editing

Blue Cross will edit the hospital's coding, upon claims submission, for accuracy and internal consistency. Such editing may require Blue Cross to return the claim to the hospital for correction of the coding.

Implantable Devices

Blue Cross will review claims for consideration of additional reimbursement on appeal for inpatient procedures involving implantable devices when the following are met:

- The invoice cost of the device is equal to or greater than \$12,000.
- The total charges do not exceed the outlier threshold.
- The case rate reimbursement does not apply as defined in the Reimbursement Appendix of the Member Provider Agreement.
- DRG case rates do not apply.

Member Providers who have claims that meet the above thresholds should contact Provider Audit to have the claims reviewed. The requests for review should be mailed to:



Blue Cross and Blue Shield of Louisiana

Attn: Provider Audit

P.O. Box 98029

Baton Rouge, LA 70898-9029

Please note: When total charges for inpatient procedures involving implantable devices exceed the outlier threshold, the claim will not be eligible for additional reimbursement because additional reimbursement would have been paid under the outlier provision as outlined in the Reimbursement Appendix of your Member Provider Agreement.

Interim Bills

Blue Cross does not accept interim billings for inpatient services. Institutional claims must be submitted with a bill type. The first digit of the bill type indicates the type of facility. There are no exclusions related to the first digit of the bill type. The second digit of the bill type indicates the bill classification. There are no exclusions related to the second digit of the bill type. The third digit of the bill type indicates the frequency. There **are** exclusions related to the frequency digit. **Blue Cross will not** accept bill types with a frequency code of 2, 3, 4, 5, 6 or 9. Interim bills and late charge claims, should be aggregated into one final claim for submission and be submitted using a frequency code of 1 or 7. Use frequency code of 8 for void claims. For illustrative purposes, we will further clarify with a few examples:

Acceptable Bill Types:

- Bill Type 111 (hospital, inpatient, admit through discharge)
- Bill Type 211 (skilled nursing, inpatient, admit through discharge)
- Bill Type 187 (swing bed, inpatient, replacement claim)

Unacceptable Bill Types:

- Bill Type 112 (hospital, inpatient, interim-first claim)
- Bill Type 113 (hospital, inpatient, interim-continuing claim)
- Bill Type 114 (hospital, inpatient, interim-final)
- Bill Type 215 (skilled nursing, inpatient, late charge)

Inpatient interim and late charges normally billed with bill types ending in 2, 3, 4 or 5 would need to be aggregated with any additional bills to produce a final bill with all services and charges included and a bill type with a frequency code of 1 or 7. Failure to follow these guidelines will result in returned or denied claims.

Exception: An interim bill will be accepted only when the total charge is \$800,000 or greater and at least 60 days of service.

Mother and Newborn Claims

The hospital must submit combined billings for mothers and newborns who are discharged on the same date or newborns discharged before mothers. Maternity per diem and DRG case rates have been developed with this consideration.

For Federal Employee Program (FEP) members, when billing the newborn's claim with a NICU revenue code, it must be filed separately from the mother's claim.

Sick (Boarder) Baby Billing Protocol

Upon delivery of a newborn, if the baby's discharge date is prior to or equal to the mothers discharge date, the newborns charges are generally combined with the mother's inpatient hospital claim.

If the baby is sick and the discharge date is after mother's discharge date, the sick (boarder) baby charges should be filed as a separate claim.

- These charges should not be combined with the mothers claim. The admit date of the baby's claim should be the baby's date of birth, not the mother's discharge date.

- The facility should request a "temporary" authorization for the baby's stay under "baby girl" or "baby boy." A temporary authorization can be requested within 48 hours of admission or when mom is discharged.

Organ Transplant Services

Inpatient stays involving transplants of heart, heart-lung, lung, liver, kidney, pancreas or bone marrow require prior written Authorization from Plan based on the Member Contract/Certificate and requirements of Blue Cross. In the absence of a global pricing reimbursement arrangement, the inpatient hospital reimbursement provisions apply.

Patient Expired

The date the patient expired is treated as the date of discharge.

Preadmission Testing Billing

All outpatient services provided within 72 hours prior to an inpatient admission are included in the Reimbursement Amount for the inpatient stay and must be billed to Blue Cross as part of the inpatient claim. This provision applies only to outpatient services performed at the same (or related) facility where the patient is subsequently admitted.

National Provider Identifier Usage

Member Providers should submit the appropriate NPI number in box 56 on the UB-04 claim form to ensure payment is made accurately and on time.

Readmissions

Blue Cross will review readmissions for the same diagnosis or condition for Medical Necessity.

Transfers In

Transfers In are treated as regular admissions and are subject to Medical Necessity review.

Transfers Out

Transfers Out are subject to Medical Necessity review and eligible for outlier payment only if the hospital initiates concurrent review procedures with Blue Cross.

Section 5

OUTPATIENT ACUTE CARE REIMBURSEMENT

Overview

Blue Cross' acute outpatient reimbursement consists of both an Outpatient Procedure Services Program and a Diagnostic and Therapeutic Services Program. Each program is fee schedule based. The relativity within the fee schedules is based on Medicare's APC program and other applicable Medicare programs; however, the payment methodology is based on the existing Blue Cross outpatient methodology.

In 2014, Blue Cross implemented Medicare APC grouper and outpatient code editor (OCE) on applicable services. The program will be rolled out at renewal date or at a future date mutually agreed upon by the participating hospital and Blue Cross.

Outpatient Procedure Services Program

Outpatient Procedure Services include most services contained within the surgery section of CPT as well as significant procedures defined in the Medicine Section such as cardiac catheterizations. The range of applicable codes is listed under the Billing Guidelines in this section.

Blue Cross edits the hospital's outpatient coding upon claims submission for accuracy and internal consistency. Such editing may require Blue Cross to reassign reimbursement and/or medical codes for services that have been Unbundled or incorrectly coded or to reject codes for mutually exclusive or incidental procedures. Mutually exclusive procedures are two (2) or more procedures that usually are not performed at the same operative session on the same patient on the same date of service, for which separate billings are made. Mutually exclusive procedures also may include different procedure codes and descriptions for the same type of procedures in which the provider should be submitting only one (1) of the codes. An incidental procedure is carried out at the same time as a more complex primary procedure. However, the incidental procedure requires little additional provider resources and/or is clinically integral to the performance of the primary procedure. Reimbursement for incidental procedure codes is factored into the reimbursement for the primary procedure codes.

After editing the claim, if **all** of the procedures are on the Outpatient Procedures Reimbursement Schedule, the claim will be priced based on the lesser of the charge or the appropriate discounted Outpatient Procedures Reimbursement Schedule amount. If multiple procedures are performed, the primary procedure is reimbursed based on 100 percent of the discounted Outpatient Procedures Reimbursement Schedule amount and the secondary procedure(s) are reimbursed based on 50 percent of the discounted Outpatient Procedures Reimbursement Schedule amount. Select procedures are exempt from the multiple procedure discount and will be reimbursed at 100 percent of the discounted Outpatient Procedures Reimbursement Schedule. The total Reimbursement Amount for the claim is the lesser of the Billed Charges or the sum of the Reimbursement Amounts for all procedure codes. All other services, including diagnostic and therapeutic services, are bundled to the outpatient procedure services and reimbursement is based on the Outpatient Procedures Reimbursement Schedule.

After editing the claim, if **any** of the procedures are not on the Outpatient Procedures Reimbursement Schedule, and if there are diagnostic and therapeutic services billed, the entire claim is priced based on the lesser of the appropriate discounted Diagnostic and Therapeutic Services Reimbursement Schedule amount or the line-item charge, plus a provider-specific discounted amount on the remaining charges. If there are no diagnostic and therapeutic services billed, the claim is priced based on the provider-specific discounted charge as defined in the Reimbursement Appendix to the Member Provider Agreement.

“Outpatient Procedure(s)” means Medically Necessary procedure(s) performed at the Member Provider that, according to accepted professional medical judgment, cannot be safely rendered in a physician’s office and does not require overnight hospitalization. Procedures normally performed in a physician’s office that meet the following criteria, as determined by Plan, will not be considered Medically Necessary Outpatient Procedures:

- Can be performed in the physician office setting without perceived increase in risk or adverse effect on the quality of care
- Is usually the primary or sole procedure being performed
- Does not usually require general anesthesia
- Does not involve complex pre-service care or postservice recovery from anesthesia

“Outpatient Procedure Services” include the Outpatient Procedure(s) as defined under “Billing Guidelines” in this manual and the following:

- Pre-service blood tests, urinalysis and other necessary laboratory and radiological procedures directly related to the procedure
- Pre-service preparation
- Use of Member Provider, including pre-service area, operating rooms, primary and secondary recovery rooms
- Equipment, monitors, anesthesia and supplies, drugs, implants, prostheses and nourishments
- All pre-operative services should be included on the bill in conjunction with the procedure performed

Outpatient Procedure Services do not include the following:

- Administration of anesthesiology/anesthesia by anesthesiologists’ services
- Professional pathologists’ services
- Professional radiology services
- Diagnostic or therapeutic tests not directly related to the procedure

Charge Master Increase

Blue Cross requires facility providers to provide advance notice of changes and updates to all services charge master. Failure to furnish timely charge master changes may result in delays to agreed-upon reimbursement adjustments.

Facility providers billed charges should be provided in the format referenced in the sample Charge Increase Worksheet below:

Exhibit Z1

Illustrative Aggregate Charge Increase Calculation

Inpatient

A	B	C	D	E	F	G	H	I	J	K
Chg #	Description	Comment	Annual Blue Cross Frequency	Rev Code	CPT (where Applicable)	Old Charge	Weighted Old Charges (D x G)	New Charges	Weighted New Charge (D x I)	Weighted Increase
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Code 3			95	Rev Code 3	CPT 3	\$ 81.00	\$ 7,695.00	\$ 81.00	\$ 7,695.00	0%
Code 4			2	Rev Code 4	CPT 4	\$ 102.00	\$ 204.00	\$ 102.00	\$ 204.00	0%
Code 5			--	Rev Code 5	--	--	--	--	--	--
Code 6			--	Rev Code 6	--	--	--	--	--	--
Code 7		NEW	NA	Rev Code 7	CPT 7	NA	NA	\$ 98.00	NA	NA
Code 8			15	Rev Code 8	CPT 8	\$ 88.00	\$ 1,320.00	\$ 88.00	\$ 1,320.00	0%
Code 9			5	Rev Code 9	CPT 9	\$ 93.00	\$ 4,650.00	\$ 93.00	\$ 4,650.00	0%
Code 10			65	Rev Code 10	CPT 10	\$ 61.00	\$ 3,965.00	\$ 61.00	\$ 3,965.00	0%
Code 11			14	Rev Code 11	CPT 11	\$ 91.00	\$ 1,274.00	\$ 91.00	\$ 1,274.00	0%
Code 12			29	Rev Code 12	CPT 12	\$ 72.00	\$ 2,088.00	\$ 300.00	\$ 26,400.00	10%
Code 13			43	Rev Code 13	CPT 13	\$ 87.00	\$ 3,741.00	\$ 87.00	\$ 3,741.00	0%
Code 14		DELETED	NA	Rev Code 14	CPT 14	\$ 52.00	NA	NA	NA	NA
Code 15			64	Rev Code 15	CPT 15	\$ 68.00	\$ 4,352.00	\$ 68.00	\$ 4,352.00	0%
Total							\$ 55,359.00		\$ 57,823.00	4.5%

INPATIENT AND OUTPATIENT FREQUENCY MUST BE SEPARATED!

Outpatient

A	B	C	D	E	F	G	H	I	J	K
Chg #	Description	Comment	Annual Blue Cross Frequency	Rev Code	CPT (where Applicable)	Old Charge	Weighted Old Charges (D x G)	New Charges	Weighted New Charge (D x I)	Weighted Increase
Code 1			12	Rev Code 1	CPT 1	\$ 72.00	\$ 864.00	\$ 72.00	\$ 864.00	0%
Code 2			55	Rev Code 2	CPT 2	\$ 70.00	\$ 3,850.00	\$ 70.00	\$ 3,850.00	0%
Code 3			43	Rev Code 3	CPT 3	\$ 81.00	\$ 3,483.00	\$ 81.00	\$ 3,483.00	0%
Code 4			0	Rev Code 4	CPT 4	\$ 102.00	\$ -	\$ 102.00	\$ -	#DIV/0!
Code 5			--	Rev Code 5	--	--	--	--	--	--
Code 6			--	Rev Code 6	--	--	--	--	--	--
Code 7		NEW	NA	Rev Code 7	CPT 7	NA	NA	\$ 98.00	NA	NA
Code 8			32	Rev Code 8	CPT 8	\$ 88.00	\$ 2,816.00	\$ 88.00	\$ 2,816.00	0%
Code 9			29	Rev Code 9	CPT 9	\$ 93.00	\$ 2,604.00	\$ 93.00	\$ 2,604.00	0%
Code 10			86	Rev Code 10	CPT 10	\$ 61.00	\$ 5,246.00	\$ 61.00	\$ 5,246.00	0%
Code 11			12	Rev Code 11	CPT 11	\$ 91.00	\$ 1,092.00	\$ 91.00	\$ 1,092.00	0%
Code 12			41	Rev Code 12	CPT 12	\$ 72.00	\$ 2,952.00	\$ 300.00	\$ 24,300.00	10%
Code 13			7	Rev Code 13	CPT 13	\$ 87.00	\$ 609.00	\$ 87.00	\$ 609.00	0%
Code 14		DELETED	NA	Rev Code 14	CPT 14	\$ 52.00	NA	NA	NA	NA
Code 15			70	Rev Code 15	CPT 15	\$ 68.00	\$ 4,760.00	\$ 68.00	\$ 4,760.00	0%
Total							\$ 47,356.00		\$ 49,624.00	4.8%

Notices should be mailed to:



Net Dev - BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

Charge Increase Worksheet.xls



Blue Cross and Blue Shield of Louisiana
Member Provider Policy & Procedures Manual
December 2016

Billing Guidelines

Outpatient Procedure Services (1 through 6 below):

Providers are allowed to file line-item charges; however, each claim line must have a charge greater than \$0. The appropriate CPT/HCPCS code should be placed in the HCPCS/Rate field on the UB-04 claim form. If multiple procedures are performed, each procedure should be listed with the appropriate CPT/HCPCS code. The appropriate diagnostic and therapeutic services CPT/HCPCS code(s) and revenue codes should be listed separately. The date of service should be included in block 45 of the UB-04 claim form.

1. The CPT/HCPCS procedure code range is:

0019T-0020T	0221T-0222T	0404T	36601-51700	92943-92944	C9728-C9732
0027T	0229T-0229T	0406T-0416T	51703-51797	92950-92998	C9736-C9737
0031T-0032T	0234T-0238T	0419T-0421T	51799-57154	93451-93464	C9739-C9742
0046T-0050T	0245T-0254T	0424T-0438T	57157-69990	93501-93572	C9800
0054T-0057T	0256T-0259T	0440T-0443T	77372	93580-93583	G0104-G0105
0061T-0063T	0262T-0271T	10021-10022	91000-91009	93650-93657	G0121
0071T-0072T	0274T-0277T	10030	91014-91021	96920-96922	G0167
0075T-0076T	0281T-0284T	10035-10036	91023-91033	99183	G0259-G0260
0084T	0288T-0290T	10040-20696	91041-91055	C1088	G0268
0086T	0293T-0294T	20698-33945	91100-91110	C1300	G0277
0090T-0102T	0299T-0300T	33950	91113-91116	C1718	G0280
0120T	0302T-0304T	33960-33961	91118-91119	C1720	G0289-G0291
0123T-0124T	0307T-0309T	33967-33968	91121-91199	C2616	G0298
0133T	0312T-0325T	33970-33983	91201-91299	C2638-C2641	G0341-G0343
0135T	0334T-0336T	33990-34838	92018-92019	C5271-C5278	G0364
0155T-0158T	0338T-0340T	34840-35999	92511	C9352-C9353	G0413-G0415
0163T-0167T	0343T-0345T	36002-36399	92920-92921	C9600-C9608	G0448
0170T-0172T	0355T-0356T	36417-36429	92924-92925	C9700-C9702	G0455
0176T-0177T	0375T-0377T	36431-36539	92928-92929	C9708	G6018-G6025
0184T	0387T-0388T	36541-36590	92933-92934	C9712-C9716	G6027-G6028
0190T-0193T	0392T-0393T	36594-36597	92937-92938	C9718-C9721	
0200T-0202T	0396T-0397T	36599	92941	C9724-C9725	

2. A valid CPT/HCPCS code within the code range listed in #1 above is required when Revenue codes 36X, 481, 49X, 790, and 799 are billed unless ICD-9-CM diagnosis codes V64.1, V64.2, or V64.3 are present. If multiple 481 revenue codes are billed, only one of the lines has to contain a valid CPT/HCPCS code.
3. Modifiers approved for hospital outpatient use with valid CPT/HCPCS codes are 25, 27, 50, 52, 58, 59, 73, 74, 76-79, 91, CA, E1-E4, FA, F1-F9, GA, GG, GH, LC, LD, LT, QM, QN, RC, RT, TA and T1-T9.
4. For claims with multiple procedures, a charge greater than \$0 is required for each valid CPT/HCPCS code.
5. Since a Value Code and corresponding Value Amount in fields 39-41 on the UB-04 claim form (Louisiana Mandated Service Charge) indicates an outpatient procedure was performed, a claim without a valid CPT/HCPCS code listed in #1 will be returned.

6. A valid CPT/HCPCS code is required for the following revenue codes: 420, 430, 440, 45X, 471, 480, 634-636, 750, 759, 761, 829, 940, and 949. The CPT/HCPCS code does not have to but can be a procedure or diagnostic or therapeutic code listed in #1 or #7. When procedures or diagnostic and therapeutic services are performed, the appropriate CPT/HCPCS code must be given.

Diagnostic and Therapeutic Services (7 through 14 below):

Under the Diagnostic and Therapeutic Services Reimbursement Schedule Reimbursement Program, Member Providers must file line-item charges. The appropriate CPT/HCPCS code(s) should be placed in the HCPCS/Rate field on the UB-04 claim form. If multiple services are performed, each service should be listed with the appropriate CPT/HCPCS code. If Diagnostic and Therapeutic services are performed with outpatient procedures, the charges should be listed separately with the appropriate revenue codes and the appropriate CPT/HCPCS code(s). The date of service should be included in block 45 of the UB-04 claim form.

7. The Diagnostic and Therapeutic CPT/HCPCS code range is:

0028T-0030T	0310T-0311T	77373-89399	90725	92521-92524
0041T-0043T	0326T-0333T	90281-90284	90727	92537-92538
0058T-0060T	0337T	90291	90732-90736	92540
0064T-0070T	0341T-0342T	90371	90738-90740	92543
0073T	0346T-0354T	90375-90376	90743-90744	92550
0082T-0083T	0358T-0374T	90378-90379	90746-90748	92557-92558
0085T	0378T-0386T	90384-90386	90760-90761	92570
0087T-0089T	0389T-0391T	90389	90765-90776	92585
0103T-0111T	0394T-0395T	90396	90779-90788	92609
0126T	0398T-0402T	90460-90461	90853	92611-92612
0137T	0417T-0418T	90465-90468	90867-90870	92614
0140T	0422T-0423T	90470-90474	90899	92616
0144T-0151T	0439T	90581	90935	92618
0154T	0444T-0445T	90585-90586	90939	92620-92621
0159T	20697	90620-90621	90945	92625-92627
0162T	33946-33949	90625	91010-91013	92630
0168T-0169T	33951-33959	90630	91022	92633
0183T	33962-33966	90632-90634	91034-91035	92640
0185T-0187T	33969	90636	91037-91038	92700
0198T-0199T	33984-33989	90644-90651	91040	93000-93351
0203T-0204T	34839	90653-90670	91060-91065	93355
0206T-0218T	36000	90672-90673	91111-91112	93600-93649
0223T-0225T	36400-36416	90675-90676	91117	93658-96919
0239T-0244T	36430	90680-90681	91120	96923-97003
0255T	36540	90685-90688	91200	97010-97602
0272T-0273T	36591-36593	90690-90693	92014	97605-97608
0278T-0280T	36598	90696-90698	92025	97610
0285T-0287T	36600	90700-90708	92071-92072	97760-97762
0291T-0292T	51701-51702	90710	92132-92134	97810-97811
0295T-0298T	51798	90712-90718	92145	97813-97814
0301T	57155-57156	90720-90721	92227-92228	98966
0305T-0306T	70010-77371	90723	92506-92507	99174

99177	C1204	G0001	G0456-G0458	Q3005
99184	C1749	G0027	G0460-G0464	Q3008
99188	C1774	G0030-G0047	G0466-G0473	Q3025-Q3028
99195-99220	C1821-C1822	G0050	G0475-G0483	Q4074-Q4077
99224-99226	C1830	G0102-G0103	G0490	Q4079-Q4081
99281-99292	C1840-C1841	G0106-G0109	G0498	Q4083-Q4099
99366-99368	C1886	G0120	G3001	Q4101-Q4143
99406-99409	C2613	G0122	G6001-G6017	Q4145-Q4165
99446-99449	C2623	G0125	G6030-G6032	Q5101-Q5102
99477	C2633	G0130-G0132	G6034-G6058	Q9941-Q9970
99481-99482	C2642-C2645	G0202	G8402-G8403	Q9972-Q9983
99485-99490	C2698-C2699	G0204	G9017-G9020	S0012
99495-99498	C8900-C8914	G0206	G9033-G9036	S0014
A4216-A4217	C8918-C8936	G0210-G0239	G9041-G9044	S0016-S0017
A4248	C8950-C8955	G0242-G0247	G9141	S0020-S0021
A4337	C8957	G0252-G0255	G9157	S0023
A4641-A4648	C9021-C9023	G0257	G9362-G9363	S0028
A4650	C9025-C9027	G0261-G0262	G9481-G9489	S0030
A9500-A9510	C9105	G0269	J0120-J9999	S0032
A9516-A9518	C9120-C9121	G0274-G0275	P9016	S0034
A9520-A9521	C9127-C9139	G0278-G0279	P9021	S0039-S0040
A9524-A9535	C9202-C9203	G0281-G0283	P9034-P9035	S0071-S0074
A9537-A9545	C9218-C9220	G0288	P9037	S0077-S0078
A9547-A9548	C9223-C9240	G0295	P9040-P9041	S0080-S0081
A9551-A9553	C9242	G0297	P9043	S0088
A9555-A9558	C9244	G0299-G0300	P9045-P9048	S0090-S0093
A9560-A9566	C9249-C9298	G0302-G0307	P9070-P9072	S0104
A9569	C9350-C9351	G0329-G0331	Q0081	S0106-S0109
A9572	C9354-C9369	G0338-G0340	Q0084	S0114-S0119
A9575-A9579	C9400-C9406	G0344-G0351	Q0090	S0122
A9581-A9586	C9410-C9411	G0353-G0363	Q0136-Q0139	S0126
A9599-A9600	C9413-C9415	G0365-G0371	Q0144	S0128
A9604-A9606	C9417-C9433	G0374-G0379	Q0161-Q0180	S0132
B4100-B4104	C9438	G0383-G0384	Q0187	S0136-S0141
B4149-B4162	C9440-C9461	G0389-G0390	Q0480-Q0505	S0144-S0148
B4185	C9470-C9483	G0392-G0394	Q0507-Q0509	S0155-S0195
B4189	C9497	G0396-G0397	Q0515	S5010-S5014
B4193	C9704	G0402-G0405	Q2004-Q2009	S5550-S5553
B4197	C9722-C9723	G0416-G0419	Q2011-Q2014	S9901
B4199	C9727	G0422-G0424	Q2017-Q2028	
C1080-C1083	C9733-C9735	G0428-G0435	Q2033-Q2051	
C1093	C9743-C9744	G0451-G0454	Q3000-Q3001	

Professional-only CPT/HCPCS codes are NOT valid for billing radiological facility services. A few examples of these codes follow: 76140, 77427 and 77261-77263.

8. A valid CPT/HCPCS code is required for Diagnostic and Therapeutic Service revenue codes 30X, 31X, 32X, 333, 34X, 35X, 40X, 410-412, 46X, 482, 483, 61X, 730, 731, 74X, 921 and 922.
9. The number of diagnostic and therapeutic tests for each CPT/HCPCS code reported must be provided in the Units field.

10. The quantity of pharmaceutical dispensed must be given in appropriate units for each CPT/HCPCS code reported with revenue code 636.
11. If the revenue code line items exceed 22, the remaining revenue lines must be split into a separate claim(s). If there are more than 22 line items and the services are all performed on the same date of service, then both claims should be filed with the same date of service. However, these claims must be filed as interim claims using the appropriate type of bill code in form locator 4 (132, 133 and 134).
12. Member Provider agrees not to bill Subscriber or Plan a separate facility charge for an examining room, treatment room or any other facility charge normally included in the practice component of the physician's charge when outpatient services are rendered to a Subscriber.
13. Observation status claims NOT followed by an inpatient admission should be entered on a UB-04 claim form following the Outpatient Submission Guidelines.
14. Medicare Demonstration Project codes should not be billed and are not reimbursable by the Plan.

Blue Cross may expand the Diagnostic and Therapeutic Services Reimbursement Schedule for new codes developed by the American Medical Association subsequent to the production of this manual. Any new amount on the Diagnostic and Therapeutic Services Reimbursement Schedule established for new codes will be communicated to the Member Provider prior to the change being made and will be made part of this manual.

Drug Allowable Charge

Claims with eligible high cost drugs may be reimbursed based on Drug Allowable Charge schedule per provider specific contracts. The Drug Allowable Charge schedule is communicated to Providers periodically or at least twice a year. Provider contracts contain more specific information on the drug reimbursement.

Drug Screening Assays

We only accept claims with CPT drug screen codes.

Presumptive drug screening: CPT codes 80305-80307

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

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

Definitive Drug Testing:

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

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

(for the same patient for the same encounter)

- First or initial lab will be considered for 100 percent of the allowable charge;
- Second lab will be considered for 100 percent of the allowable charge;
- Third lab will be considered for 50 percent of the allowable charge;
- Fourth lab will be considered for 25 percent of the allowable charge;
- Fifth lab and any additional labs will be considered for five (5) percent of the allowable charge;
- Multiple services for urine validity will be bundled.

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

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

Billing of Drug Eluting Intracoronary Stent(s):

CPT code C9600/C9602 may be billed once per major coronary artery utilizing the appropriate modifier (LC, LD, LM, RC, RI). If the C9600/C9602 is not filed with one of these accepted modifiers the claim may not be reimbursed correctly. Note: You may only bill "1" unit per coronary artery even if multiple stents are placed in that one artery.

Other Outpatient Services

Claims with services other than outpatient procedures or diagnostic and therapeutic services that are appropriate in the outpatient setting will be priced based on the provider-specific discounted charge as defined in the Reimbursement Appendix of the Member Provider Agreement.

Outpatient Code Updates

Blue Cross may expand the Outpatient Procedures Reimbursement Schedule for new codes developed by the American Medical Association subsequent to the production of this manual. Any new amount on the Outpatient Procedures Reimbursement Schedule established for new codes will be communicated to the Member Provider prior to the change and will be made part of this manual.

Services Exempt from the Multiple Procedure Discount

The following medical codes are exempt from the multiple procedures discount as defined in the Reimbursement Appendix of the Member Provider Agreement. This means that they will be reimbursed at 100 percent of the Reimbursement Amount.

10022	28296	29450	36520-26522	64643	0184T
10036	28415	29505	36825	64645	0190T-0191T
11040-11044	29000	29515	36830-36833	65205	0221T-0222T
11975	29010	29520	36860-36861	65210	0250T
11977	29015	29530	36870	65220	0263T-0265T
11981-11983	29020	29540	37215-37216	65222	0268T
16000	29025	29550	37222-37223	65430	0281T-0284T
16010	29035	29580-29584	37232-37235	66990	0344T
16015	29040	29590	37237	67346	0396T-0397T
16020	29044	29700	37239	67350	0408T-0416T
16025	29046	29705	37252-37253	67500	C1300
16030	29049	29710	38205-38206	68110	C2641
16035	29055	29715	38220-38221	68200	C5272
19082	29058	29720	38230-38232	68761	C5274
19084	29065	29730	38240-38242	68801	C5276
19086	29075	29740	38900	68810	C5278
19103	29085-29086	29750	43283	68840	C9701-C9702
19282	29105	29799	43338	68899	C9713
19284	29125-29126	29855	43753-43757	69090	C9716
19286	29130-29131	31500	47542-47544	69710	C9725
19288	29200	31620	49327	77301	G0167
19295-19298	29220	31627	49412	77372	G0256
20612	29240	31654	50606	77418	G0259
20690	29260	32501	50705-50706	92018-92019	G0277
20975	29280	32506	51703	92950	G0279
22534	29305	32507	51798	92953	G0280
23410	29325	32552	57267	92960-92961	G0341
23420	29345	33282	57288	92978-92979	G0342
23515	29355	36002	58300	93655	G0343
24685	29358	36420	61651	93657	
25575	29365	36425	61781-61783	96920-96922	
25607-25609	29405	36440	61795-61800	99183	
25620	29425	36450	62252	0047T-0048T	
26841	29435	36455	62367-62369	0050T	
27524	29440	36460	64462	0075T-0076T	
27871	29445	36511-36516	64614		

Please note: This list is subject to change as medical codes are updated and deleted. For a current copy of the "Services Exempt from Multiple Procedure Discount," please call Network Administration at 1-800-716-2299, option 3 or (225) 295-2430.

Multiple Service Reduction for Diagnostic Imaging Services

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

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

For Professional Providers

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

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

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

For Facility Providers

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

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

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

New Codes

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

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

Not Separately Reimbursable Codes

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

Observation

Charges for outpatient procedure services (as defined by the CPT/HCPCS procedure code range available in this manual) rendered to a member classified by the member provider as observation status for 30 hours or longer will be reimbursed according to the Member Provider Agreement Reimbursement Appendix. Charges for outpatient services in which an outpatient procedure was NOT performed and is classified by the member provider as observation status for 30 hours or longer will be reimbursed according to the lesser of:

1. The Member Provider Agreement Reimbursement Appendix for Outpatient Services limiting the payment for observation to the first 30 hours of observation (claim will require review and adjustment) or;
2. The contracted inpatient reimbursement (the Member Provider must follow inpatient billing guidelines)

The 30-hour count commences when outpatient services begin (when the member arrives at the hospital for treatment), not when the stay in observation begins.

The POS is based on the status the patient is at the time of the physician visit.

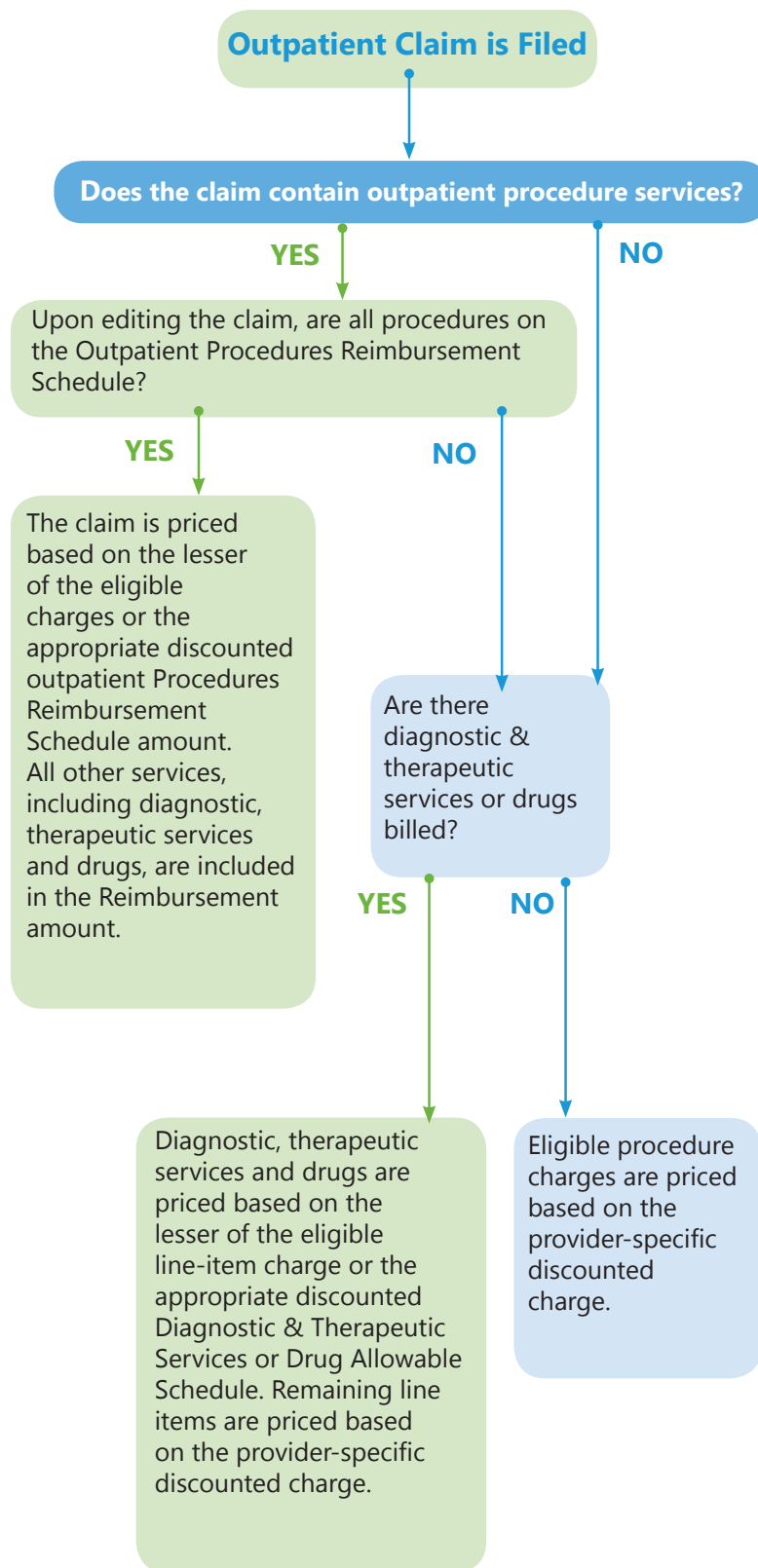
Emergency Room

Claims for services related to outpatient emergency room charges will be priced based on the provider-specific discounted charge and/or provider-specific fee schedule as defined in the Reimbursement Appendix of the Member Provider Agreement except in the case where a procedure is performed as defined under Billing Guidelines listed below. If one or more procedures are performed with established fees and in conjunction with other line item charges, only the procedures will be allowed.

Charges for outpatient emergency services rendered to a Member and classified by the Member Provider as in an outpatient emergency status for 30 hours or longer will be reimbursed according to the observation guidelines listed above.

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.

Pricing Flowchart for Outpatient Acute Care Reimbursement



Section 6

ADDITIONAL REIMBURSEMENT INFORMATION

Other Facility Reimbursement Programs

Inpatient

The reimbursement amount for chemical dependency, psychiatric, rehabilitation, or skilled nursing facility inpatient hospital services is based upon the lesser of the provider-specific daily per diem rate as outlined in the Reimbursement Appendix to the Member Provider Agreement or the Member Provider's Billed Charge or the Case Management rates agreed to by Member Provider and Blue Cross. The inpatient payment provisions and/or outlier provisions outlined in this manual and the Reimbursement Appendix to the Member Provider Agreement do not apply to reimbursement at these types of facilities.

Outpatient

Reimbursement for chemical dependency and psychiatric outpatient services is based on the specific contractual agreement. The Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) are reimbursed based on contracted rates or a discounted charge methodology. All other psychiatric and chemical dependency outpatient services are reimbursed on a discounted charge methodology.

Rehabilitation and Hospice services are reimbursed based on either contracted rates or a discounted charge methodology.

Physician Reimbursement

Reimbursement Amount/Allowable Charge

Blue Cross reimburses Member Providers for hospital-based physician (see below for more information) services according to established allowable charges. The allowable charge amount is the lesser of the billed charge or the amount established by Blue Cross, as the maximum amount allowed for provider services covered under the terms of the Member Contract/Certificate. By signing a Member Provider Agreement, the Member Provider agrees to accept the allowable charge as payment in full for covered services for all parties on whose behalf the Member Provider bills and receives payment from Blue Cross directly for hospital-based physician services, i.e., including but not limited to anesthesiologists, radiologists, pathologists and emergency room physicians.

You should always bill your usual charge to us regardless of the allowable charge. Allowable charges are provided to Member Providers to help avoid refund situations. They are for informational purposes and not intended to establish fees in all cases; e.g. where an outlier determines payment. Blue Cross allowable charges for professional services may be obtained by accessing iLinkBlue.

Diagnostic and Therapeutic Services

When billing for diagnostic and therapeutic hospital-based physician services, you should only bill the professional component and such billing should be submitted on the CMS-1500 claim form. Modifier 26 should be used for billing professional component only.

Hospital-Based Physicians

A "hospital-based physician" only performs medical services in the facility where they may be employed or where they may be independent contractors. These physician providers perform services in the following specialties: anesthesiology, pathology, radiology, emergency medicine and neonatology. Other types of hospital-based physicians are hospitalists. These physicians treat patients on behalf of the patient's routine physician.

Section 7

CLAIMS SUBMISSION & PAYMENT

Important Rules for All Claims Submissions

- All claims must indicate if work-related injuries or illnesses are involved, if the services are related to an accident or if the Member has other coverage and, if so, the identity of the other carrier or Plan.
- The Member Provider cannot require any Member (before or after rendering a service) to pay any amount in excess of any Deductible, Coinsurance, Copayments and amounts for Noncovered Services. The Member Provider shall look only to Plan for payment of Covered Services for Hospital Services except for the Deductible, Coinsurance, Copayments and amounts for Noncovered Services. The Member Provider cannot bill the Member in excess of the Reimbursement Amount (Allowable Charge). Please see the Consumer Directed Health Plan section of this manual for billing and reimbursement details for members with those type of plans.
- Blue Cross will inform the Member Provider of services not included as Covered Services under the various Member Contracts/Certificates. The Plan will also identify the amounts for these services that the Member Provider can collect from the Member. However, the Member Provider must include all such charges on the claim submitted.
- The Member Provider cannot bill Members for services which Blue Cross has determined to be not Medically Necessary, Experimental or Investigational, unless the Member Provider has notified the Member in advance in writing that certain not Medically Necessary, Experimental or Investigational services will be the Member's responsibility. Generic or all-encompassing notifications will not be deemed to meet the specific notification requirement mentioned above.
- Member Providers should submit the appropriate NPI number in box 56 on the UB-04 claim form to ensure payment is made accurately and on time.

When filing claims on the CMS-1500 form

- Claims should include all services rendered during the visit. Our reimbursement allowable for the Evaluation and Management (E&M) service includes the components for physician work, practice expense and malpractice insurance. No additional room usage charge should be billed by any party, since the practice expense component includes overhead expenses and is an integral part in the E&M or procedure allowable charge. This methodology applies to hospital owned and physician owned practices and helps ensure that contractual benefits for our members are correctly applied to claims.
- All completed claim forms should be forwarded to the following address for processing:



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

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

Overpayments

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



Special Claims Review - BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

Please include the following information:

- Contract number
- Patient name
- Date of service
- Patient account number
- Reason for the overpayment
- Copy of remittance

Please note: Facilities should actively work credit balances due to Blue Cross and return overpayments to Blue Cross. Refunds greater than \$10,000 should be identified back to Blue Cross within 120 days from the occurrence date. This should be done even when credit balance recovery vendors are assisting with this process. Failure to do so will result in the facility being responsible for the fees incurred for the recovery.

Federal Employee Program (FEP) Non-network Claims - Direction of Payment

Blue Cross pays FEP members directly for all services performed by a provider that does not have a contract with us. A Non-participating provider is defined as one that has chosen not to sign a contract with Blue Cross and a non-network provider is a provider/specialty type that Blue Cross does not offer contracts to.

Claims Resubmission (or Refiling)

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

Adjustment and Void Claim Submissions

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

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

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

Electronic (837I & 837P) Adjustment and Void Claims

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

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

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

Adjustment Claim

- Enter the frequency code "7" in Loop 2300 Segment CLM05-03.
- Enter the 10-character ICN of the original claim (assigned on the processed claim) in Loop 2300 in an REF segment and use F8 as the qualifier.

Note: The Adjusted claim should include all charges (not just the difference between the original claim and the adjustment).

Void the Claim

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

iLinkBlue Facility UB-04 Adjustment and Void Claims

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

iLinkBlue Professional 1500 Adjustment and Void Claims

- Field 19A Professional Claim Adjustment/Void Indicator is required:
 - A - Adjust original claim
 - V - Void original claim
- Field 19B Internal Control Number (ICN Number) – The ICN Number is the claim number from the Blue Cross Remittance Advice (Provider Payment Register).

Diagnosis/Procedure Coding

The International Classification of Diseases, 10th Revision, Clinical Modifications (ICD-10-CM) is the basis of diagnosis and procedure coding at Blue Cross. This system is comprised of three volumes:

Volume 1 Diseases:	Tabular List
Volume 2 Diseases:	Alphabetic Index
Volume 3 Procedures:	Tabular List and Alphabetic Index

The diagnoses are classified by three digit categories with the addition of a fourth or fifth digit to provide specificity or more information regarding etiology, site or manifestations. The appropriate diagnosis code is found by using Volume 2, then verifying the code in Volume 1.

Volume 3 contains both a tabular and alphabetic listing of procedure codes. These codes are required for most facility coding but are not used by Blue Cross for professional procedure coding. The CPT coding system is used routinely to report professional procedures.

It is necessary to use the current edition of the code book reflective of the date of service of the claim. The applicable code books include, but are not limited to, ICD-10-CM Volumes 1, 2 and 3, CPT and HCPCS.

New CPT and HCPCS codes will be accepted by Blue Cross beginning January 1 of each year.

Helpful Hints for Diagnosis Coding

- Always report the primary diagnosis code on the claim form. Principal Diagnosis - "Reason for service or procedure".
- Report each diagnosis code when services for multiple diagnoses are filed on the same claim form.
- Report all digits of the appropriate ICD-10-CM code(s).
- Report the date of accident if the ICD-10-CM code is for an accident diagnosis.
- Provide a complete description of the diagnosis if an appropriate ICD-10-CM code cannot be located.
- Include all documented co-morbidities, to the highest level of specificity.

Coding Reminder

Participating providers should follow the coding guidelines published in the current edition of the Physicians' Current Procedural Terminology (CPT) when submitting claims to Blue Cross and Blue Shield of Louisiana, HMO Louisiana for processing. Blue Cross follows these coding guidelines unless otherwise identified in our policies.

Procedure Codes and Guidelines When Filing Professional and Certain Outpatient Services

Blue Cross processes professional, outpatient surgery and outpatient diagnostic and therapeutic claims using CPT, a systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. By using these procedure codes, you can enhance the speed and accuracy of claims payments. As a Member Provider, you should always include the appropriate CPT code(s) when filing these types of claims.

Because medical nomenclature and procedural coding is a rapidly changing field, certain codes may be added, modified or deleted each year. Please ensure that your facility is using the current edition of the code book reflective of the date of service of the claim. The applicable code books include, but are not limited to, ICD-10-CM Volumes 1, 2 and 3; CPT and HCPCS.

Modifiers

A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed, has been altered by some specific circumstance but not changed in its definition or code. For Blue Cross claims filing, modifiers, when applicable, always should be used by placing the “valid” CPT or HCPCS modifier in block 24D of the CMS-1500 or block 49 of the UB-04 claim form. A complete list of valid modifiers is listed in the most current CPT code book. Please ensure that your facility is using the current edition of the code book reflective of the date of service of the claim.

Helpful Hints for Using Modifiers

Do’s:

- Use valid modifiers. Blue Cross considers only CPT and HCPCS modifiers that appear in the current CPT and HCPCS books as valid.
- Indicate the valid modifier in block 24D of the CMS-1500 or block 49 of the UB-04. Our Blue Cross system can read up to four modifiers per code.

Don’ts:

- Don’t use other descriptions in the modifier section of the claim. In some cases, our system may read the description as a set of modifiers and this could result in lower payment for you.
- Avoid excessive spaces between each modifier.
- Don’t use dashes, periods, commas, semicolons or any other punctuation in the modifier portion of the claim form.

Modifier 33

Providers can append Modifier 33 to indicate that the screening colonoscopy (45378) was converted to a polypectomy (45383). In this scenario, Modifier 33 appended to 45383 will ensure that the claim is paid correctly. **Modifier 33 will impact how the claim is paid only for colonoscopy procedures.** Modifier 33 should not be applied to non-preventive colonoscopies (done to evaluate signs, symptoms, follow-up or existing conditions).

Modifier 50 - Billing Single Bilateral Procedures

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

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

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

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

Proper billing of bilateral procedures ensures correct reimbursement and eliminates the need for refund requests and payment adjustments.

Modifier 51 - Multiple Procedures

- **Modifier 51** generally pays primary or highest allowable procedure at 100 percent of allowable charge and the remaining procedures at 50 percent of allowable charge.

Modifier 52 - Partially Reduced or Eliminated Procedures

- **Modifier 52** is used when services were modified mid-procedure at the physician's discretion such that the service furnished is less than usually required. Effective July 1, 2014, outpatient facility reduced services will be reimbursed at 50 percent of the allowable charge.

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

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

Modifier PO - Off-campus Services

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. Technical component of services already reimbursed in global fees to off-campus providers are not eligible for reimbursement in facility claims.

Modifiers RT and LT Clarification:

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

Modifiers TA and T1-T9

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

HCPCS Level II toe modifiers are anatomical modifiers that describe procedures performed on the right and left foot digits. It is incorrect to additionally append Modifiers LT and/or RT. It is also incorrect to use Modifier 59 and/or Modifier 59 subset "X modifiers" (XE, XS, XP, XU).

Failure to use these modifiers appropriately may result in claims denial. Additionally, post audits will be performed and will result in recoupments if documentation reviewed supports unbundling by incorrect use of Modifiers 59, XE, XS, XP, XU, LT and RT.

Provider Access to Medical Code Editing Section on iLinkBlue

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

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

Serious Preventable Events and Present on Admission Indicators

Serious Preventable Events are specific, inpatient adverse events or errors in medical care that are clearly identifiable and serious in their consequences for the patient/member. These events include both Hospital Acquired Conditions (HACs) and Never Events. Participating acute care inpatient hospitals (excluding inpatient psychiatric hospitals, long term acute care facilities, inpatient rehabilitation facilities and cancer hospitals) may not seek payment from and must waive any claims against Blue Cross and/or Blue Plan members, for a Serious Preventable Event or services required to correct or treat the problem created by

the Serious Preventable Event when such an event occurred under facilities' control. Both Blue Plan and Member shall not be billed for any charges related to Serious Preventable Events.

Below is the list of HACs:

- Pressure ulcers stages III & IV
- Catheter-associated urinary tract infections
- Vascular catheter-associated infection
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)
- Air embolism
- Blood incompatibility
- Foreign object retained after surgery
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, other injuries)
- Surgical-site infections following certain orthopedic procedures
- Surgical-site infections following bariatric surgery for obesity
- Manifestations of poor glyceic control
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures
- Iatrogenic pneumothorax with venous catheterization
- Surgical site infection following cardiac implantable electronic device (CIED)

Please note: The conditions listed above are consistent with Centers for Medicare & Medicaid Services' (CMS) IPPS October 2016 list of HACs.

A **Never Event** is a surgical event that never should have occurred. Below is the list of Never Events:

- Surgery performed on a wrong body part
- Surgery performed on a wrong patient
- Wrong surgical procedure performed

Please note: The events above are consistent with CMS' January 2009 list of Never Events.

Present on Admission (POA) Indicators

The POA indicator is reported on the UB-04 claim form and used to note a condition that was present at the time the order for inpatient admission occurs. It is noted by using one of the five values below that identifies whether primary or secondary diagnoses are present when the patient is admitted to a hospital:

POA Indicator Value	Description	Expectation of Payment
(matched with appropriate diagnosis code)	The POA indicator is required on all paper and electronic inpatient hospital claims.	
Y	Yes, diagnosis was present at time of inpatient admission.	Payment may be permitted.
N	No, diagnosis was not present at time of inpatient admission.	No payment may be permitted when diagnosis code identifies Serious Preventable Event.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment may be permitted when diagnosis code identifies Serious Preventable Event.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment may be permitted.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.	CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list. For a complete list of codes on the POA exempt list, see the Official Coding Guidelines for ICD-10-CM.
"Blank"	A blank is not valid for reporting purposes. Claims will be returned to provider for a valid POA indicator.	No payment permitted. Claims to be returned for a valid POA indicator.

**Diagnosis codes may be exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission. A list of exempt diagnoses is available in Appendix 1 – Present on Admission Reporting Guidelines of CMS' ICD-10-CM Official Guidelines for Coding and Reporting Manual.*

Please note that Serious Preventable Event diagnosis codes are not identified on the exempt list.

Filing Claims for Serious Preventable Events

Hospital Acquired Condition (HAC)

Report the HAC to Blue Cross on the claim form by indicating the appropriate diagnosis code and POA indicator. Hospitals should not include any charges related to the HAC on the claim form.

Blue Cross will identify the HAC based on the diagnosis code and POA indicator submitted on the claim. Routine auditing of claims will occur to ensure that facilities are adhering to this policy.

Never Event

Report Never Events in writing to Blue Cross' Chief Medical Officer within 30 days of the occurrence.



BCBSLA – CMO
P.O. Box 98029
Baton Rouge, LA 70898-9029

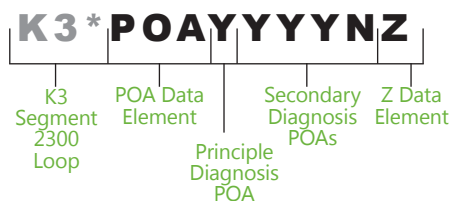
Please DO NOT report Never Events to Blue Cross via a claim form

Claims will be returned to the hospital if:

1. Primary or secondary diagnosis codes are submitted with a blank POA indicator.
2. An invalid POA indicator (other than Y, N, U, W, 1) is submitted.
3. POA indicators are submitted without an associated primary or secondary diagnosis code.
4. Electronic claims are submitted in an improper format – i.e., if the POA field contains improper spaces, or if the number of POA indicators does not equal the number of diagnosis codes submitted.

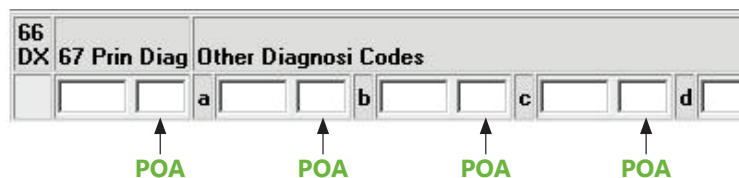
Electronic Claims using HIPAA 837I

The K3 segment in the 2300 Loop is designated for POA indicators in the HIPAA 837I transaction, version 4010A1. "POA" is always required first, followed by a single indicator for the principle and secondary diagnoses reported on the claim. The principal diagnosis is always the first indicator after "POA." Next, POA indicators for the secondary diagnoses are listed in corresponding order to the secondary diagnosis codes entered. The last secondary diagnosis POA indicator is followed by the letter Z. If ECI diagnosis codes are submitted, POA indicators for the ECI codes must be listed in corresponding order to the ECI diagnosis codes and should follow the Z, which indicates the end of the POA indicators for the other diagnosis codes.



Electronic Claims through iLinkBlue

When submitting electronic inpatient hospital claims directly through iLinkBlue, the POA indicator is placed in the block immediately following each diagnosis code block (much like on the hardcopy claim).



Hardcopy Claims

On the UB-04 claim form, the principle diagnosis code is listed in Block 67. Secondary diagnosis codes are listed in Blocks 67A-67Q. The POA indicator should be placed in the gray area at the right-hand side of the Principal Diagnosis and Secondary Diagnosis code blocks on the UB-04 claim form.

If the hospital discovers that a claim for a Serious Preventable Event has been submitted for compensation, hospital must immediately notify Blue Cross and shall refund any payment received within 30 days of discovery or receipt of payment.

If Blue Cross discovers a claim for a Serious Preventable Event, we will notify the hospital that payment will not be made for the Serious Preventable Event.

If the claim has already been paid to the hospital, Blue Cross will review the appropriate medical records to determine if a Serious Preventable Event occurred and if so, the claim may be adjusted resulting in modified reimbursement. The hospital will be notified of such event in advance of any proposed adjustment.

66 DX	244.9	Y	250.01	N	296.20	U	V15.81	W	D	M
	↑		↑		↑		↑			
	Principle Diagnosis		Secondary Diagnoses							

Diagnoses shown are for illustrative purposes only and do not represent an actual claim submission.

Diagnosis codes associated with reporting Serious Preventable Events

A complete listing of the Serious Preventable Events ICD-10 codes may be found on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

Reminder: Inpatient hospital claims should not include any charges associated with a Serious Preventable Event or services required to correct or treat the problem created by the Serious Preventable Event when such event occurred under hospital's control.

National Provider Identifier (NPI)

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

To comply with the legislation mentioned above, all covered entities must use their NPI and corresponding taxonomy code, where applicable, when filing claims. All providers who are being

credentialed or who are undergoing recredentialing, regardless of network participation, must include their NPI(s) on their application. **Claims processing cannot be guaranteed unless you notify Blue Cross of your NPI(s) prior to filing claims using your NPI(s).**

Notifying Blue Cross of your NPI

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

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

Filing Claims with NPIs

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

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

Referring Physician NPIs

Referring physician NPIs are required on all claims filed with Blue Cross and HMO Louisiana in which a referring physician was used. For more information on NPIs, visit www.bcbsla.com/providers >NPI. Failure to include the referring/ordering physician NPI could result in your claim being returned requesting the referring/ordering physician's NPI.

Tax Identification Numbers (TIN)

If your TIN or NPI should change, please notify Blue Cross as soon as possible by sending a copy of your IRS Employer Identification Number Letter to the following address prior to the effective date of the new number:



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



1-800-716-2299, option 3



(225) 295-2750 (fax)

Reporting National Drug Code (NDC) on Claims

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

Providers should use the following billing guidelines to report NDCs on professional 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 which meet the requirements for an NDC but have no valid NDC on the claim.
 - NDCREQD – NDC CODE REQUIRED
 - INVNDC – INVALID NDC

For Hardcopy Claims

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

For Electronic Claims 837i

Report the NDC in loop 2410, Segment LIN03 of the 837. The code should consist of a CMS 11-digit NDC in a fixed length 5-4-2 (no hyphens) configuration. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

For iLinkBlue Claims

NDC codes cannot be filed on facility outpatient claims via iLinkBlue at this time. This capability will be offered in the near future. Any iLinkBlue facility outpatient claim that requires an NDC code should be filed via hard copy claim until this capability has been added.

Coordination of Benefits

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

You can assist in the COB process by asking your BCBS patients if they have other coverage and indicating this information in block 50 on the UB-04 claim form for facility claims. For professional claims, this information should be indicated in block 9 of the CMS-1500 claim form. When COB is involved, claims should be filed with the **primary** insurance carrier first. When an Explanation of Benefits (EOB) is received from the primary carrier, the claim then should be filed with the secondary carrier, attaching the primary carrier EOB.

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

Medicare Primary Coordination of Benefits for OGB Members

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

Subrogation

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

All claims you submit to Blue Cross must indicate if work-related injuries or illnesses are involved, if the services are related to an accident. Member Providers should:

- Not require the Blue Cross Member or the Member's lawyer to guarantee payment of the entire billed charge.
- Not require the Blue Cross Member to pay the entire Billed Charge up front.
- Not bill the Blue Cross Member for amounts above the Reimbursement Amount/Allowable Charge.
- Charge the Member no more than what is ordinarily charged other patients for the same or similar service.
- Bill only for any applicable Deductible, Coinsurance, Co-pay and/or Noncovered Service.
- If amounts in excess of the Reimbursement Amount/Allowable Charge were collected, you should refund that amount to the Member.

OGB Subrogation

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

BlueCard Subrogation

Each state handles subrogation differently or the member's policy may have language to reject a claim to investigate if there is other insurance responsible. If a BlueCard claim is pended or denied for subrogation or related reason, Blue Cross' policy of pay and pursue does not apply. You can inquire about a plan's subrogation policy when obtaining verification of benefits. Otherwise, you must follow your contractual agreement with Blue Cross.

Employment-related Injuries or Illness

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

- Workers' Compensation under state law – Workers' Compensation under state law is a legal remedy whereby an employee who is injured within the course and scope of employment is usually entitled to certain benefits regardless of whether anyone was at fault.
- Longshore & Harbor Workers' Compensation Act (LHWCA) - The LHWCA is a federal law that provides for the payment of medical care to employees who suffer "on the job" injuries that occur on the navigable waters of the United States or in adjoining areas used in loading, unloading, repairing, or building certain vessels, regardless of whether anyone was at fault.
- Jones Act – The Jones Act is a federal law that provides protection only to "seamen" who are injured while working on a vessel.

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

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

Coordination of benefits does not apply in any of these scenarios.

Medicare Supplemental Claims

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

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

Provider information at Medicare and Blue Cross of Louisiana

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

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

How to determine if the claim was crossed over from Medicare

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

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

Example 2: Claim information forwarded to: BCBS of Alabama

If the remittance does not contain a message similar to the above, the claim was not crossed over to the payer. This claim must be filed on paper to the Plan listed on the member's ID card. The following claims are excluded from the crossover process for Blue Cross:

- Original Medicare claims paid at 100 percent
- 100 percent denied claims with no additional beneficiary liability
- Adjustment claims that are non-monetary/statistical
- Medicare Secondary Payer (MSP); claims for which other insurance exists for beneficiary
- National Council for Prescription Drug Programs (NCPDP) claims

What to do when the claim WAS NOT crossed over from Medicare

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

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

Follow-up on Crossover Claims

Blue Cross Blue Shield of Louisiana:

- Wait 21 days before conducting follow-up on iLinkBlue

Blue Cross Blue Shield **out-of-state** plans:

- Wait 30 days before contacting the out-of-state plan

Services Excluded or Not Covered by Medicare

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

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

Medicare Payment Rules for Consultation Services

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

Please note: These codes are still valid CPT codes and Blue Cross continues to accept these consultation codes. We have current allowable charges for these codes and any changes in allowable amounts or billing policies for these codes will be communicated to our providers with a 90-day notice. At this time, we do not anticipate any changes.

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

1. Bill the primary payer an Evaluation and Management code that is appropriate for the service and then report the amount actually paid by the primary payer, along with the same Evaluation and Management code, to Medicare for determination of whether a payment is due; or
2. Bill the primary payer using a consultation code that is appropriate for the service and then report the amount actually paid by the primary payer, along with an Evaluation and Management code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Note: The first option may be easier from a billing and claims processing perspective.

For more on this from the Centers for Medicare & Medicaid services (CMS), go to www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf and www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf.

Medicare Part A Benefit Exhaust Claims Requirements

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

Medicare exhaust letter, including the date Medicare benefits exhausted. Medicare Part A charges and Explanation of Benefits (EOB) must match.

Blue Cross authorization from the date Medicare benefits exhausts.

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

If you have questions, please email network.administration@bcbsla.com.

Non-participating Acute Hospital Provider Benefits Payment Policy

Payment for services rendered by a hospital or unit that does not participate in the member's network will be paid directly to the member, unless the member signed a valid assignment of benefits (AOB). Without

a valid AOB, the hospital or unit must collect all charges from the member. If a valid AOB is present, payment will be made directly to the hospital or unit, at the non-network level of benefits specified in the Member's Contract/Certificate.

If the member is enrolled in the Federal Employee Program or is covered by another Blue plan, payment for services rendered by a Non-participating hospital or unit will be paid directly to the member, even if the member signed an AOB. The hospital or unit must collect all charges from the member.

Members may be covered under a national account or another Blue plan. Account-specific non-network benefit provisions are set by those accounts and Blue plans and enforced by them. This coverage often requires reduced payments being paid directly to the member, as determined by the account or Blue Cross plan issuing the member certificate.

Timely Filing and Refunds Process

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

There may be times when Blue Cross must request providers to refund payments previously made to them. When refunds are necessary, Blue Cross or its agent notifies the provider within 15 months of payment of the claim in question. The notification letter explains that Blue Cross or its agent will deduct the amount owed from future Payment Registers/Remittance Advices unless the provider contacts us within 30 days.

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

If Blue Cross has made any omissions or underpayments, Blue Cross will make payment for such errors as soon as they are discovered or within 30 days of written notice from the Member Provider regarding the error. Recoveries and payments for omissions and underpayments shall be initiated within 15 months of the claim's last date of payment or adjustment. In accordance with the Member Provider Agreement, Blue Cross and the Member Provider agree to hold each other and the member harmless for underpayments or overpayments discovered after 15 months from the date of payment.

Blue Cross claims for OGB members must be filed within 12 months of the date of service. Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim. OGB claims are not subject to late payment interest penalties.

Member Refunds

Member refunds should be based on actual payment(s) made by Blue Cross when there are two primary payers (no COB). The Member's Coinsurance, lifetime benefits and premiums are based on the reimbursement amount paid to the member provider. The above allowable charge amount (Contractual Allowance) should not be part of the member refund.

Example UB-04 CLAIM FORM

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

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM
			7 THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		c	d
10 BIRTHDATE	11 SEX	12 DATE	13 HR
14 TYPE	15 SRC	16 DHR	17 STAT
18	19	20	21
22	23	24	25
26	27	28	29 ACDT STATE
30			
31 OCCURRENCE DATE	32 CODE	33 OCCURRENCE DATE	34 CODE
35 OCCURRENCE DATE	36 CODE	37 OCCURRENCE DATE	38 CODE
39 VALUE CODES AMOUNT	40 CODE	41 VALUE CODES AMOUNT	42 CODE
43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS
47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
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18			
19			
20			
21			
22			
23			
PAGE	OF	CREATION DATE	TOTALS
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASSO. BEN.
54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
66 DX	67	A	B
C	D	E	F
G	H	I	J
K	L	M	N
O	P	Q	R
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
73	74 PRINCIPAL PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 ATTENDING NPI
77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 REMARKS
81CC a	b	c	d



UB-04 Claim Form Explanation

Block 1	Enter billing provider name and address.
Block 2	Enter pay-to provider name and address, if different than Block 1.
Block 3A	Patient Control Number: Enter the number or code that is used by your facility to retrieve or post financial records.
Block 3B	Medical Record Number: Enter the number or code that is used by your facility to retrieve or post medical/health records.
Block 4	Type of Bill: This is a three-position code that indicates the type of facility, the bill classification and the frequency.
Block 5	Fed. Tax ID: Enter the tax identification number of the facility.
Block 6	Statement Covers Period: Enter the first date associated with this claim in the "From" box and enter the final date of the claim in the "Through" box.
Block 8A-8B	Patient Name: Enter the patient's name with last name first, then first name and middle initial, if any. Do not use titles or nicknames.
Block 9A-9E	Address: Patient address must be completed.
Block 10	Birthdate: Enter the patient's actual date of birth in MM-DD-YYYY format.
Block 11	Sex: An "M" for male or an "F" for female must be present.
Block 12	Admission Date: This field is required for inpatient claims and not required for outpatient claims.
Block 13	HR: This field is required for inpatient claims and not required for outpatient claims.
Block 14	Type: This field is required for inpatient claims and not required for outpatient claims.
Block 15	SRC: This field is required for inpatient claims and not required for outpatient claims.
Block 16	DHR: Discharge hour field is required on all final inpatient claims except for 021x. This includes claims with a Frequency Code of 1 (admit through Discharge), 4 (Interim- Last Claim) and 7 (Replacement of Prior Claim) when the replacement is for a prior final claim.
Block 17	STAT: Enter the applicable discharge status code. This field is not required for outpatient claims, but can be present.
Blocks 18-28	Condition Codes: The condition code(s) is a two-position code that identifies conditions, if any, relating to this bill that may affect payer processing.



Block 29	Two digit state abbreviation where the accident occurred.
Block 30	Reserved for assignment by the National Uniform Billing Committee (NUBC).
Blocks 31-34	Occurrence Codes and Occurrence Dates: The occurrence code is a two-position code used to determine liability, coordination of benefits and to administer subrogation clauses in the member contract/certificate. The occurrence date is the date that corresponds with the preceding occurrence code. The date must be in MM-DD-YYYY format and is required if occurrence codes are used.
Block 35-36	Occurrence Span Codes and Dates: These fields are used when the patient was seen as an outpatient for follow-up treatment. In the "From" field, enter the first date the patient was treated for this condition. In the "Through" field, enter the last date the patient was treated for this condition. This field is not required for inpatient claims.
Block 37	Reserved for assignment by the NUBC.
Block 38	The name and address of the party responsible for the bill.
Blocks 39-41	Value Code/Amount: Value code(s) identify data necessary for processing claims. The value amount is the dollar amount or number associated with the corresponding value code. A value amount must be present for each value code. If the amount does not represent a dollar amount, two zeros should be entered following the number. Example: If the patient received three units of blood, enter 300.
Block 42	Rev CD: The revenue code is the code that best identifies a particular accommodation/ ancillary service that was rendered to the patient. Revenue codes can be duplicated only if the rates differ.
Block 43	Description: The provider reports the NDC code. The provider enters a narrative description or standard abbreviation for each revenue code shown. This field is not required but may be present.
Block 44	HCPCS/Rates: The rate is the actual charge for the services rendered. If rates are different, duplicate the revenue code to show the different rates. Revenue codes can only be duplicated when the rates are different. Rate multiplied by units must equal charges.
Block 45	Serv. Date: Date of service for HCPCS code listed. If there are multiple dates of service for the same HCPCS code, each date must be listed on a separate line.
Block 46	Service Units: Service units are the number of times a service was rendered per date of service.
Blocks 42-47	Line 23: The PAGE__ of __, CREATION DATE and total charges TOTALS should be reported on all pages of the UB-04.

- Block 47** Total Charge: Enter the amount charged for each of the revenue codes given. If rates and units are present, multiply these to get the total charges except when rates are zeros.
- Block 49** Reserved for assignment by the NUBC.
- Block 50** Payer Name: This field is required only on lines 50B and 50C when indicating other payer information.
- Block 52** REL INFO: The release information field must be "Y" if you are filing electronically. This indicates that you have signed written authority to release medical or billing information for purposes of claiming insurance benefits. If "N," you must file hardcopy.
- Block 53** ASG BEN: Enter one of the following codes to indicate who will receive payment for the claim:
- Y - Assignment/payment to provider N - Assignment/payment to member
- Blue Cross pays all participating providers directly unless assignment indicates to pay the member.
- Block 56** NPI: Enter the appropriate national provider identifier (NPI) number in this field.
- Block 57** Other Prv ID: Enter your Blue Cross assigned five-digit or ten-digit provider number in this field.
- Block 58** Insured's Name: If the patient is not the insured, enter the member's name exactly as it appears on the BCBS identification card.
- Block 59** P REL: If the patient and insured are the same, this field is not required. If the patient is not the insured, enter one of the following codes that identifies the patient's relationship to the contract holder:
- | | |
|-----------------|-----------------------|
| 01 Spouse | 18 Self |
| 19 Child | 20 Employee |
| 21 Unknown | 39 Organ donor |
| 53 Life partner | G8 Other relationship |
- Block 60** Insured's Unique ID: Enter the member's identification number exactly as it appears on the ID card.
- Block 61** Group Name: This field is required if known.
- Block 62** Insurance Group No.: Enter the group number as it appears on the member's ID card.
- Block 63** Treatment Authorization Codes: Enter the Blue Cross authorization number, when available.



- Block 65** Employer Name: Enter the patient's employer in this field. If patient is a housewife, retired, unemployed or a student in college, enter this. Do not enter the member's employer, unless the patient is the employer.
- Block 66** ICD Version Indicator: Qualifier Code "9" required on claims representing services through September 30, 2015. Qualifier Code "0" required on claims representing services on October 1, 2015 and beyond.
- Block 67** Principle Diagnosis Code: The principal diagnosis code must be entered in this field. You must use ICD-10-CM codebook. The first position should contain "V" or a numeric character. The second and third positions must be numeric with no punctuation. Fourth and fifth positions must be numeric or blank.
- Blocks 67A-Q** Other Diagnosis Codes: These fields should be used when additional conditions exist at the time of admission or develop subsequently and affect the treatment received or the length of stay. Follow the coding guidelines for the principal diagnosis code.
- Block 68** Reserved for assignment by the NUBC.
- Block 69** Admit Dx: Enter the ICD-10-CM diagnosis code related to the patient's admission.
- Block 70** The ICD-CM diagnosis code describing the patient's reason for visit at the time of outpatient registration.
- Block 71** The Prospective Payment System (PPS) code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
- Block 72** The ICD diagnosis code pertaining to external cause of injuries, poisoning, or adverse effect. See ICD-10-CM Guidelines for Coding and Reporting. The industry-wide move to ICD-10 will occur on October 1, 2015.
- Block 74** Principal Procedure Code/Date: The principal procedure should be entered in this field. This is the procedure that was performed for treatment rather than diagnostic or exploratory purposes, or the procedure that is most related to the principal diagnosis. The procedure coding method must be ICD-10-CM. Enter the date the primary/principal procedure was performed in MM-DD-YYYY format.
- Block 74A-E** Other Procedure Code/Date: For outpatient billing, if a CPT code is not required, enter the ICD-10-CM procedure code. Enter the date of the additional procedure(s) in MM-DD-YYYY format.
- Block 75** Reserved for assignment by the NUBC.
- Block 76** Attending: Enter the NPI, last name and first name of the attending physician who rendered the services. This field is required.

Block 77	Operating: Enter the NPI, last name and first name of the operating physician who had primary responsibility for surgical procedures. This is only required when a surgical procedure code is listed.
Block 78-79	Other: Required. Enter the NPI, last name and first name of referring physician, assistant surgeon or rendering physician, as applicable.
Block 80	Remarks: The remarks field must be completed if the type bill is "XX5" or "XX6" or if the third digit of a revenue code is "9" or if revenue codes 920 or 940 are present.
Block 81	Enter B3-qualifier and then your respective taxonomy code. All claims need to be filed with a taxonomy code to ensure timely and accurate claims processing.
Remarks	If the claim is for a federal employee contract and therapy revenue codes 42X, 43X or 44X are present, the actual dates of service for each revenue code must be entered in the remarks field.



Example CMS-1500 CLAIM FORM



Blue Cross only accepts CMS-1500 "version 02/12." No black and white copies or faxed claims are accepted.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)																		
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)																				
CITY			STATE			8. RESERVED FOR NUCC USE			CITY			STATE																	
ZIP CODE			TELEPHONE (Include Area Code) ()			8. RESERVED FOR NUCC USE			ZIP CODE			TELEPHONE (Include Area Code) ()																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER																				
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. RESERVED FOR NUCC USE			c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO																	
b. RESERVED FOR NUCC USE			c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME			a. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)																	
b. RESERVED FOR NUCC USE			c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME																	
b. RESERVED FOR NUCC USE			c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																							
SIGNED _____						DATE _____			SIGNED _____																				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.						15. OTHER DATE QUAL. MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						17b. NPI _____						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____						A. _____ B. _____ C. _____ D. _____						22. RESUBMISSION CODE ORIGINAL REF. NO. _____																	
E. _____ F. _____ G. _____ H. _____						I. _____ J. _____ K. _____ L. _____						23. PRIOR AUTHORIZATION NUMBER _____																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			C. _____			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSTD Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #		
25. FEDERAL TAX I.D. NUMBER			SSN EIN <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$			29. AMOUNT PAID \$			30. Rsvd for NUCC Use											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____						33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____																	
SIGNED _____						DATE _____																							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Health Insurance Claim Form (CMS-1500 Version 02-12) Explanation

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



Louisiana

designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the CMS-1500 Claim Form are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code.

Block 11 Not required.

Block 11D When appropriate, enter an X in the correct box. If marked "YES," complete 9, 9A, and 9D. Only mark one box.

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

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

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

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

Block 14 Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the present illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported.

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

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

Block 17 Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the

professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:

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

Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported to the left of the vertical, dotted line.

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

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

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

Block 19 Additional Claim information to be completed by NUCC.

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

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

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

Block 24A Date(s) of Service - Enter the "from" and "to" date(s) for service(s) rendered. Report the NDC in the shaded area.

We follow CMS billing requirements for CMS1500 claims when billing the NDC codes: (CMS Claims Processing Manual, chapter 26, section 10.4) states the following:

Item 24 - The six service lines in section 24 have been divided horizontally to



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accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g., UN2 or F2999999).

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

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

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

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

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

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

Block 24J Rendering Provider ID# - Enter the national provider identifier (NPI) for the rendering physician for each procedure code listed when billing for multiple physicians' services on the same claim. Laboratory, Durable Medical Equipment, Emergency Room Physicians,

Diagnostic Radiology Center, Laboratory and Diagnostic Services, and Urgent Care Center providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed.

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

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



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iLinkBlue 1500 Claim Electronic Entry Screen

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

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

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

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

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

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

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

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

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

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

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

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



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- Block 17A** Other ID#. The non-NPI ID number of the referring physician, when listed in Block 17.
- Block 17B** **NPI – Required.** Enter the national provider identifier (NPI) for the referring physician, when listed in Block 17.
- Block 18** For Services Related to Hospitalization - Enter dates of admission to and discharge from hospital.
- Block 19** (Designated by NUCC) - Additional Claim information to be completed by NUCC.
- Block 20** Laboratory Work Performed Outside Your Office - Enter, if applicable.
- Block 21** **Diagnosis or Nature of Illness or Injury** - Enter the applicable ICD indicator to identify which version of ICD codes is being reported: "9" for- ICD-9-CM or "0" for ICD-10-CM codes- Note: All transactions, electronic or paper-based, for services on and after October, 1, 2015, must contain ICD-10 codes or they will be rejected. Blue Cross will not accept ICD-9 codes with dates of services on or after October 1, 2015. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
- Block 23** Prior Authorization Number- Enter the authorization number obtained from Blue Cross/HMO Louisiana, if applicable.
- Block 24A** Date(s) of Service - Enter the "from" and "to" date(s) for service(s) rendered.
- Block 24B** Place of Service - Enter the appropriate place of service code. Common place of service codes are:
Inpatient - 21 Outpatient - 22 Office - 11
- Block 24C** EMG - Enter the Type of Service code that represents the services rendered.
- Block 24D** Procedures, Services, or Supplies - Enter the appropriate CPT or HCPCS code. Please ensure your office is using the most current CPT and HCPCS codes and that you update your codes annually. Append modifiers to the CPT and HCPCS codes, when appropriate.
- Block 24E** Diagnosis Pointer - Enter the diagnosis code reference letter (pointer) as listed in Block 21 to relate the date of service and the procedures performed to the primary diagnosis. When

multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.

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

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

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

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

Block 24K **Expand claim line to report NDC, Quantity, and Measurement.**

Block 25 Federal Tax I.D. Number - Enter the provider's/clinic's federal tax identification number to which payment should be reported to the Internal Revenue Service.

Block 26 Patient's Account Number - Enter the patient account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register/Remittance Advice only if it is indicated on the claim form.

Block 27 Accept Assignment - Not applicable - Used for government claims only.

Block 28 Total Charge - Total of all charges in Item F.

Block 29 Amount Paid - Not required.

Block 30 Not required.

Block 31 Signature of Provider - Provider's signature required, including degrees and credentials.



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- Block 32** Name and Address of Facility - Required, if services were provided at a facility other than the physician's office.
- Block 32A** NPI - Enter the NPI for the facility listed in Block 32.
- Block 32B** Other ID. The non-NPI number of the facility refers to the payer-assigned unique identifier of the facility.
- Block 33** Billing Provider Info & Ph# - Enter complete name, address, telephone number for the billing provider.
- Block 33A** NPI - Enter the NPI for the billing provider listed in Block 33.
- Block 33B** Other ID# - The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional.

Payment Register/Remittance Advice Explanation

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

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

Section 7-A

ELECTRONIC CLAIMS SUBMISSION & PAYMENT

Electronic Data Interchange (EDI)

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

iLinkBlue

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

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



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

To learn more about iLinkBlue:

- Go to www.bcbsla.com/providers >Electronic Services
- Email us at: iLinkBlue.ProviderInfo@bcbsla.com
- Call (225) 293-LINK (225-293-5465).

Electronic Transaction Exchange

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

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

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

Security Administrative Representative

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

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

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

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

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

Electronic Payment Register/Remittance Advice (HIPAA 835 Transaction)

Providers, who submit their claims electronically, can receive an electronic file containing their Weekly Provider Remittance Advice/Payment Register. Once downloaded at the provider's office, the remittance file can be uploaded into an automated posting system, thus eliminating a number of manual procedures. The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible.

ERA specifications are available from Blue Cross at no cost to vendors and providers, but they do require programming changes by your practice management billing system vendor. Traditionally, there is an up-front fee from your vendor for programming. From that point, you may receive the Blue Cross weekly Remittance Advice/Payment Register at no charge. For more information, please contact Blue Cross EDI at EDICH@bcbsla.com or (225) 291-4334.

Electronic Funds Transfer (EFT)


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

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


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

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


To initiate EFT, please contact Network Operation at 1-800-716-2299, option 3 or Provider File at (225) 297-2758.



**Online
EFT Speed Guide**
www.bcbsla.com/providers
> Education on Demand



**Online
Electronic Funds
Transfer Form**
www.bcbsla.com/providers
> Forms for Providers





Blue Cross and Blue Shield of Louisiana requires that participating providers enroll in our electronic funds transfer (EFT) service. EFT allows providers to receive payment electronically directly into their accounts. You can download a copy of the EFT Enrollment Form at www.bcbsla.com/providers >Forms for Providers. The following information should help you complete the form.

1 CONSENT

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

2 PROVIDER INFORMATION

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider

Street Address – The number and street name where a person or organization can be found

City – City associated with provider address field

State/Province – The two character code associated with the State/Province/Region of the applicable country

ZIP Code/Postal Code – System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities

3 PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) / Employer Identification Number (EIN) – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity

National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted by HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Group NPI (if applicable) – If part of a provider group, please also report the NPI for your group.

4 PROVIDER CONTACT INFORMATION

Provider Contact Name – Name of a contact in provider office for handling ERA issues

Title – Title of the contact person

Telephone Number – Associated with the contact person

Email Address – An electronic mail address at which the health plan might contact the provider

Fax Number – A number at which the provider can be sent facsimiles

5 RETAIL PHARMACY INFORMATION *(this section should be completed by pharmacies only)*

Pharmacy Name – Complete name of pharmacy

NCPDP Provider ID Number – The NCPDP-assigned unique identification number

6 FINANCIAL INSTITUTION INFORMATION

Financial Institution Name – Official name of the provider's financial institution

Financial Institution Routing Number – The 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited

Type of Account at Financial Institution – The type of account the provider will use to receive EFT payments (e.g. checking, savings, etc.)

Provider's Account Number with Financial Institution – The provider's account number at the financial institution to which EFT payments are to be deposited

Account Number Linkage to Provider Identifier – Choose then enter either the Provider TIN or NPI for the purpose of grouping (bulking) claim payments. Provider preference for grouping (bulking) claim payments must match preference for v5010 X12 835 remittance advice.

7 SUBMISSION INFORMATION

Reason for Submission

- **New Enrollment** – check to indicate applying for new EFT enrollment

Include with Enrollment Submission

- **Voided Check** – A voided check is attached to provide confirmation of Identification/Account Numbers. Temporary checks are not accepted.

or

- **Bank Letter** – A letter on bank letterhead that formally certifies the account owners routing and account numbers

Authorized Signature – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.

Written Signature of Person Submitting Enrollment – The (usually cursive) rendering of a name unique to a particular person used as conformation of authorization and identity

Printed Name of Person Submitting Enrollment – The printed name of the person signing the form

Submission Date – The date on which the enrollment is submitted

8 RETURN INFORMATION

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

Mail to: Attn: NAD / BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

Fax: 1.225.297.2750

Email: network.administration@bcbsla.com

Providers should contact their financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. Shown below are the Data Elements that are necessary for re-association:

CCD Record #	Field #	Field Name
5	9	Effective Entry Date
6	6	Amount
7	3	Payment Related Information

Late/Missing EFT and ERA Transactions Resolution Procedures:

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

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

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

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

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

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

Blue Cross does not set up ERAs for out-of-state providers.



Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions (*included with this form*).

CONSENT		
<p>I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.</p> <p>I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the iLinkBLUE <i>Provider Suite</i>.</p>		
PROVIDER INFORMATION		
Provider Name		
Provider Address: Street		
City	State/Province	Zip Code/Postal Code
PROVIDER IDENTIFIERS INFORMATION		
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)		
National Provider Identifier (NPI)	Group NPI (if applicable)	
PROVIDER CONTACT INFORMATION		
Provider Contact Name		Title
Telephone Number	Email Address	Fax Number
RETAIL PHARMACY INFORMATION		
Pharmacy Name		
NCPDP Provider ID Number		
FINANCIAL INSTITUTION INFORMATION		
Financial Institution Name		
Financial Institution Routing Number	Type of Account at Financial Institution	Provider's Account Number with Financial Institution
Account Number Linkage to Provider Identifier		
<input type="checkbox"/> Provider Tax Identification Number (TIN): _____ <input type="checkbox"/> National Provider Identifier (NPI): _____		

~Over~

SUBMISSION INFORMATION

Reason for Submission

New Enrollment

Include with Enrollment Submission

Voided Check (*temporary checks are not accepted*)

or

Bank Letter

Authorized Signature

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

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Submission Date

RETURN INFORMATION

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

Mail to: Attn: NAD/BCBSLA
P.O. BOX 98029
Baton Rouge, LA 70898-9029

Email: network.administration@bcbsla.com

Fax: (225) 297-2750

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

Phone: (800) 716-2299, option 3

Email: network.administration@bcbsla.com

For internal use only: iLB set up complete.



23XX0278 R02/16

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Section 8

BILLING GUIDELINES

The following billing guidelines are included in this section:

- **Ambulance** page 108
- **Anesthesia** page 115
- **Behavioral Health** page 124
- **Chiropractic and Therapy Services** page 134
- **Delivery of Pregnancy** page 138
- **Dialysis** page 140
- **Dietitian** page 141
- **Laboratory - Using Preferred Reference Labs** page 143
- **Sleep Study** page 147
- **Home Sleep Study Services for OSA** page 149
- **Home Health** page 150

The Ambulance Transport Benefit

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

Blue Cross covers and processes two types of ambulance claims:

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

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

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

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

Report Full Ambulance Miles

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

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

Ambulance Modifiers

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

- D Diagnostic or therapeutic site other than P or H when these are used as origin codes
- E Residential, domiciliary or custodial facility
- G Hospital-based dialysis facility
- H Hospital
- I Site of transfer between modes of ambulance transport
- J Non-hospital based dialysis facility

- N Skilled nursing facility (SNF)
- P Physician's office
- R Residence
- S Scene of accident or acute event
- X Intermediate stop at physician office on the way to the hospital (destination code only)

The ambulance provider must retain all appropriate documentation on file for an ambulance transport furnished to a member. This documentation must be presented to Blue Cross upon request and may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category and any other criteria necessary for payment. The ambulance transport is not covered if some means of transportation other than ambulance could be used without endangering the member's health, regardless of whether the other means of transportation is actually available.

Ground Ambulance Transports

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

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

Ground ambulance transports include the following:

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

- Advanced Life Support, Level 2 (ALS2) – Includes the provision of medically necessary supplies and services and:
 - o At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids)
 - o At least one of the following procedures:
 - Manual defibrillation/cardioversion;
 - Endotracheal intubation;
 - Central venous line;
 - Cardiac pacing;
 - Chest decompression;
 - Surgical airway; or
 - Intraosseous line.
- Specialty Care Transport (SCT) – Includes the provision of medically necessary supplies and services beyond the scope of an EMT-Paramedic. SCT is the inter-facility transportation of a critically ill or injured member that is necessary because the member’s condition requires ongoing care furnished by one or more professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training).
- Paramedic Intercept (PI) – When an entity that does not provide the ambulance transport provides ALS services. PI may be required when a provider can provide only a BLS level of service and the member requires an ALS level of service (such as electrocardiogram monitoring, chest decompression or intravenous therapy).

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

Air Ambulance Transports

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

- The member’s medical condition requires immediate and rapid ambulance transport.
- It cannot be furnished by BLS or ALS ground ambulance transport because one of the following pose a threat to the member's survival or seriously endangers his or her health.
 - The Point-of-pick-up (POP) is not accessible by ground vehicle (this requirement may be met in remote or sparsely populated areas). POP is the location of the member at the time he or she

is placed on board the ambulance. The ZIP code of the POP or the nearest ZIP code to the POP must be reported on the claim.

- The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30 - 60 minutes).
- The instability of ground transportation.

The medical conditions that may justify air ambulance transport include, but are not limited to, the following (this list is not intended to justify air ambulance transport in all localities):

- Intracranial bleeding that requires neurosurgical intervention;
- Cardiogenic shock;
- Burns that require treatment in a burn center;
- Conditions that require treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

Specialized medical services that are generally not available at all facilities include, but are not limited to, the following:

- Burn Care
- Cardiac Care
- Trauma Care
- Critical Care

An air ambulance transport to transfer a member from one hospital to another hospital must meet the following requirements:

- A ground ambulance transport endangers the member's health;
- The transferring hospital does not have the needed hospital or skilled nursing care for the member's illness or injury; and
- The second hospital is the nearest appropriate facility.

Include Zip Codes on Air Ambulance Claims

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

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

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

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

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

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

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

If the pick-up location is outside of the United States, Puerto Rico or U.S. Virgin Islands, the claim must be filed to the BlueCard Worldwide Program (www.bluecardworldwide.com).

Non-transport Ambulance Services

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

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

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

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

Non-Contracted/Non-Participating Ambulance Services

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

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

General Transportation Rules and Definitions

A member/subscriber is transported

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

The destination is local

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

The facility is appropriate

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

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

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

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

- Within the locality of the institution. Locality is the service area surrounding the institution to which individuals normally travel or expected to travel to receive hospital or skilled nursing services; or

- Outside the locality of the institution but in relation to the member's home, it is the nearest appropriate facility.

A member/patient is inpatient

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

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

Non-emergency Transport

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

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

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

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

Ambulance Vehicles

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

- A stretcher
- Linens
- Emergency medical supplies
- Oxygen equipment

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

Ambulance Personnel

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

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

Statement about Ambulance Vehicles and Personnel

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

- The first aid, safety and other patient care items with which the vehicles are equipped;
- The extent of first-aid training acquired by the personnel assigned to the vehicles;
- An agreement to notify Blue Cross of any change in operation that could affect the coverage of ambulance transports; and
- Documentary evidence (such as a letter or copy of a license, permit or certificate issued by State and/or local authorities) indicating that the vehicles are equipped as required.

Anesthesia Billing Guidelines

Definitions

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

single procedure and whether these other procedures overlap each other. The physician can medically direct two, three or four concurrent procedures involving qualified CRNAs.

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

Personally Performed Anesthesia

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

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

Medical Direction

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

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

If the physician is involved with a single case with a CRNA, we will pay the physician service and the CRNA service in accordance with the medical direction payment policy outlined in these guidelines.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate that the services were furnished by physicians and identify the physician(s) who furnished them.

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

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

Filing Claims

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

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

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

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

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

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

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

Required Modifiers - CRNA

Modifier	Modifier Description	Percentage of Allowable Charge
QX	Billed by CRNA when providing the anesthesia service while being medically directed by an anesthesiologist	40 percent
QZ	Billed by CRNA when providing anesthesia services without medical direction by an anesthesiologist	100 percent

Listing of Acceptable and Non-Acceptable Modifiers for Subsequent Claims

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

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

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

Base Units

The Base Unit is the value assigned to each CPT code and includes all usual services except the time actually spent in anesthesia care and the qualifying factors. This usually includes pre-op and post-op visits. When multiple anesthesia services are performed, only the anesthesia service with the highest base unit value should be filed with total time for all services reported on the highest base unit value code. The base unit is informational only for the provider and should not be included in the "units" field when billing.

Anesthesia Time and Calculation of Time Units

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

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

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

1 minute to 15 minutes	=	1 unit
16 minutes to 30 minutes	=	2 units
31 minutes to 45 minutes	=	3 units
46 minutes to 60 minutes	=	4 units
61 minutes to 75 minutes	=	5 units, etc.

Qualifying Factors

Physical Status

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

Physical Status Modifier	Description	Units
P1	A normal patient	0 units
P2	A patient with mild systemic disease	0 units
P3	A patient with severe systemic disease	1 unit
P4	A patient with severe systemic disease that is a constant threat to life	2 units
P5	A moribund patient who is not expected to survive without the operation	3 units
P6	A declared brain dead patient whose organs are being removed for donor purposes	0 units

Qualifying Circumstances

When any of the CPT codes defined in this section are provided in addition to anesthesia procedures, the allowable charge is the basis for reimbursement. Do not bill these procedures with anesthesia modifiers, physical status modifiers or anesthesia minutes; otherwise, delay or rejection of payment may occur.

- Qualifying circumstances are those factors that significantly affect anesthesia services. Examples are the extraordinary condition of the patient, notable operative conditions and unusual risk factors. These procedures would not be reported alone, but as additional procedures qualifying an anesthesia procedure or service. Each qualifying circumstance is listed here: 99100; 99116; 99135; 99140.
- Specialized forms of monitoring also fall into the category of Qualifying Circumstances. Those that qualify are listed below. Although there are other forms of monitoring that are not listed here, these are the only ones for which an additional amount may be allowed. Any other charges should be combined with the total charge without an additional allowable charge. When billed in conjunction with an anesthesia procedure, the following CPT codes or combination of CPT codes are reimbursed over and above the anesthesia procedure, based on the provider's allowable charge and medical necessity.
 - Arterial line (36620 or 36625)
 - Central venous line (36555; 36556; 36568; 36569; 36580; or 36584)
 - Swan Ganz line (93503)

Obstetrical Anesthesia/Epidural

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

Code	Units
01961	7 base units plus time units based on standard 15-minute time calculation
01967	8 units plus \$50 per hour
01968	3 units (no additional time allowed)

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

Pain Management

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

Outpatient Pain Management

1. An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral, single level should be coded 64483 and paid based on the appropriate allowable charge. Code 64484 should be billed for each additional level.
2. An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral is considered a surgical procedure for benefit purposes. Surgical procedures (including nerve blocks) should be

billed as "1" unit per CPT guidelines. The Base Units value should never be entered in the "units" field of your claim. The injection must be performed by an M.D. or D.O. for diagnostic or therapeutic purposes. If an injection is provided on the same day the surgery is performed, the service will be included in the base units and time charged for the administration of anesthesia. If an injection is provided on a day subsequent to the surgery, the procedure will be considered a surgical service and appropriate benefits allowed.

Post-operative Pain Management

- 1. Epidural:** Daily management of epidural or subarachnoid drug administration should be coded 01996 for the professional charge, and the medication should be billed by the hospital as an ancillary charge. CPT 01996 should be utilized to bill for a pain management service when drug administration is being monitored by the provider or an injection is inserted into an existing catheter. Payment will be based on a maximum of three units per day for a maximum of three days of epidural management, including the day of surgery. Billing anesthesia minutes, anesthesia modifiers or physical status modifiers with CPT 01996 is not appropriate, and, if billed, a delay in payment or non-payment may occur.
- 2. IV PCA:** Provider should bill CPT 99231* for the IV PCA daily management. The allowable charge is the basis for reimbursement. The set-up charge is included in the Evaluation and Management allowance of the daily management and should not be billed separately. Billing anesthesia minutes, anesthesia modifiers or physical status modifiers with CPT 99231 is not appropriate, and, if billed, a delay in payment or non-payment may occur.
**Evaluation and Management Code 99231 is the recommended coding by the ASA and is the industry standard for this service. All components must be medically necessary and documented in the anesthesia record in order to bill this code.*
- 3. Pump Setup:** The pump setup is included in the allowable charge for the daily management fee for both IV PCAs (CPT 99231) and Epidural PCAs (CPT 01996), and should not be billed separately.
- 4. Nerve Block Injections:** Nerve blocks performed for postoperative pain management, provided that they are not the mode of anesthesia and are distinct procedures, are eligible for reimbursement when identified by the Modifier 59 as a distinct procedure. These services should not be included as additional anesthesia time. Reimbursement is made only for services provided by a physician/CRNA when performed outside of the intraoperative area. Postoperative pain management will be appropriate for most major intrathoracic, intraabdominal, vascular and orthopedic procedures. The intent of the procedure should be documented as to why post-operative pain relief is not achievable through the use of alternative measures and be procedure specific as would be supported by acceptable peer-reviewed literature and guidelines. The documentation must support the medical necessity of the nerve block service performed by the anesthesiologist instead of the service being performed by the surgeon. Nerve block services will be considered for reimbursement only when there is written documentation that the surgeon has requested such a service. Surgical procedures (including nerve blocks) should be billed as "1" unit per CPT guidelines. The Base Units value should never be entered in the "units" field of your claim. The surgeon should manage post-operative pain except under unique circumstances. Operative notes, anesthesia procedure notes, anesthesia record and pre/post-operative orders should be available when requested to support claim review.

Clinical editing is applicable to all anesthesia services.

Postoperative pain management following surgical procedures is included in the performing physician's global surgical package and is not eligible for separate reimbursement. Continuous infusion pump (e.g., On-Q Pain Buster, Stryker Pain Pump) catheter placement and removal are considered included in the allowable for the primary procedure. Charges for these services should not be billed separately. There are no CPT or HCPCS codes (including unlisted codes) that should be used for placement of a pain pump catheter.

Conscious Sedation

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

Claims Example

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

M.D. Personally Performed or Non Medically Directed CRNA	M.D. Medically Directing 2-4 Concurrent Procedures	Medically Directed CRNA Claim
(Base Units + Time Units + Physical Status Modifier Units) x Unit Value = Allowable Charge	[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 60% = Allowable Charge for each case being medically directed	[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 40% = Allowable Charge for each case being medically directed
CPT 00790 AA (or QZ) Base Units 7 + Time Units (50 mins.) 4 <hr/> Total Units 11 x Unit Value \$40* Allowable Charge \$440	CPT 00790 QK (or QY) Base Units 7 + Time Units (50 mins.) 4 <hr/> Total Units 11 x Unit Value \$40* Subtotal \$440 x Medically Directed 60% Allowable Charge \$264	CPT 00790 QX Base Units 7 + Time Units (50 mins.) 4 <hr/> Total Units 11 x Unit Value \$40* Subtotal \$440 x Medically Directed 40% Allowable Charge \$176

*For illustration purposes only.

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

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

If any modifiers were applicable for physical status, those units would be added to the above calculations as noted in the formulas. **The allowable charges represent the total amount collectable from Blue Cross and the member (if deductible, copayment and/or coinsurance apply). The difference between the provider's charge and the allowable charge is not collectable from the member.**

Documentation Requirements

All billing should be supported by the anesthesia record. Records are required with claims submissions in the following cases:

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

Behavioral Health Billing Guidelines

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

Prior to January 1, 2016

Magellan Health managed the behavioral health network for our HMO Louisiana, Blue Connect, Community Blue, Federal Employee Program (FEP) and Office of Group Benefit (OGB) Magnolia Local members.

Behavioral health claims with a 2015 date of service should be filed directly to Magellan. The runout period for Magellan to process these claims is 15 months.* On April 1, 2017, Magellan will no longer accept 2015 behavioral health claims for our members. Blue Cross will not process these claims.

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

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

Effective January 1, 2016

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

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

Refer to the chart on the next page for the appropriate provider network for each of our member benefit plans.

Benefit Plan Type	Network	Authorizations
PPO	Preferred Care PPO network of professional and facility providers	New Directions 1-800-991-5638
Blue Connect	Blue Connect network of professional and facility providers	
Community Blue	Community Blue network for professional and facility providers	
HMO (HMO & HMO POS)	HMO Louisiana network of professional and facility providers	
Federal Employee Program (FEP)	Preferred Care PPO network of professional and facility providers	

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

Authorizations

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

Authorizations: 1-800-991-5638

Behavioral health services that require an authorization:

- Inpatient Hospital (including detox)
 - Intensive Outpatient Program (IOP)*
 - Partial Hospitalization Program (PHP)*
 - Residential Treatment Center (RTC)*
 - FEP Residential Treatment Center (RTC)
 - Facility must be licensed and accredited and,
 - Member must be enrolled in Case Management and,
 - Prior approval must be obtained before admission
- *Prior approval is not required for FEP PHP and IOP for mental health substance abuse services**
- Applied Behavior Analysis (ABA) (requires completion and submission of the forms below, which are available online at www.bcbsla.com/providers >Behavioral Health)
 - Initial Assessment Request Form
 - Initial Treatment Request Form

New Direction’s electronic authorization tool is available on iLinkBlue. Facilities must use the Behavioral Health authorizations portal to request authorizations for behavioral health services. By using this tool to request authorizations, facilities are able to seek a higher level of care for patients.



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

Post-discharge Standards

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

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

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

Autism Services

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

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

Applied Behavior Analysis (ABA)

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

Code	Time	Clinician Type	Modifier
0359T	1 hour	LBA	TG
		SCABA	TF
0360T	30 min	LBA	TG
		SCABA	TF
		TECH	
0361T	30 min	LBA	TG
		SCABA	TF
		TECH	
0364T	30 min	LBA	TG
		SCABA	TF
		TECH*	HN
		TECH	
0365T	30 min	LBA	TG
		SCABA	TF
		TECH*	HN
		TECH	
0366T	30 min	LBA	TG
		SCABA	TF
		TECH	
0367T	30 min	LBA	TG
		SCABA	TF
		TECH	
0368T	30 min	LBA	TG
		SCABA	TF
0369T	30 min	LBA	TG
		SCABA	TF
0370T	1 hour	LBA	TG
		SCABA	TF
0371T	1 hour	LBA	TG
		SCABA	TF
0372T	1 hour	LBA	TG
		SCABA	TF

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

Failure to include a modifier may result in your claim being returned or denied.

Claims filed with a primary diagnosis of autism will be subject to the patient's autism maximum and limitations. Claims filed with a secondary diagnosis of autism will be processed according to the primary diagnosis code listed on the claim.

Psychotherapy E&M Codes

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

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

Intensive Outpatient Program (IOP) and Partial Hospital Program (PHP) Services

Blue Cross defines an intensive outpatient program (IOP) as having the capacity for planned, structured, service provision of at least two hours per day and three days per week, although some patients may need to attend less often. IOP encounters are usually comprised of coordinated and integrated multi-disciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. IOP models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatments." Treatment for substance-related disorders typically includes involvement in a self-help program such as Alcoholics Anonymous or Narcotics Anonymous. The program time as described here excludes time spent in these self-help programs, which are offered by community volunteers without charge.

Blue Cross defines a **partial hospital program (PHP)** as a structured program with frequent nursing and/or physician supervision, active treatment each program day and program services provided to patients at least four hours per day and available at least three days per week by a professional nurse or a physician, one of which must be by a physician, although some patients may need to attend less often. A partial hospital program can safely substitute for, or shorten, a hospital stay. PHP services must essentially be the same nature and intensity (including medical and nursing) as would be provided in a hospital except that the patient is in the program less than 24 hours per day. The patient is not considered a resident at the program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. The range of services offered is designed to address a behavioral health and/or substance-related disorder through an individualized treatment plan. Programs that primarily provide social, recreational or diversionary activities are not considered partial hospitalization.

General IOP and PHP coverage criteria:

IOP and PHP services may be considered for reimbursement (included in the facility's per diem) when criteria are met and the member has coverage. An authorization may be required, based on the member's benefit plan.

- Patient must be under the care of a physician who certifies the need for the service as evidenced by the patient's plan of care.
- Services must be incidental to the physician's service; and
- Services must be reasonable and necessary for the diagnosis or treatment of the patient's condition (must be for the purpose of the diagnostic study or reasonably expected to improve the patient's condition).
- Individual and group therapy must be with a physician, psychologist or other behavioral health professional authorized by the State and/or through Blue Cross.
- Occupational therapy services may be covered if the patient requires the skills of a qualified occupational therapist. Services must be performed by or under the supervision of a qualified occupational therapist or therapy assistant.
- May include the services of social workers, trained psychiatric nurses and other staff trained to work with behavioral health patients.
- Drugs and biologicals administered by a healthcare professional for therapeutic purposes may be covered.
- Activity therapies may be covered, but only if they are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.
- Family counseling services with members of the household may be covered only where the primary purpose of such counseling is for the treatment of the patient's condition.
- Patient education programs may be covered, but only where the educational activities are closely related to the care and treatment of the patient.
- Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas and to formulate and continue a treatment plan may be covered.
- All laboratory services beyond the scope of treatment must be performed by a network reference laboratory. See the Reference Laboratory section of this manual for more on reference lab services.
- All IOP- or PHP-specific patient eligibility criteria are met.

IOP-specific patient-eligibility criteria:

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric or substance-related patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus not continuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further or require hospitalization, this criterion is met.

The patient must:

- Have a behavioral health or substance-related disorder that severely interferes with multiple areas of daily life, including social, vocational and/or educational functioning

- Be able to cognitively and emotionally participate in the active treatment process
- Be capable of tolerating the intensity of an IOP program
- Require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care

PHP-specific patient-eligibility criteria:

PHPs work best as part of a community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served.

The patient must:

- Require active treatment that incorporates an individualized treatment plan and services that meet the particular needs of the patient.
- Require a multi-disciplinary team approach to patient care under the direction of a physician.

The following IOP/PHP services are generally **NOT COVERED** (except as indicated):

- Services, treatment or supplies otherwise not covered by the member's benefit plan.
- Meals.
- Transportation.
- Self-administered drugs and biologicals are not considered.
- Services for patients who are otherwise psychiatrically stable or require medication management only.
- Services to inpatient hospital patients.
- Treatment of chronic conditions without acute exacerbation of symptoms that place the individual at risk of relapse or hospitalization.
- Activity therapies, group activities or other services and programs that are primarily recreational or diversional in nature. Outpatient psychiatric day-treatment programs that consist entirely of activity therapies are not covered.
- Day care programs for the chronically mentally ill that attempt to maintain behavioral health wellness, where there is no risk of relapse or hospitalization.
- Day care programs that provide primarily social, recreational or diversionary activities, custodial or respite care; including, but not limited to "geriatric day care." Such programs are not covered as they are not considered reasonable and necessary for a diagnosed behavioral health disorder, nor do such programs routinely have physician involvement.
- Psychosocial programs are generally community support groups in non-medical settings for chronically mentally ill persons for the purpose of social interaction. Outpatient programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they may be covered. However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it is not covered.
- Vocational training services and prevocational assessments related solely to specific employment opportunities, work skills or work settings are not covered.

- Patients who cannot or refuse to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of IOP or PHP services.

Frequency and duration of IOP/PHP Services:

There are no specific limits on the length of time that services may be covered unless otherwise specified in the member's benefit plan. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, goals of treatment and patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice for the provider type, coverage may be continued as long as the member has benefits that cover the service/treatment(s) at the time of service. If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, the patient's case should be evaluated in terms of the criteria to determine if continued treatment at the facility is a reasonable expectation of improvement.

IOP/PHP Individualized Treatment Plan:

- Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members.
- The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services are furnished.)

IOP/PHP Physician Supervision and Evaluation:

- Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized.
- The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews.
- Physician entries in medical records must support this involvement.
- The physician must provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.
- Continued treatment--in order to maintain a stable behavioral health or substance-related condition or functional level--requires evidence that lesser treatment options (e.g., day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Discharge planning from an IOP/PHP:

- Patients may be discharged by either stepping up to an inpatient level of care, which would be required for patients needing 24-hour supervision, or stepping down to a lesser level of outpatient care when the patient's clinical condition improves or stabilizes and he/she no longer requires structured, multimodal treatment.
- May reflect the types of best practices recognized by professional and advocacy organizations that ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.

IOP/PHP Expectation of Improvement:

Some patients may undergo a course of treatment that increases their level of functioning, but then reach a point where further significant increase is not expected. Such cases are not automatically considered non-covered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are non-covered only where the evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less treatment.

IOP/PHP Documentation Requirements and Physician Supervision:

The following components will be used to help determine whether the services provided were accurate and appropriate.

1. Initial Psychiatric Evaluation/Certification - Upon admission, a certification by the physician must be made that should identify the diagnosis and psychiatric need for the program treatment. Program services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, services that are reasonable and necessary to treat the presentation of serious psychiatric or substance-related symptoms and to prevent relapse or hospitalization.

2. Physician Recertification Requirements

- a. Signature - The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.
- b. Timing - The first recertification is required as of the 18th calendar day following admission to the program. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
- c. Content - The recertification must describe the following:
 - The patient's response to the therapeutic interventions provided by the IOP;
 - The patient's psychiatric or substance-related symptoms that continue to place the patient at risk of hospitalization; and
 - Treatment goals for coordination of services to facilitate discharge from the program.

3. **Treatment Plan** - IOP and PHP programs provide active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as IOP/PHP services.

4. **Progress Notes** - must document necessary and sufficient information that shows that services were provided and to determine the billable services to the Plan. A provider may submit progress notes to document the services that have been provided upon request from the Plan. The progress notes should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention and its relation to the goals indicated in the treatment plan.

IOP and PHP Billing Instructions

When filing a UB-04 claim for IOP/PHP services the following combination of HCPCS/revenue codes are appropriate to ensure accurate reimbursement per your provider contract. The combination to use will be determined based on the primary reason the member is receiving IOP/PHP services:

Level of Care	Type of Service	Revenue Code	Required HCPCS Code (with short description)	Service Units
IOP	Psychiatric	905	S9480: intensive outpatient psychiatric services, per diem	1
IOP	Chemical Dependency	906	H0015: alcohol and/or drug services; intensive outpatient treatment	1
PHP	Chemical Dependency or Psychiatric	912	H0035: mental health partial hospitalization treatment less than 24 hours	1
PHP	Chemical Dependency or Psychiatric	913	H0035: mental health partial hospitalization treatment less than 24 hours	1

**Please refer to the most current HCPCS books for complete descriptions.*

As outlined in your provider agreement, billed services that are not defined in your IOP or PHP network agreement are not separately payable.

When the UB-04 Statement Covers Period, field 6, is longer than one day, each date of service should be billed on a separate claim line and include Revenue Code, HCPCS, service unit of one (1) and Total Charges, field 42-47.

Blue Cross does not accept decimals for units of service. Please use whole numbers when reporting units.

Residential Treatment Center (RTC)

Blue Cross defines a residential treatment center as a 24 hour, non-acute care treatment setting for the active treatment of specific impairments of Mental Health or substance abuse. A psychiatric RTC provides services to individuals under age 21, in a residential setting. A substance abuse RTC provides non-emergency residential treatment services 24 hours a day, seven days a week and includes a planned, professionally implemented regime for people suffering from substance use disorders.

Chiropractic and Therapy Services

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

Date of Service

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

Skilled, Reasonable and Necessary Care

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

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

Direct Patient Contact Required

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

Time Based Services

Blue Cross and Blue Shield of Louisiana follows the American Medical Association CPT® guidelines for billing time-based codes. **Time is the face-to-face time with the patient delivering skilled services. A unit of time is attained when the mid-point is passed unless specific CPT guidelines state otherwise.** For example, 15 minutes is attained when 8 minutes have elapsed. Incremental intervals of the same treatment at the same visit may be accumulated.

Untimed Services

Untimed services should only be billed once per day regardless of the number of areas treated (i.e. 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028).

No Duplication of Treatment

If patients receive physical and occupational therapy, they must have separate goal and treatment plans. There should be no duplication of treatment.

Reevaluation

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

Treatment Sessions and Documentation

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

Documentation Elements

1. Initial Evaluation

- Medical diagnosis
- History
- Exam
- Assessment
- Plan

2. Plan of Care

- Medical diagnosis
- Treatment details
- Long-term functional goals
- Type of services
- Frequency of treatment
- Duration of treatment

3. Flow sheets

- Must be legible
- Patient's Name
- Name of licensed performing provider providing services
- Dates of service
- CPT code and the activity performed
- Start time and total time that supports the service rendered and clearly differentiates each service
- Modalities to include specific locations treated

4. Daily Notes

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

Multiple Procedure Reduction

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

Individual CPT or HCPCS codes billed with multiple units will be reimbursed based on the allowable charge at:

- 100 percent for the first unit
- 90 percent for the second, third and fourth unit
- 5 percent for five or more units

Each CPT or HCPCS will be reduced as follows:

- 100 percent for the primary, secondary and tertiary procedure
- 50 percent for the fourth procedure
- 5 percent for any additional procedures

Examples

Code	Units	Fee	Code	Units	Fee	Code	Units	Fee
97110	2	\$19	97140	2	\$19	97140	1	\$10
97140	1	\$10	97110	2	\$19	97014	1	\$10
97014	1	\$10				97012	1	\$5
97010	1	\$0				97110	2	\$19
						97010	1	\$0

A \$10 fee is used in the calculation examples above for ease of illustration purposes only.

Supplies are Not Billed Separately

Supplies (i.e. tape, gloves, electrical stimulation pads, hot and cold packs, etc.) are included in the service. Supplies should not be billed separately or directly to members.

Hot and Cold Packs

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

Elastic Therapeutic Taping

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

Application of Surface Neurostimulator

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

Speech Therapy

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

Therapeutic Activities and Neuromuscular Reeducation

Codes 97530 (therapeutic activities) and 97112 (neuromuscular reeducation) should not be used to describe massage therapy.

Manual and Massage Therapy Performed as Part of Chiropractic Care

Physical medicine modalities that are used to relax or prepare the patient for manipulation are considered fundamental to the manipulation and are included in the manipulation reimbursement when they are performed on the same day.

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

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

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

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

Delivery of Pregnancy Billing Guidelines

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

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

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

denied as not medically necessary, the delivering provider may refile the ante-partum (59426) and/or post-partum (59430) care services for separate reimbursement consideration.

Effective for claims processed on and after September 1, 2014, the provider performing the delivery will be required to include a modifier. Use one of the following modifiers when billing for a delivery of pregnancy (CPT codes 59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622):

Modifier	Description
GB	Report when delivery is 39 weeks or more, whether spontaneous or elective
AT	Report when delivery is less than 39 weeks and medically necessary
GZ	Report when delivery is less than 39 weeks and NOT medically necessary
NO MODIFIER	<i>Claim will DENY for incomplete information</i>

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

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

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

Global Billing for Maternity Care

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

If a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and is there to confirm pregnancy, this visit may be reported with the appropriate level evaluation and management services code as a separately payable service, outside the global delivery package. Global

obstetrical care begins after the initial visit when the obstetrical record is initiated as part of the physician's comprehensive obstetrics work-up which includes the comprehensive history and physical.

The global period for the obstetrical care, represented by CPT codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 or 59622 includes all routine pregnancy-related evaluation and management office services, after the initial evaluation, and the delivery service.

If more than one obstetrician is involved in a patient's routine maternity care, Blue Cross would expect to see itemized services specific to the care delivered by the obstetrician for that patient. For example, a patient begins treatment in another state and then relocates to Louisiana and a Louisiana obstetrician begins routine care for that patient in the third trimester of pregnancy, the physician would bill the appropriate evaluation and management code (99201-99215) or antepartum care CPT procedure code (59425 or 59426) based on the number of visits and the delivery code (with or without postpartum care) rather than a global delivery procedure.

Antepartum care for split providers should be billed as:

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

For More Information

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

For information on Sick Baby Billing Protocol go to the Inpatient Billing Guidelines section of this manual.

Dialysis Billing Guidelines

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

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

Revenue Codes	Type of Dialysis
821	Hemodialysis
831	Intermittent Peritoneal Dialysis
841	Continuous Ambulatory Peritoneal Dialysis
851	Continuous Cycling Peritoneal Dialysis

Providers should use one of the following revenue codes, along with the appropriate HCPCS code, for Epogen when submitting a UB-04 claim form:

Codes	Type of Dialysis
634	EPO, less than 10,000 units
635	EPO, 10,000 or more units
J0886	Injection, epoetin alfa, 1000 units
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)

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

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

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

Dietitian Billing Guidelines

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

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



1. Nutritional Counseling – counseling to develop a dietary treatment plan to treat and/or manage health-related conditions other than diabetes.

- No visit limitation
- A maximum benefit limitation* per benefit period
- Services that exceed the dollar limitation are considered non-covered and will not accrue toward the member's out-of-pocket amount

* The maximum benefit limitation does not apply for all Blue Cross policies.

2. Diabetes Counseling – counseling to develop a dietary treatment plan to treat and/or manage diabetes.

- Dietitian visits related to diabetes services are not subject to the nutritional counseling maximum benefit limitation. Services billed with diabetes diagnosis codes are instead subject to a member's Diabetes Education and Training for Self-Management benefits.
- Members who have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin using diabetes need to be educated on their condition and trained to manage their condition, if prescribed by the Member's physician. Coverage is available for self-treatment training and education, dietitian visits and for the equipment and necessary supplies for the training.
- Evaluation and training programs for diabetes self-management are covered subject to the following:
 - a. The program must be determined to be medically necessary by a physician and provided by a licensed health care professional who certifies that the Member has successfully completed the training program.
 - b. The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Outpatient vs. Inpatient

Outpatient/Office Services

- Services should be filed on a CMS-1500 claim form
- Payable to the dietitian

Inpatient Services

- Services should be filed on a UB-04 facility claim form
- Payable to the facility

Filing for Services

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

Code	Units
97802	Each 15 minutes
97803	Each 15 minutes
97804	Each 30 minutes
G0108	Each 30 minutes
G0109	Each 30 minutes
G0270	Each 15 minutes
G0271	Each 30 minutes
S9470	Per session
S9452	Per session

- The service units field must be used to indicate the number of sessions provided within the dates of service that appear on the claim.
- All other billed charges for services or products rendered must be itemized and the appropriate HCPCS code should be included on the claim.

Laboratory Billing Guidelines—Use Preferred Reference Labs

All providers participating in the Preferred Care PPO network must refer members to preferred reference lab vendors when lab services are needed and are not performed in the provider facility. If a preferred reference lab is not used, providers could be subject to a lower allowable charge.

Please refer to the following preferred reference lab requirements to ensure your patients with Preferred Care PPO coverage receive the maximum benefits to which they are entitled. A list of preferred statewide reference labs is also included in this manual.

Preferred Labs

We use a preferred lab program with multiple statewide and regional lab vendors. Physicians who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts. Laboratory services provided to Preferred Care PPO Louisiana members **must** be submitted to one of the following labs:

Statewide Preferred Reference Lab Name	Phone
Clinical Pathology Labs	1-800-595-1275
Laboratory Coporation of America (LabCorp)	1-800-621-8037
Quest Diagnostics	1-800-MYQUEST (1-866-697-8378)

Regional Preferred Reference Lab Name	Phone
Baton Rouge Region	
Mobile Tech Medical, Inc.	(225) 267-6860
Lafayette Region	
Acadiana Family Practice Lab, Inc.	(337) 334-7558
Acadia Laboratory LLC	(337) 783-0961
Eunice Medical Laboratory, Inc.	(337) 457-5562
Lake Charles Region	
The Pathology Laboratory	(337) 436-9557
New Orleans Region	
Advanced Clinical Laboratory	(504) 520-8970
Laboratory Management Services	(318) 841-9526
Morgan City Lab & X-Ray	(985)384-3848
Physicians Group Laboratories LLC	(985) 872-5572
Shreveport Region	
Drs Lab	1-800-828-9227

* **Please note:** This is the current list of preferred statewide reference labs as of the date this manual was published. To view a list of preferred labs by region, visit our website at www.bcbsla.com/providers > Doctor & Hospital Search and enter the member's ID number or network, city, parish or ZIP, type "Laboratory" for Specialty or Keyword and click search.

Requirements for PPO Providers

Laboratory services provided to PPO members must be submitted to preferred reference labs, if not performed in your facility. Some laboratory services may be covered under the member's office copayment. Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by Preferred Care PPO participating hospitals or the member's selected hospital.

Requirements for HMO Louisiana Providers In-office Labs

Physicians may perform a selection of lab tests in their CLIA certified offices, which may be covered under the member's office copayment. See the In-office Lab List on the next page. **Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by HMO Louisiana participating hospitals.**

Blue Connect Network physicians may ONLY perform the selection of laboratory test listed in the In-Office Lab List (Please see In-Office Lab List below). Physicians who do not perform any of the test below

in their office **must** send Blue Connect member-patients to one of the following preferred reference labs and may bill for the specimen collection handling fee with CPT Code 36415 or 99000.

- Clinical Pathology Labs www.cpllabs.com 1-800-595-1275
- Quest Diagnostics www.questdiagnostics.com 1-866-MYQUEST
(1-866-697-8378)

Community Blue Network physicians may ONLY perform the selection of laboratory test listed in the In-Office Lab List (Please see In-Office Lab List below). Physicians who do not perform any of the tests below in their office must send Community Blue member-patients to one of the following preferred reference labs and may bill for the specimen collection handling fee with CPT code 36415 or 99000.

Baton Rouge & Shreveport Areas

- Clinical Pathology Labs www.cpllabs.com 1-800-595-1275
- Quest Diagnostics www.questdiagnostics.com 1-866-MYQUEST
(1-866-697-8378)

Baton Rouge Area Only

- LabCorp www.labcorp.com 1-800-621-8037

In-office Lab List

HMO Louisiana, Blue Connect and Community Blue physicians may perform the following selection of lab tests (CPT codes shown) in their CLIA certified offices, which may be covered under the member’s office copayment.

80300	81025	82952	84132	85610	87172	87491	87660
80301	82044	82962	84437	85651	87177	87502	87804
80320	82247	83013	84702	85652	87205	87510	87807
80321	82270	83014	84830	86308	87210	87590	87880
80322	82272	83026	85007	86403	87220	87591	88331
81000	82565	83036	85013	86485	87275	87660	89190
81001	82570	83037	85018	86490	87276	87804	89220
81002	82947	83518	85025	86510	87430	87807	89230
81003	82948	84030	85027	86580	87480	87880	
81015	82951	84112	85032	86756	87490	88331	

Working With Preferred Reference Labs

Contact preferred reference labs directly to obtain the necessary forms for submitting lab services for your PPO patients.

Physicians who do not collect specimens in their offices may refer their PPO/HMO Louisiana patients to a preferred reference lab draw site. You may use our online provider directories available at www.bcbsla.com or the list included in this manual to locate preferred reference lab draw sites. No specimen collection billing would be appropriate in this situation.

Clinical Laboratory Improvement Amendments

If you perform laboratory testing procedures in your facility, we require that a copy of your Clinical Laboratory Improvement Act (CLIA) certification be provided along with your Louisiana Standardized Credentialing Application when applying for credentialing or recredentialing with Blue Cross.

Out-of-state Labs

If you refer patients to a reference lab that is not in Louisiana, the out of state reference lab must be a participating provider for the member's plan in the state where the specimen is drawn in order for the member to receive the highest level of member benefits. If you are collecting the specimen* and sending the specimen to an out of state reference lab, you need to ensure that the out of state reference lab you are using is participating with Blue Cross Blue Shield of Louisiana, otherwise your patient will be subject to a much higher cost share for this service. In addition, using a non-participating reference lab could subject you to a lower allowable charge.

Ordering Physician Requirements

The ordering/referring provider NPI is required on all laboratory claims otherwise the claim will be returned requesting that the claim be refiled with the ordering provider's NPI number. If you are CLIA certified to provide lab services in your facility and you are billing Blue Cross for these services, please include the ordering provider NPI information. For more information on NPIs, visit www.bcbsla.com/providers >NPI.

Place the NPI in the indicated blocks of the referenced claim forms:

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

Scenario:

An independent laboratory receives and processes the Louisiana member's blood specimen. Member's blood was drawn in Louisiana* but processed in Texas by a reference lab. The out of state reference lab should file the claim to Blue Cross and Blue Shield of Louisiana; the service area where the specimen was drawn. The Texas reference lab should be participating with Blue Cross and Blue Shield of Louisiana in order for the member to receive the highest level of benefits.

**Where the specimen was drawn will be determined by which state the referring provider is located.*

Pass-through Billing Not Permitted

Pass-through billing occurs when the ordering provider requests and bills for a lab service, but the lab service is not performed by the ordering provider. Blue Cross and HMO Louisiana do not permit pass-through billing. Only the performing provider should bill for these services. You may only bill for lab services that you perform in your facility. Furthermore, no other provider may bill for services you have performed.

Specimen Collection/Handling Fee

To compensate physicians for their time and effort associated with collecting specimens and handling lab tests sent to preferred reference labs, physicians may be paid a specimen collection handling fee per member/per visit when no other in-office lab tests are performed and billed on the same day. To be paid the specimen collection handling fee, you must bill CPT code 36415 or 99000. **Please note:** If you perform the lab test(s) in your office and send out any lab test(s) on the same date of service, you are not eligible to bill and receive separate reimbursement for specimen collection.

Special Arrangements

Special arrangements for weekend or after-hour pickups may not be available at all preferred reference labs. Please contact the preferred reference labs directly to make special arrangements.

Provider Inquiries and Satisfaction

Providers can access member's benefits, eligibility and allowable charges using iLinkBlue. If you have questions regarding a member's coverage, please call Provider Services at 1-800-922-8866.

Please let us know if any quality issues arise so we can work with the appropriate lab to improve service and ensure that you and your patients receive the service you expect and deserve. If you have any questions about your network participation, please call Network Administration at 1-800-716-2299, option 3.

Sleep Study Billing Guidelines

Sleep lab facilities, DME providers and physicians should adhere to the following guidelines when filing claims for Blue Cross and HMO Louisiana members:

Eligible Sleep Lab Facilities

- Free standing accredited sleep labs (non-hospital based)
- Hospital-based accredited sleep lab

Sleep studies payment eligibility when:

- Services are performed in accredited sleep lab
- Services are medically necessary

Authorization and Accreditation Required for Sleep Lab Services

All Blue Cross and HMO Louisiana member policies, issued or renewed, require authorization for sleep lab services. It is required that facility based sleep studies be performed in an accredited sleep center. Authorizations are not to be issued by Blue Cross to non-accredited sleep lab providers. Call the Blue Cross authorizations line at 1-800-523-6435, to obtain authorization for sleep lab services.

InterQual criteria are used in the authorization process to determine medical necessity. Unauthorized facility based sleep study services are not eligible for benefits. Please verify member eligibility for sleep study services as authorization is not a guarantee of benefits.

Sleep Lab InterQual Guidelines

When benefits are available, InterQual (IQ) criteria are used to determine if a sleep lab service is eligible for coverage. Medical records such as progress notes and Epworth sleepiness scales may be required in reviewing authorization requests.

Patients with complicated comorbidities such as congestive heart failure, chronic obstructive pulmonary disease, central sleep apnea syndromes, and hypoventilation syndromes associated with obesity, chronic opioid use, and neuromuscular disease affecting respiration will be considered for a facility based sleep study.

Network Requirements & Reimbursement

Sleep centers must meet all credentialing criteria to be eligible for Blue Cross and HMO Louisiana network participation including specific sleep center accreditation by either:

- The Joint Commission (TJC);
- American Academy of Sleep Medicine (AASM); or
- Accreditation Commission for Healthcare (ACHC)

In order for the medical necessity of facility based sleep studies to be considered for authorization and maximum member benefits, services must be performed by an in-network accredited free-standing or hospital-based sleep lab that has been surveyed and approved by TJC, AASM or ACHC.

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

Coding and Claims Filing

Total or technical-only components are allowed if billed by an accredited sleep lab and are medically necessary based on IQ criteria.

The professional component of a medically necessary facility based sleep study may be billed by a physician in accordance with CPT guidelines.

Free-standing sleep centers and rehabilitation and long term acute care facilities with sleep labs should use "office" as the place of service (POT 3) along with their Blue Cross sleep studies provider number when filing claims.

Acute care hospital-based sleep labs should use "outpatient hospital" as the place of service (POT 2) and the hospital's Blue Cross acute care provider number when filing claims. Please do not use other ancillary provider numbers, such as "rehab." Sleep study services filed with a provider number other than the hospital's acute care provider number will not be considered as eligible providers for sleep lab services.

Sleep lab facilities should use the appropriate CPT or HCPCS codes when submitting sleep study services.

Home Sleep Study Services for Obstructive Sleep Apnea (OSA)

When benefits are available, Blue Cross considers home sleep to be eligible for coverage. Home Sleep Studies (HST) do NOT require authorization, except for a few ASO groups. Make sure to check the members Prior Authorization requirements prior to providing services.

Patients without any type of comorbidities and are over the age of 18 will be directed to a HST.

Uncomplicated OSA patients diagnosed with a HST will be required to utilize an APAP (Auto-Titrating/ Auto-adjusting CPAP) trial in the home setting.

Billing Guidelines for Home Sleep Study Services for OSA

Use the guidelines below to ensure proper reimbursement and avoid denied or returned claims. Always verify member benefits prior to performing this or any other service as benefits may vary for some of our self-funded groups.

CPT codes 95800, 95801 and 95806 are not appropriate codes for billing home sleep study services.

Credentialing Requirements for Network DME Providers Performing Home Sleep Studies

Blue Cross recognizes two types of durable medical equipment (DME) providers; full-service DME providers and sleep study DME providers. A full list of acceptable accreditation organizations for full service DME providers can be found in the DME section of this manual.

Blue Cross requires that sleep study DME providers must be accredited by at least one of the following organizations in order to participate in our provider networks:

- The Joint Commission (TJC);
- American Academy of Sleep Medicine (AASM); or
- Accreditation Commission for Healthcare (ACHC)

Home Health Billing Guidelines

Home Health agencies provide a wide range of health and social services delivered at home to persons recovering from an illness or injury, or persons who are disabled and/or chronically ill. They provide "skilled services" such as nursing, social services and therapeutic treatments (physical, speech, occupational therapy). Blue Cross recognizes two types of home health agencies:

1. Free-Standing facilities that are not associated with an acute care facility
2. Hospital-Based facilities that have the same tax identification number as the acute care facility with which it is affiliated.

Blue Cross recognizes the need to maintain consistency of billing requirements for both Blue Cross and Medicare whenever possible. Therefore, we require home health claims to be billed on UB-04 forms in accordance with Medicare guidelines with the following exceptions:

1. The revenue codes accepted by Blue Cross that may be entered in UB-04 field 42 are limited and revenue code descriptions for field 43 have been modified. These modifications are necessary due to Member Contract/Certificate variations.

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

Revenue code 261, IV Therapy Pump, requires a modifier in order for the correct type of service to be assigned (See Appendix A of this manual).

The revenue codes with descriptions accepted by Blue Cross from participating home health agencies are shown on the following pages. The appropriate HCPCS or CPT code must be included in field 44 of the UB-04 when billing revenue codes with double asterisks (**), shown under the column heading "Code Req'd." This is necessary for proper pricing and payment of the service. **(Please refer to your Blue Cross Home Health Reimbursement Appendix for information on reimbursement, if applicable.)**

2. Accumulative billing of services will be accepted by utilizing a "From" and "Through" date with the total units of service for a specific revenue code or HCPCS code. However, some Member Contracts/Certificates and/or groups require that the individual date of service be shown for each day on which services were provided. When this situation applies, you will be notified when you Authorize services and also via the written confirmation of the Authorization.
3. **Authorization is required for all home health services.** Blue Cross requires 48 hours advance notice of all home health services to be provided. The Authorization must include the service and/or code to be provided and in some cases, the quantity/units of services authorized. The services that Blue Cross generally approves are shown on the following pages and include the range of CPT/HCPCS codes that should be billed with appropriate revenue code. **To obtain authorization, please call the Blue Cross authorizations line at 1-800-523-6435 or the number on the back fo the member's ID card.**

Revenue Code	Description	HCPCS/ CPT Range	Code Req'd	Program Rate
258	Pharmacy - IV Solutions	J0000 thru J9999, B4150 thru B5200		Allowable Charge (iv)
261*	IV Therapy - Infusion Pump	E0781 thru E0784, E1520, A4220		Allowable Charge (iv)
264	IV Therapy - IV Therapy Supplies	A4230 thru A4232, A4221, A4222, B4034 thru B4083, B9000 thru B9999,		Allowable Charge (iv)
271	Medical/Surgical Supplies & Devices, <i>Nonsterile Supply</i>	A4206 thru A6457		Allowable Charge (iv)
272	Medical/Surgical Supplies & Devices, <i>Sterile Supply</i>	A4206 thru A6457		Allowable Charge (iv)
274	Medical/Surgical Supplies & Devices, <i>Prosthetic/Orthotic Devices</i>	L0000 thru L4999, L5000 thru L9999		Allowable Charge (iv)
291	DME (Other than Renal), Rental	E0100 thru E1406, E1700 thru E1830		Allowable Charge (iv)
292	DME (Other than Renal), Purchase of New DME	E0100 thru E1406, E1700 thru E1830		Allowable Charge (iv)
293	DME (Other than Renal), Purchase of Used DME	E0100 thru E1406, E1700 thru E1830		Allowable Charge (iv)
294	DME (Other than Renal), Supplies/ Drugs for DME Effectiveness	E0100 thru E1406, E1700 thru E1830		Allowable Charge (iv)
300-319	Laboratory	80002 thru 89398, 36415		Allowable Charge (iv)
421	Physical Therapy - <i>Visit Charge</i>			Allowable Charge (iv)
424	Physical Therapy - <i>Evaluation or Reevaluation</i>			Allowable Charge (iv)
431	Occupational Therapy - <i>Visit Charge</i>			Allowable Charge (iv)
434	Occupational Therapy - <i>Evaluation or Reevaluation</i>			Allowable Charge (iv)
441	Speech-Language Pathology - <i>Visit Charge</i>			Allowable Charge (iv)
444	Speech-Language Pathology - <i>Evaluation or Reevaluation</i>			Allowable Charge (iv)
550**	Skilled Nursing- <i>Hourly Charge</i> (Licensed Practical Nurse)			Allowable Charge (iv)
551**	Skilled Nursing- <i>Visit Charge</i> (Registered Nurse)			Allowable Charge (iv)
552**	Skilled Nursing- <i>Hourly Charge</i> (Registered Nurse)			Allowable Charge (iv)
559**	Skilled Nursing- <i>Visit Charge</i> (Licensed Practical Nurse)			Allowable Charge (iv)
561	Medical Social Services - <i>Visit Charge</i>			Allowable Charge (iv)
571**	Home Health Aide - <i>Visit Charge</i>			Allowable Charge (iv)
600	Oxygen (Home Health)	E0424 thru E0480, E0400, E0600, E0601, E0550 thru E0585, E1353 thru E1406	**	Allowable Charge (iv)
999	Patient Convenience Items			Allowable Charge (iv)

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

(iv) The Allowable Charge information is available via iLinkBlue.

* More on IV Therapy - Infusion Pump (Revenue Code 261) on the following page ►

** More on Skilled Nursing Revenue Codes below ►

Visit charge is defined as a consecutive period of time up to two hours during which home health services are rendered. Hourly charges exceeding two hours require additional Authorization from Blue Cross. Hourly charges for home health aides and private duty nursing (in shifts of at least eight (8) continuous hours) must be billed using the revenue codes below appropriate to the level of professional training.

More on Revenue Codes for Skilled Nursing

Revenue Code	Description
550	Skilled Nursing – Hourly Charge – Licensed Practical Nurse (Private Duty Nursing)
552	Skilled Nursing – Hourly Charge – Registered Nurse (Private Duty Nursing)
572	Home Health Aide – Hourly Charge

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

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

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

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

99070	A4421	A4649
A4206-4210	A4450	A4663
A4212	A4452	A4670
A4215	A4455- 4456	A4770
A4233-4236	A4490	A4913
A4244-4246	A4495	A4927
A4250	A4500	A5051-5055
A4259	A4510	A5061-5063
A4328	A4550	A5071-5073
A4330	A4554	A5081
A4335	A4627	A5082
A4364	A4630	A5093
A4398	A4635-4637	A6216-6221
A4402	A4640	A6260

The following is a list of modifiers that must be included with IV Therapy - Infusion Pump (Revenue Code 261):

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

Section 9

FEDERAL EMPLOYEE PROGRAM

The Federal Employee Program (FEP) Service Benefit Plan is based on a Preferred Provider Organization plan that has benefit incentives encouraging the use of Preferred Care PPO providers. FEP members may choose from two types of coverage: Standard Option and Basic Option.

Standard Option

With Standard Option, members do not need referrals for any provider, including out-of-network providers. However, if a member chooses to use non-Preferred Care PPO providers, their out-of-pocket expenses will be greater.

Office Visits: Members have a \$25 copayment when they see a Preferred Primary Care provider. If members go to a specialist, they have a \$35 copayment for the office visit.

Routine Physicals and Screenings: Members are covered at 100 percent for periodic routine physicals performed by preferred providers. During these visits, members are also covered at 100 percent for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings. Preventive care benefits are limited to one per calendar year.

Maternity Care: Members pay nothing for covered physician and hospital services related to maternity care when they use Preferred Care PPO providers. Well child visits are paid in full.

Basic Option

With Basic Option, members must use preferred providers for all their medical care. Benefits are only available for care provided by non-network providers in certain situations, such as emergency care. Under Basic Option, there is no calendar year deductible. Basic Option benefits are paid in full or in full after members pay a copayment amount when they use Preferred Care PPO providers.

Office Visits: Members have a \$30 copayment for office visits to PCPs. If members go to a specialist, they have a \$40 copayment for the office visit.

Routine Physicals and Screenings: Members are covered at 100 percent for periodic routine physicals performed by preferred providers. During these visits, members are also covered at 100 percent for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings. Preventive care benefits are limited to one per calendar year.

Maternity Care: Members pay nothing for covered pre-natal and post-natal care rendered by a Preferred Care PPO provider. Benefits for the inpatient hospital admission to a Preferred Care PPO hospital for the delivery are paid in full, after the member pays a \$175 copayment. Well child visits are paid in full.

Cancer Screening

There are no age or frequency limitations applicable to covered cancer screenings.

Provider Tips

- Determine the member's financial responsibility by contacting the customer service department listed on the back of the member's ID card before requesting payment.
- Ask members for their ID card regularly.
- First check eligibility and benefits through iLinkBlue.

Section 10

PROVIDER AUDITS

Audits

Plan Audits may consist of the following, including but not limited to:

- Verification of Medical Necessity of services
- Medical coding accuracy
- MS-DRG assignment
- Claims and charge audits
- Payment Discrepancies

Audits are conducted in accordance with Blue Cross' Medical Policy, Claims Policy and Medical Coding Policies. Bill audits comply with the National and Louisiana Billing Audit Guidelines. The Plan may conduct on-site audits during the Member Provider's regular business hours.

Many audits require patient medical records. Blue Cross or a designated agent acting on behalf of Blue Cross and the member are held harmless for the cost of providing the medical records required to conduct audits.

Section 11

MEDICAL MANAGEMENT

Overview

Medical management is a system for a comprehensive approach to healthcare delivery. Blue Cross established the Care Management Department to ensure that our members receive the highest quality healthcare that is medically appropriate and cost-effective.

Utilization Review Organization

Blue Cross is authorized as a Utilization Review Organization (URO) and therefore follows the regulations promulgated by the Department of Insurance that governs these entities. However, certain employer groups, primarily self-funded employer groups and the Federal Government plan, are not subject to the legislation that created these regulations. Since Blue Cross handles a wide range of fully funded and self-funded employer groups, it is not possible to have a uniform policy in all instances. The following descriptions note where differences occur.

Authorization Process

The authorization process ensures that members receive the highest level of benefits to which they are entitled and that the most appropriate setting and level of care for a given medical condition are provided.

A Blue Cross nurse reviews all pertinent information submitted by physicians and providers and applies defined criteria to determine if a service is medically appropriate. The criteria used by the nurses is reviewed and approved by physicians at least annually, and more often if indicated. If the information received from a physician or other provider varies from the defined criteria, a nurse will forward the information for review by a Blue Cross physician.

Pre-service Authorizations

A pre-service authorization is the review and authorization of a procedure prior to the service being rendered. The medical necessity and appropriateness of selected surgical procedures, selected diagnostic procedures and various other services are reviewed prior to the service being performed. A listing of services that require authorization is provided in this manual. Authorization requirements may vary slightly by product. The following describes the process and procedural steps for obtaining pre-service authorizations:

- The provider must initiate the authorization process at least 48 hours prior to the service by contacting the Authorization Unit:
Phone: 1-800-523-6435
Fax: 1-800-586-2299
- The Authorization Coordinator will request the following information:

1. Patient/Member name, date of birth, Blue Cross ID/contract number;
 2. Physician's name, NPI, address and telephone number;
 3. Name of the facility at which the service will be rendered;
 4. Anticipated date of service;
 5. Requested length of stay (if applicable);
 6. Diagnosis (to include ICD-10-CM codes), major procedures (and related CPT and/or HCPCS codes), plan of treatment, medical justification for services or supplies and complications or other factors requiring the requested setting; and
 7. Caller's name and phone number.
- The initial request received prior to a scheduled inpatient admission or outpatient procedure is classified as a pre-service authorization. Decisions are made within 15 calendar days of receipt of claim, regardless of whether all information is received.
 - If the request is approved, the contact person is notified within 24 hours of the determination. Confirmation for continued hospitalization or services includes the date of admission or onset of services, the number of extended days or units of service, the next anticipated review point and the new total number of days or services approved.
 - Types of notification include verbal (by telephone at the time of the call) voice mail or electronic means including email and fax. (A letter of confirmation is also sent to the member, physician and hospital, if applicable, within two working days of the decision being made.)
 - If the decision is to non-certify the authorization, the contact person is notified of the principal reasons for determination not to certify and appeal rights verbally (by telephone or voice mail) within 24 hours of the determination. A non-certification letter is sent to the member, physician and hospital, if applicable, within one working day of the decision. The letter will list appeal rights based on regulatory guidelines.

Urgent Care Authorizations

- The initial request for authorization of an urgent illness is processed as soon as possible based on the clinical situation, if using the online authorization tool authorizations may be approved within minutes of completion if medical criteria is met, or within 72 hours of the request regardless of whether all information is received.
- If the request is approved, the contact person/practitioner is notified by telephone and a confirmation letter is sent to the member, physician and hospital, if applicable.
- If the request is denied, the contact person is notified by telephone and is given the reason for the denial and the procedure for initiating the expedited appeal process. A letter is sent to the member, physician and hospital, if applicable, within one business day of the determination. The notification will list appeal rights based on regulatory guidelines.

NOTE: The authorization process is designed only to evaluate the Medical Necessity of the service. AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT OR A CONFIRMATION OF

COVERAGE FOR BENEFITS. Payment of benefits remains subject to all other Member Contract/Certificate terms, conditions, exclusions and the patient's eligibility for benefits at the time expenses are incurred.

Notification of Admission/Status Change

A pre-service authorization is valid for 15 days. Occasionally, it may be necessary to change or cancel a service, or the circumstances may require an adjustment to the anticipated length of stay. When a change in the nature, duration or reason(s) for an authorized service occurs, the provider should notify the Authorization Unit of the change. This will help prevent confusion and unnecessary delay or errors when processing claims for services associated with the service. Another certification must be obtained if the approved service does not occur within 15 days of the originally scheduled admission date.

Concurrent Review

The Concurrent Review Unit evaluates the medical and service needs of patients confined to an inpatient facility. Concurrent review promotes and works to ensure optimal outcomes, continuity of care, development of a timely discharge plan and ongoing quality of care.

The Concurrent Review Nurse is the central focus and link of communication between a hospitalized member, a Member Provider and the Care Management Department. Concurrent Review nurses conduct telephonic review of all new admissions or continued care cases prior to the end of an approved length of stay. Concurrent Review nurses use clinical information made available and nationally recognized criteria to authorize extensions for additional inpatient care. If the Concurrent Review nurse is not able to authorize an extension based on medical necessity with the clinical information made available and the criteria, the case is referred to a Blue Cross Medical Director for a determination.

If additional services or days are requested, the provider should contact the Concurrent Review Unit. You may either contact the Concurrent Review Nurse assigned to your facility or you may contact the Blue Cross authorizations line at 1-800-523-6435. A Concurrent Review Nurse, in collaboration with the Medical Director, will conduct a review of the information provided to document the medical necessity for continued stay. This review will be done either in person or by telephone.

A decision is made within one working day of receiving all necessary information from the provider. If the decision is to approve the continued stay or course of treatment, the provider rendering the service is notified by telephone or via fax. If a decision to deny the continued stay or course of treatment is made, the provider rendering the service is immediately notified and given the reason for the denial and the procedure for initiating the appeal process.

Self-funded employer groups handled by Blue Cross will generally be handled in the same way as fully funded groups for operational efficiency. Insureds not subject to URO regulations may have denial

determinations issued on a retrospective basis if a review is not requested prior to discharge from service or prior to receipt of the initial claim for payment.

Case Management

The Case Management Unit systematically identifies high-risk members and assesses opportunities to assist with coordinating care. The focus of case management is to assist with coordinating services and resources for members with catastrophic or chronic health conditions in an attempt to resolve barriers to optimum health outcomes and decrease future risk.

Case Management Nurses encourage collaborative relationships among a member's healthcare providers and they help members and their families maximize efficient utilization of available healthcare resources.

Members can be referred to Case Management and Disease Management through a variety of sources, including direct referrals from practitioners, claims data or referrals from inpatient and outpatient utilization review nurses. Members who may benefit from case management include:

- Patients with a newly diagnosed chronic condition, such as diabetes mellitus
- Patients with an acute phase of an illness requiring coordination of multiple services
- Patients with unstable chronic illnesses
- Patients identified by Health Risk Assessments
- Patients and families who experience catastrophic illness
- Patients with depression having an adverse affect on medical outcomes

After a member has been referred to Case Management, the Case Management nurse conducts a thorough and objective assessment of the member's current status. Using this data, the nurse identifies the immediate, short-term and long-term needs of the member, as well as whether or not the member's needs can be best be met in a disease management or case management program.

You may contact Case Management by calling 1-800-317-2299.

Retrospective Review

Blue Cross' Retrospective Review Unit reviews claims to ensure that the services rendered were medically appropriate and meet the definition of covered services under the Member Contract/Certificate. A retrospective review may be performed to assess the medical need and correct billing level for services that have already been performed.

As part of this review process, staff members examine diagnoses, treatments or procedures, including but not limited to cosmetic, experimental or investigational procedures, that may be limited or excluded by the Member's Contract/Certificate. Nurses also conduct medical reviews for possible pre-existing conditions.

Medical Policy Inquiry

Provider inquiries related to medical policy coverage eligibility guidelines or investigational status determination of treatments, procedures, devices, drugs or biological products will be considered upon written request by a member provider. All current medical policy coverage guidelines are available on iLinkBlue.

Requests for consideration must be accompanied by peer-reviewed scientific evidence-based outcomes that substantiate why the specific treatment, procedure, device, drug or biological product is addressed within a medical policy.

Supporting data will be assessed against the following criteria:

- Have final approval from the appropriate government regulatory body;
- Have the scientific evidence that permits conclusions concerning the effect of the technology on health outcomes; or
- Improve the net health outcome; or
- Be as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

Procedure:

Participating network member providers who contact Blue Cross to address coverage eligibility or investigational status of a treatment, procedure, device, drug or biological product addressed in a Blue Cross medical policy will be directed to submit:

- a written request that includes the nature of their inquiry; AND
- pertinent peer-reviewed scientific evidence-based outcomes specific to the coverage eligibility guidelines or investigational status of the treatment, procedure, device, drug or biological product addressed within the medical policy.

A. Written requests must include a return address or fax contact number and should be submitted to:



Medical Director of Medical Policy
Director of Medical Policy
Blue Cross and Blue Shield of Louisiana
P.O. Box 98031
Baton Rouge, LA 70809-9031



(225) 298-2906 Attn: Medical Policy

- B. Supporting data will be reviewed by the Medical Director of Medical Policy and or appropriate Plan medical directors and consultants.
- C. Upon determination of review outcome written notification will be directed to the requesting provider within 60 days of receipt of request.

Direct Access

Direct Access allows HMO Louisiana's POS members to receive care through their network PCP or they may go directly to the network specialist of their choice without a referral.

As a part of the Direct Access Program, HMO Louisiana's POS members are responsible for different copayments for physician services—one for PCPs, one for specialists, one for urgent care clinics and one for emergency room services. This means that members will pay a lower copayment when they receive services from PCPs.

The following provider specialties are considered primary care under HMO Louisiana's POS. Physicians who specialize in these areas of medicine and who are classified as PCPs by Blue Cross should collect the PCP copayment from members with Direct Access:

- Family Practice
- Internal Medicine
- General Practice
- Pediatrics

Please note: The following specialties also should collect the PCP copayment when they perform services for members with Direct Access:

- Chiropractors
- Physical Therapists
- Rural Health Clinics (Federally qualified)
- Speech Therapists
- Occupational Therapists
- Therapy Assistants

The member's identification card will list the copayment amount you should collect. Authorizations are still required for some services under the Direct Access Program. Please review the following lists of services that require authorization from the Plan. Authorization requirements may vary by group. For any questions about the Direct Access Program, please call Provider Services at 1-800-922-8866.

- Alcohol/Drug Abuse Treatment
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment that exceeds \$300
- Drugs Requiring Authorization – Complete list of drugs that require authorization available online at: www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations; see the following pages of this manual for more on drug authorization
- Electric & Custom Wheelchairs

Services That Require Authorization Prior to Rendering Services

The following services and/or procedures may require Blue Cross/HMO Louisiana approval. The lists below may vary for self-insured groups. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (www.bcbsla.com/ilinkblue). See the following pages of this manual for more information on drug and high-tech imaging authorizations.

Preferred Care PPO

- Air Ambulance - Non-Emergency
- Applied Behavior Analysis
- Bone Growth Stimulator
- Compound Drugs greater than \$250
- CT Scans**
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over \$2000 (including but not limited to defibrillators and insulin pumps)
- Inpatient Hospital Services (except routine maternity stays)*
- Intensive Outpatient Programs
- MRI/MRA**
- Nuclear Cardiology**
- Partial Hospitalization Program
- PET/SPECT Scans**
- certain Prescription Drugs - the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations.
- Private Duty Nursing
- Prosthetic Appliances
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Stereotactic Radiosurgery (including but not limited to gamma knife and cyberknife procedures)
- Transplant Evaluations & Transplants
- Vacuum Assisted Wound Closure Therapy

* Maternity Admissions:

Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for Cesarean section delivery.

**Authorization Requests:

Request for authorization for these services may also be completed online through iLinkBlue using AIM's Provider Portal.

HMO Louisiana, Inc., Blue Connect and Community Blue

- Air Ambulance - Non-Emergency
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Compound Drugs greater than \$250
- CT Scans**
- Day Rehabilitation Programs
- DME greater than \$300
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over \$2000 (including but not limited to defibrillators and insulin pumps)
- Infusion Therapy – includes home and facility administration (exception: physician's office, unless the drug to be infused may require authorization)
- Inpatient Hospital Services (except routine maternity stays)*
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA**
- Nuclear Cardiology**
- Oral Surgery (major medical only)
- Orthotic Devices greater than \$300
- Outpatient Pain Rehabilitation/Pain Control Programs
- Partial Hospitalization Programs
- PET/SPECT Scans**
- Certain Prescription Drugs - the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations
- Private Duty Nursing
- Prosthetic Appliances
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Stereotactic Radiosurgery (including but not limited to gamma knife and cyberknife procedures)
- Transplant Evaluations & Transplants
- Vacuum Assisted Wound Closure Therapy

Office of Group Benefits (OGB) Plan Services Requiring Authorization

Plan approval is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary to another Blue Cross and Blue Shield plan (Louisiana providers only). When Medicare is primary, an authorization is required once the combined benefit limit of 50 visits of PT/OT have been achieved. Providers may request authorization by calling 1-800-523-6435 or fax request to 1-800-586-2299. Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans effective January 1, 2017.

INPATIENT

- Inpatient Hospital Services (except routine maternity stays*) including continued stay review (CSR)
- Mental Health/Substance Abuse Services (including residential treatment center and partial hospitalization program services)
- Skilled Nursing Facility
- Transplant Services (organ, bone marrow)

* Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for Cesarean section delivery.

**Request for prior authorization for these services may be completed online through iLinkBlue (www.bcbsla.com/ilinkblue) using AIM's Provider Portal. For more information on Imaging Authorizations, visit www.bcbsla.com/providers >Imaging Authorizations.

! Failure to obtain prior authorization for these services for OGB members will result in denial of payment for services.

OUTPATIENT

- Air Ambulance (non-emergency)
- Applied Behavioral Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Day Rehabilitation Programs
- Dialysis
- DME greater than \$300 (including electric & custom wheelchairs)
- High-tech Diagnostic Imaging Services(including but not limited to CT/CAT Scan, MRI/MRA, Nuclear Cardiology and PET Scan)**
- Home Health Care
- Hospice Care
- Hyperbarics
- Implantable Medical Devices over \$2000 (including but not limited to defibrillators and insulin pumps)
- Infusion Therapy (includes home and facility administration) Exception: Infusion therapy performed in a physician's office (the drug to be infused may require authorization)
- Intensive Outpatient Programs
- Low Protein Food Products
- Oral Surgery (not required when performed in the physician's office)
- Orthotic Devices greater than \$300
- Outpatient Non-Surgical Procedures (exceptions: x-rays, lab work, speech therapy, observations and chiropractic services do not require prior authorization. Non-surgical procedures performed in a physician's office do not require prior authorization.)
- Outpatient Pain Rehabilitation/Pain Control Programs
- Outpatient Surgical Procedures (not performed in the physician's office)
- Partial Hospitalization Programs
- Physical/Occupational Therapy for visits over the combined benefit limit.
- Prosthetic Appliances greater than \$300
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Specialty Pharmacy (see billing guidelines in the *Professional Provider Office Manual*, available online at www.bcbsla.com/providers > Education on Demand.
- Stereotactic Radiosurgery (including but not limited to gamma knife & cyberknife)
- Transplant Evaluations and Procedures (organ, bone marrow)
- Vacuum Assisted Wound Care Therapy

Authorization for High-tech Imaging Services

Blue Cross and HMO Louisiana are contracted with AIM Specialty Health, an independent company, to administer authorization services for select elective outpatient high-tech imaging studies.

Ordering physicians must contact AIM directly for authorization of the services mentioned in this section for Blue Cross, HMO Louisiana and Federal Employee Program (FEP) members. AIM conducts authorization services for the following outpatient, non-emergent imaging services for Blue Cross and HMO Louisiana:

- Computerized Tomography (CT) Scans
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI) – excluding CPT 70336 as these authorizations are handled directly by Blue Cross. Most Blue Cross member contracts do not cover this service; however, a few large employers do provide some level of coverage.
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology Procedures
- Positron-Emission Tomography (PET) Scans

Please note: Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or 30-hour observations are not included in this radiology program.

Ordering physicians (whether a primary care physician (PCP) or specialist) are required to provide AIM with basic clinical information and patient demographics to obtain the authorization. The PCP will not be expected to obtain the authorization number if a specialist orders the test. Hospitals and freestanding facilities that perform the technical component of the imaging services cannot obtain an authorization number and should not obtain authorizations for ordering physicians; however, they may check the status of an authorization request through iLinkBlue.

Blue Cross implements a full utilization review program in which all clinical information provided by the ordering physician will be reviewed against AIM's clinical guidelines for medical necessity. If a request for authorization is denied, AIM notifies the ordering physician of the denial and the process for appeals. Reconsiderations and first-level appeals on authorizations denied for *medical necessity* and *experimental/investigational* should be sent directly to Blue Cross. Please allow ample time in scheduling diagnostic services to insure the authorization process is completed and approved before the patient receives services.

Ordering physicians should contact AIM to obtain authorization in one of two ways:

1. Use iLinkBlue to access AIM's web-based application, **ProviderPortalSM**. Ordering physicians can easily enter authorization requests and get immediate response for most requests. Additionally, both ordering and performing providers can check authorization status and view authorization numbers using the **ProviderPortalSM**.
2. Contact AIM directly by calling 1-866-455-8416.

Please note: AIM's **ProviderPortalSM** authorization process can issue one authorization number for multiple diagnostic services for the same patient and same date of service. Simply enter the first authorization request, confirm that you have additional services when prompted, then enter authorization request(s) for the additional diagnostic services(s).

Blue Cross medical policies determine if a service is experimental/investigational. There will continue to be denials for services that are experimental/ investigational and those that are out-of-network. You may search and view all Blue Cross medical policy coverage guidelines on iLinkBlue. AIM's clinical guidelines can be found under the forms section of their website.

AIM is an independent company that serves as the imaging authorization manager for Blue Cross and HMO Louisiana.

Authorization Penalties for Providers

Outpatient Authorization Penalty (PPO and HMO Louisiana/POS Providers)

A 30 percent penalty will be imposed on Preferred Care and HMO's POS network providers for failing to obtain authorization prior to performing outpatient services that require authorization on a PPO or HMO Louisiana POS member. This penalty will be applied to the provider's benefit payment of the allowable charge. The network provider is responsible for the penalty amount. The member is responsible for any applicable copayment, deductible, coinsurance percentage and/or non-covered services. This does not apply to PPO providers of other Blue Plans outside of Blue Cross. Failure to authorize service(s) for an OGB member will result in a claim denial. OGB does not authorize Blue Cross to reconsider these denials at the appeal level.

Inpatient Authorization Penalty (HMO Louisiana/POS Facilities)

A \$1,000 penalty will be applied to inpatient hospital claims if the patient's policy requires an inpatient stay to be authorized, and the provider fails to obtain the authorization prior to the stay. This penalty will be applied to inpatient stays of patients covered by any Blue Cross and/or Blue Shield plan or subsidiary, when the patient's policy requires the authorization to be performed.

When a patient is covered by Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc., and the patient's policy contains a different penalty for failure to authorize an inpatient stay, the terms of the patient's policy will control and not this \$1,000 penalty provision. Examples are the policies with OGB or HMO Louisiana (failure to prior authorize an inpatient stay results in a claim denial). Failure to authorize service(s) for an OGB member will result in a claim denial. OGB does not authorize Blue Cross to reconsider these denials at the appeal level.

When a patient is covered by a policy issued by another (non-Louisiana) Blue Cross and/or Blue Shield plan or subsidiary, and the patient's policy contains a different penalty for failure to authorize an inpatient stay, this \$1,000 penalty provision will control and not the terms of the patient's policy.

Drug Authorizations

Blue Cross and HMO Louisiana have contracted with Express Scripts, Inc. (ESI), a pharmacy benefit manager, to perform prior authorizations for targeted medications. Ordering physicians are required to contact ESI to complete authorizations for targeted medications for members of our Preferred Care PPO and HMO Louisiana networks.

To request a prior authorization, providers can continue to use the same phone number used for authorizations or by calling ESI directly at 1-800-842-2015, 24 hours a day, seven days a week.

Prior authorization for non-targeted medications will continue to be handled by Blue Cross. Please do not contact ESI for these medications. Additionally, ESI services do not affect the current processes for Benefit Management Services (BMS) and Federal Employee Program (FEP) members. For BMS and FEP members, please continue to contact the member's current pharmacy benefit manager for these members. For more information on covered drugs, see www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations or www.bcbsla.com/pharmacy.

Appeals for drugs denied for *medical necessity or experimental/investigational* are handled by ESI or Blue Cross depending the member's network.

Quality Management Program

The goal of the Quality Management (QM) Program is to continuously maximize and improve the healthcare services delivered to members. The scope of the QM Program includes, but is not limited to, the following:

- Quality of Care Issues
- Health Management and Wellness Activities
- Grievance and Appeal Resolution
- Performance Measures

The Program is designed to objectively and systematically monitor and evaluate aspects of healthcare including the delivery of care that is medically appropriate and readily accessible.

This is achieved in several ways:

- Development of Preventive Medicine Guidelines
- Implementation of clinical quality improvement projects
- Distribution of member wellness reminders
- Review and evaluation of member complaints and grievances
- Review and evaluation of quality of care referrals from members, providers, and internal staff

The QM Program has been established to facilitate the exchange of information and ideas for identifying opportunities for improvement as well as maintaining high standards of performance.

Step Therapy Program

The Step Therapy program requires the member to try a generic drug, within select drug classes, prior to trying a more costly brand-name drug. Some examples of these classes of drugs are:

- Frequent Urination Medications
- Long-acting Pain Medications
- Acne Treatment Medications
- Oral Diabetes Medications
- Bone Medications

A benefit of this program is to lower out-of-pocket costs, ultimately decreasing the member's likelihood to stop taking medications due to the cost.

Step 1 – The member first tries the generic "Step 1 Medication" or generic drug to treat a medical condition before Blue Cross/HMO Louisiana will cover* a "Step 2 Medication" for that condition.

Step 2 – If the generic drug is not clinically appropriate or has been tried and does not work for the member, then Blue Cross/HMO Louisiana will cover* a brand-name prescription for that condition.

The following drug categories of prescription drugs are included in the Step Therapy program:

- Blood Pressure Medications Including Beta Blockers
- Respiratory/Allergy Medications
- Long Acting Pain Medications
- Cholesterol Medications
- Sleep Medications
- Acne Treatment Medications Including all Strengths of Crestor®
- Depression Medications
- Stomach Acid Medications
- Oral Diabetes Medications
- Pain and Inflammation Medications
- Triptan Migraine Medications
- Frequent Urination Medications
- Bone Medications

For information on drug authorizations, visit our website at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations or www.bcbsla.com/pharmacy. When a provider writes a new** prescription for a brand-name drug within the classes listed above for a member with Step Therapy, the prescription will be denied at the point of sale at the pharmacy if the member has not already tried a Step 1 drug. The pharmacy will inform the member and then contact the provider and advise of the member's Step Therapy benefits. If the provider determines one of the Step 1 drugs isn't appropriate for the member, then the provider can complete a Step Therapy authorization form found on our website and fax it to 1-877-837-5922, or call 1-800-842-2015, for an authorization, and if approved, the provider can prescribe a Step 2 drug. If the provider's request does not meet the necessary criteria to start a Step 2 drug without first trying a Step 1 drug, or if the provider or member insists on the brand-name, then the member is responsible for the full cost of the medication.

For information on specific drugs under the program, visit our website at www.bcbsla.com/providers >Pharmacy Management >Drug Authorizations >Step Therapy Drug List.

* Coverage determination is subject to the member's eligibility and benefits.
** Members with an existing prescription for a "Step 2" brand-name drug that has been filled within four (4) months prior to the implementation of Step Therapy to their policy benefits will not be required to revert to a "Step 1" generic drug.

Maternity Management Program - Healthy Blue Beginnings

Our maternity management program, Healthy Blue Beginnings, helps promote early and compliant prenatal care and offers case management support when required. If a provider has patients who are pregnant or are thinking of becoming pregnant, they should notify our maternity management program staff who will assess the patient for risks and provide lifestyle risk modification coaching, and reliable information resources. Providers can go to www.bcbsla.com/providers >Care Management >Blue Touch and click on "Maternity" under the Areas of Case Management section. There is a link to the Care Management Disease Management (CMDM) Referral Form here. Providers should complete it and return via fax to (225) 298-3184 to have a patient enrolled. Providers may also contact us directly at 1-800-226-9947, or have the patient call Blue Cross and ask to speak with a nurse. Once a patient is enrolled, providers will receive the following:

- Written or telephonic notification of the patient's enrollment along with the nurse's contact information.
- Notification when the Blue Cross nurse identifies the patient may be in need of healthcare services via a care coordination nurse call.
- Access to claims-based Blue Health Records with up to three years of claims history (through iLinkBlue).
- When members self-refer to the program who don't have an established physician relationship, providers receive a patient referral by Blue Cross nurses.

A successful maternity management program is dependent on early identification of patients planning to become pregnant, or who have recently identified they are pregnant. The physician plays a key role in the delivery of the program and this program is intended only to compliment the medical care received from providers.

Providers must request authorization for initial admissions and recertification of admissions for rehabilitation centers (rehab), skilled nursing (SNF) and long term acute care (LTAC) services. Providers are encouraged to complete an **Admission and Recertification Request Form**, which is part of this guide. The form is available online at www.bcbsla.com/providers.

1 Please check the box that best describes your request.

Please Choose Request Type:

- Admission Request
 Admitting from: Home Hospital
- Recertification Request

Admission Request is a request for authorization for a patient initially being admitted to a facility for treatment. Please specify if patient is being admitted from home or a hospital.

Recertification Request is an extension request of the initial admission authorization. This request must be within 24-hours prior to expiration of approved admission period.

2 Please check the type of admission for your request.

Please Choose One:			
Admission Type:	<input type="checkbox"/> Inpatient Rehab	Day Rehab: <input type="checkbox"/> Half <input type="checkbox"/> Full	<input type="checkbox"/> Skilled Nursing <input type="checkbox"/> LTAC

Inpatient Rehab

Comprehensive array of restoration services for the physically-disabled and all support services necessary to help patients attain their maximum functional capacity

Day Rehab

A program that provides greater than one (1) hour of Rehabilitative Care, upon discharge from an inpatient admission

Skilled Nursing Facility

Skilled nursing and/or rehabilitation services to patients who need a skilled level of medical care

LTAC

Nursing care and related services for individuals who require medical, nursing, rehabilitation or sub-acute care services for an extended period of time

- 3 **Member Information:** Please provide the member's name, date of birth and Blue Cross member identification number. If the member also has other insurance, please include other insurance coverage carrier's name and policy number. *(All information should be exactly as it appears on the member's ID card, including any prefixes or suffixes.)*
- 4 **Requestor Information:** Please provide the admitting facility's name and NPI number along with the name and phone number of the key contact person at the facility. Also provide the admitting physician's first and last name and NPI number as well as the name and phone number of the key contact person for the admitting physician's office.
- 5 **Clinical Information:** Please provide the admitting facility's name and NPI number along with the name and phone number of the key contact person at the facility. Also provide the admitting physician's first and last name and NPI number as well as the name and phone number of the key contact person for the admitting physician's office.
- 6 **Discharge Plan:** Please provide applicable clinical information as requested on the form (front and back). Please provide any current physical, occupational and speech therapy notes that may apply.
- 7 Once you have completed the form, **please fax to 1-800-821-2740, ATTN: Utilization Management**. If you have any questions, please contact our Utilization Management department at 1-800-523-6435.



Admission and Recertification Request
(Required for all Rehab, SNF, LTAC admits)

Fax: 1-800-821-2740

Please Choose One:

- Admission Request
Admitting from: Home Hospital
Recertification Request

Submit all Recertification Requests at least 24 hours prior to end of approval period.

Date Submitted:

Use this form for admissions and recertifications for rehabilitation centers (rehab), skilled nursing (SNF) and long term acute care (LTAC) services.

Submit form to obtain authorization. Additional documentation should be attached only if it provides information not on this form pertinent to the review request. Do not attach or send patient's entire medical record. All items must be legible and properly completed.

ADMISSION TYPE:

(Please Choose Only One) Inpatient Rehab Day Rehab: Full Half Skilled Nursing LTAC

MEMBER INFORMATION:

Last Name: First Name: MI: DOB: Member ID Number:
Other Insurance Coverage Carrier:
ID number:
Medicare days exhausted: Yes No Date exhausted:

REQUESTOR INFORMATION:

Admitting Facility Name: Facility NPI: Location:
Contact Name: Contact Ph. Number: Fax Number:
Admitting Physician Name (First and Last): Physician NPI:
Contact Name: Contact Ph. Number:

CLINICAL INFORMATION: (check all that apply)

- Medically stable for transfer Expectation of at least 25 days of continued care
Minimum of one MD visit per day Frequent diagnostic testing including clinical assessment, laboratory and imaging
Comorbidities stabilizing Requires more intensive service than can be offered (or patient has failed) at lower levels of care

Admission Date: Estimated Length of Stay: Request Level of Care:

Admission Diagnosis code(s):

Presenting Signs/Symptoms or Clinical Status:

Admission Goals/Treatment Plan:

ADL'S (FIM SCORES)

Bed Mobility Sit to Stand Supine to Sit
Bathing UE Dress LE Dress
Swallowing Transfers Bowel/Bladder
Ambulation feet

Mental Status

Oriented Yes No
Confused Yes No
Follows Commands Yes No

Other (please specify):

~over~

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Respiratory Status/Treatments

- Continued requirement for mechanical ventilation after more than 3 weeks with more than 2 weaning failures in acute hospital Trach Chest Tube

- Requires ventilator and respiratory management at least every 4 hours

Vent Settings: _____

O2 Requirements: _____

Nebulizer tx's: _____

Wounds

- Extensive wounds requiring daily assessment, drain management, debridement or complex wound care
- Drains

Wound Care – type of wound(s): _____

Location of wound(s): _____

Descriptions of wound(s): _____

Frequency of wound care: _____

Diet

- Diet: Oral NG Tube Gastric Tube

Other

IV Fluids/TPN: _____

IV Medications: _____

PO Medications: _____

Procedures: _____

EKG/EEG: _____

Lab Results: _____

Radiology: _____

DISCHARGE PLAN:

- Home alone Rehab
- Home with home health Skilled Nursing Facility
- Home with DME Nursing Home
- Home with Outpatient Services Hospice

Potential barriers to discharge plan: _____

Additional Comments/Notes: _____

Upon discharge, supply caregiver information:

Name: _____

Contact Information: _____

Fax completed form to 1-800-821-2740, ATTN: Utilization Management

Section 12

MEDICAL APPEALS

Medical Appeals are clinical in nature and involve adverse benefit determinations of not medically necessary or investigational. All other Appeals are considered Administrative Appeals and are handled by the Administrative Appeals and Grievance Department. The process and contact information for this department is located elsewhere in this document.

We recognize that disputes may arise between members (member's provider) and Blue Cross regarding covered services. An appeal is a written request from the member or authorized representative to change a prior decision that Blue Cross has made about covered services. Examples of issues that qualify as appeals include denied authorizations, claims based on adverse determinations of medical necessity or investigational denials, and benefit determinations. A rescission of coverage is also eligible for an appeal.

The Member has the right to appoint an authorized representative to speak on their behalf in their Appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an internal or external review of a denial. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing.

The Member, their authorized representative, or a Provider authorized to act on the Member's behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Member's receipt of an initial adverse Benefit determination. Requests submitted to Us after one hundred eighty (180) days of Our initial determination will not be considered.

Member appeals processes vary due to variations in state and federal laws. We will apply the law that governs the benefits purchased by the member or the member's employer. In some instances this is state law, and in others, it is federal law. The member's contract or certificate describes the appeals processes applicable to the member. We will follow the language in the member's contract or certificate, should there be any variance between that language and what is printed below.

Due to variations between federal and state laws, appeals for ERISA members are handled differently from non-ERISA member appeals. There are some plans that are not governed by either the state laws or the ERISA laws. Examples are some plans for whom we provide administrative services only and the Federal Employee Program. For these members, we will follow the appeals processes stated in their member contracts. The majority of appeals should fall within the ERISA or non-ERISA (state) processes. If members are unsure which process applies to them, they should contact their employer, Plan Administrator, Plan Sponsor or Blue Cross at 1-800-599-2583 or (225) 291-5370. Members and providers are encouraged to provide Blue Cross with all available information and documentation at the time of the appeal request to help Us completely evaluate the appeal.

Louisiana laws apply to individual contracts of insurance, employer insurance plans that are not governed by ERISA, and non-federal government insurance plans. Blue Cross generally refers to these

processes as “Non-ERISA” processes. We will follow internal appeal and external review laws as required by state and federal law. External reviews are only available for adverse determinations that involve an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or a rescission of coverage.

Standard Administrative Appeal

First Level Administrative Process

Administrative Appeals involve contractual issues other than or Investigational denials and those denials that do not require medical judgment.

If the Member is not satisfied with Our denial or partial denial of a claim (adverse benefit determination), the Member, their authorized representative, or a Provider acting on their behalf (with signed authorizations from the member), must submit a written request to Appeal within one hundred eighty (180) days following the Member’s receipt of an initial adverse benefit determination. Appeals should be submitted in writing to:

Medical Benefits:



Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
PO Box 98045
Baton Rouge, LA 70898-9045

Pediatric Dental Care Benefits: (applicable to Non-Grandfathered Individual and Small Group ONLY)



Blue Cross and Blue Shield of Louisiana
Dental Customer Service
PO Box 69420
Harrisburg, PA 17106-9420

Pediatric Vision Care Benefits: (applicable to Non-Grandfathered Individual and Small Group ONLY)



Blue Cross and Blue Shield of Louisiana
c/o Davis Vision
PO Box 791
Latham, NY 12110

Note: Requests submitted to Blue Cross after one hundred eighty (180) days of the denial will not be considered.

We will investigate the Member’s concerns. If We change Our original decision at the Appeal level, We will process the Member’s Claim and notify the Member and all appropriate Providers, in writing, of the first level Appeal decision. If the Member’s Claim is denied on Appeal, We will notify the Member and all appropriate Providers, in writing, of Our decision within thirty (30) calendar days of the Member’s

request; unless We mutually agree that an extension of the time is warranted. At that time, We will inform the Member of the right to begin the second level Appeal process, if applicable.

Second Level Administrative Process (If Applicable)

Within sixty (60) calendar days of the date of Our first level Appeal decision, a Member who is not satisfied with the decision may initiate, with assistance from the Customer Service Unit, if necessary, the second level of Appeal process. Requests submitted to Us after sixty (60) days of the denial will not be considered.

A Member Appeals Committee not involved in any previous denial will review all second level Appeals. The Committee's decision is final and binding as to any administrative Appeal and will be mailed to the Member within five (5) days of the Committee meeting.

Standard Medical Appeal

Internal Process

Medical Appeals involving a denial or partial denial based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational.

If the Member is not satisfied with Our denial of services, the Member, their authorized representative, or a Provider acting on their behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Member's receipt of an initial adverse Benefit determination. Appeals should be submitted in writing to or fax to:



Blue Cross and Blue Shield of Louisiana, Inc.

Medical Appeals

PO Box 98022

Baton Rouge, LA 70898-9022

Fax: (225) 298-1837



HMO Louisiana, Inc.

Medical Appeals

PO Box 98022

Baton Rouge, LA 70898-9022

Fax: (225) 298-1837

Note: Requests submitted to Blue Cross after one hundred eighty (180) days of the denial will not be considered.

We will investigate the member's concerns. All Appeals of Medical Necessity denials will be reviewed by a physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. If our initial denial is overturned on the Member's Medical Necessity Appeal, We will process the claim and will notify the Member and all appropriate Providers, in writing, of the Internal Appeal decision. If our initial denial is upheld, We will notify the Member and all appropriate Providers, in writing, of our decision and advise the Member

of their right to request an External Appeal. The decision will be mailed within thirty (30) days of the member's request, unless the member or their authorized representative and We mutually agree that an extension of the time is warranted. At that time, We will inform the member of their right to begin the External Appeal process if the claim meets the criteria.

External Process

If the Member still disagrees with our determination on their Claim following the internal review process, the Member or their authorized representative may request an External Appeal conducted by a non-affiliated Independent Review Organization (IRO). The Member must send their written request for an external Appeal, within one hundred twenty (120) days* of receipt of the Internal Appeal decision. The Member must grant permission for the request of an External Review by completing and submitting at the time of External Appeal request the form "I want to ask for an External Appeal." Any external review requested without the required form will not be considered.



Blue Cross and Blue Shield of Louisiana, Inc.

Medical Appeals

PO Box 98022

Baton Rouge, LA 70898-9022

Fax: (225) 298-1837



HMO Louisiana, Inc.

Medical Appeals

PO Box 98022

Baton Rouge, LA 70898-9022

Fax (225) 298-1837

We will provide the IRO all pertinent information necessary to conduct the Appeal. The IRO decision will be considered a final and binding decision on both the Member and Us. The external review will be completed within forty-five (45) days of Our receipt of the request and the IRO will notify the Member or their authorized representative and all appropriate Providers of its decision.

* Requests submitted to us after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered.

Expedited Internal Medical Appeals

We provide an Expedited Appeal process for review of an Adverse Determination involving a situation where the time frame of the standard Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard Internal Appeal decision.

The Expedited Appeal process allows for expedited appeal decisions no later than seventy-two (72) hours of our receipt of an Expedited Appeal request that meets the criteria for Expedited Appeal.

An Expedited Appeal is a request for immediate review of an initial non-certification determination concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who is requesting emergency services or has received emergency services but has not been discharged from a facility or if waiting for the standard appeal 30 day process could seriously jeopardize the member's life, health or ability to regain maximum function or in the treating physician's opinion, the patient would be subjected to severe pain without care or treatment. Expedited Appeals are not provided for services previously rendered.



Blue Cross and Blue Shield of Louisiana, Inc.

Expedited Appeal - Medical Appeals

PO Box 98022

Baton Rouge, LA 70898-9022

Fax: (225) 298-1837



HMO Louisiana, Inc.

Expedited Appeal - Medical Appeals

PO Box 98022

Baton Rouge, LA 70898-9022

Fax (225) 298-1837

In any case where the Expedited Internal Appeal process does not resolve a difference of opinion between Us and the covered person or the Provider acting on behalf of the covered person, the Appeal may be elevated to an Expedited External Appeal.

Expedited External Medical Appeals

An Expedited External Appeal of an adverse decision is available when requested by the Member, their authorized representative or a provider acting on behalf of a member.

An Expedited External Appeal is a request for immediate review of an initial non-certification determination concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who is requesting emergency services or has received emergency services but has not been discharged from a facility or if waiting for the standard Appeal 30 day process could seriously jeopardize the member's life, health or ability to regain maximum function or in the treating physician's opinion, the patient would be subjected to severe pain without care or treatment.

Expedited External Appeals are not provided for review of services previously rendered.

An Expedited External Appeal is also available if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or

treatment is deemed Investigational; and the covered person's treating Physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated. The request may be simultaneously filed with a request for an expedited internal review, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt.

We will forward all pertinent information for Expedited External Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

All external review decisions are binding on Us and You for purposes of determining coverage under a health Contract. This Appeals process shall constitute Your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary, except to the extent that other remedies are available under state or federal law.

Please Note:

Although submission of additional information is not required at the time an appeal request is requested, an explanation and/or supporting documentation for an appeal is recommended.

Multiple requests to Appeal the same Claim, service, issue, or date of service will not be considered, at any level of review.

Section 13

GENERAL DISPUTE RESOLUTION & ARBITRATION PROCESS

Dispute Resolution

Blue Cross has established a general dispute resolution process to resolve any problems and disputes concerning Blue Cross' right of offset and/or recoupment. To initiate the general dispute resolution process, providers should send a written notice with a brief description of their dispute to:



Blue Cross and Blue Shield of Louisiana

Provider Dispute

P.O. Box 98021

Baton Rouge, LA 70898-9021

Within sixty (60) calendar days of our receipt of the provider's notice, Blue Cross and the provider will assign appropriate staff members who are to arrange to discuss and seek resolution of the dispute, consistent with the terms of the provider's agreement with Blue Cross. Any and all dispute resolution procedures are to be conducted only between Blue Cross and the provider and shall not include any Blue Cross and/or HMO Louisiana member unless such involvement is necessary to the resolution of the dispute. Blue Cross, in its sole discretion, will determine if the member's involvement is necessary to the resolution of the dispute.

If Blue Cross and the provider are unable to reach resolution within the initial sixty (60) day period, then management from both Blue Cross and the provider, who were not involved in the initial discussion, will have an additional thirty (30) days to resolve the dispute. This time period may be extended by mutual agreement between Blue Cross and the provider. Blue Cross and the provider, as mutually agreed, may include a mediator in such discussions. Blue Cross and the provider shall share the costs of the mediation equally. In any event, if additional meetings are held and no resolution of the dispute is reached within sixty (60) days from the initial meeting, Blue Cross and the provider shall elect binding arbitration as described in the Arbitration section below in order to resolve the dispute. Blue Cross or the provider's failure to participate in the arbitration proceedings means that they have accepted the other's demands. If resolution of the dispute occurs, Blue Cross and the provider shall express the resolution in written form or amend the provider's agreement to include the resolution, if appropriate.

Arbitration

Both Blue Cross and the provider shall abide by the following procedures for the arbitration process:

- The party (Blue Cross or the provider) who is initiating the arbitration process shall send written notice to the other party setting forth the basis of the dispute and their desire to arbitrate. Blue Cross and the provider shall share the costs of the arbitration equally. Arbitration shall be in accordance with the rules and procedures of either the American Arbitration Association or the American Health Lawyers' Association or another nationally recognized arbitration association acceptable to both Blue Cross and the provider.



- Arbitration shall be conducted in Baton Rouge, Louisiana, before a single arbitrator mutually agreed upon by both Blue Cross and the provider.
- The arbitrator shall be bound by the terms and conditions set forth in the provider's agreement and the Member Contract/Certificate.
- The arbitrator may not award consequential, special, punitive or exemplary damages. The arbitrator may award costs, including reasonable attorney's fees, against Blue Cross or the provider. If the decision of the arbitrator does not include such award, both Blue Cross and the provider shall share the costs of the arbitration equally.
- The decision of the arbitrator shall be final and in writing and shall be binding on both Blue Cross and the provider and enforceable under the laws of the state of Louisiana.
- This provision shall survive the termination of the provider's agreement.

The general dispute resolution and arbitration processes described above do not supersede or replace the member appeals and grievances process for medical necessity and appropriateness, investigational, experimental or cosmetic coverage determinations as described in the Appeals section of this manual.

Notwithstanding the foregoing, benefits and utilization management determination issues (e.g., Medical Necessity or Investigational determinations) shall be handled in accordance with the Subscriber Contract/Certificate and as outlined in this manual.

Section 14

MS-DRG TYPE OF SERVICE LISTING

Blue Cross and Blue Shield of Louisiana MS-DRG Category Assignment

Effective October 1, 2016

MS-DRG (V32)	MS-DRG Title Service	Type of
001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	SURG*
002	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	SURG*
003	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	SURG
004	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	SURG
005	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	SURG*
006	LIVER TRANSPLANT W/O MCC	SURG*
007	LUNG TRANSPLANT	SURG*
008	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	SURG*
010	PANCREAS TRANSPLANT	SURG*
011	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W MCC	SURG
012	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W CC	SURG
013	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W/O CC/MCC	SURG
014	ALLOGENEIC BONE MARROW TRANSPLANT	SURG*
016	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	SURG*
017	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	SURG*
020	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	SURG
021	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	SURG
022	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	SURG
023	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	SURG
024	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	SURG
025	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	SURG
026	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	SURG
027	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	SURG
028	SPINAL PROCEDURES W MCC	SURG
029	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	SURG
030	SPINAL PROCEDURES W/O CC/MCC	SURG
031	VENTRICULAR SHUNT PROCEDURES W MCC	SURG
032	VENTRICULAR SHUNT PROCEDURES W CC	SURG
033	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	SURG
034	CAROTID ARTERY STENT PROCEDURE W MCC	SURG
035	CAROTID ARTERY STENT PROCEDURE W CC	SURG
036	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	SURG
037	EXTRACRANIAL PROCEDURES W MCC	SURG
038	EXTRACRANIAL PROCEDURES W CC	SURG
039	EXTRACRANIAL PROCEDURES W/O CC/MCC	SURG
040	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	SURG
041	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	SURG
042	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	SURG
052	SPINAL DISORDERS & INJURIES W CC/MCC	MED
053	SPINAL DISORDERS & INJURIES W/O CC/MCC	MED
054	NERVOUS SYSTEM NEOPLASMS W MCC	MED
055	NERVOUS SYSTEM NEOPLASMS W/O MCC	MED
056	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	MED

057	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	MED
058	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	MED
059	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	MED
060	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	MED
061	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	MED
062	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	MED
063	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	MED
064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	MED
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	MED
066	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	MED
067	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	MED
068	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	MED
069	TRANSIENT ISCHEMIA	MED
070	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	MED
071	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	MED
072	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	MED
073	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	MED
074	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	MED
075	VIRAL MENINGITIS W CC/MCC	MED
076	VIRAL MENINGITIS W/O CC/MCC	MED
077	HYPERTENSIVE ENCEPHALOPATHY W MCC	MED
078	HYPERTENSIVE ENCEPHALOPATHY W CC	MED
079	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	MED
080	NONTRAUMATIC STUPOR & COMA W MCC	MED
081	NONTRAUMATIC STUPOR & COMA W/O MCC	MED
082	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	MED
083	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	MED
084	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	MED
085	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	MED
086	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	MED
087	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	MED
088	CONCUSSION W MCC	MED
089	CONCUSSION W CC	MED
090	CONCUSSION W/O CC/MCC	MED
091	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	MED
092	OTHER DISORDERS OF NERVOUS SYSTEM W CC	MED
093	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	MED
094	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	MED
095	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	MED
096	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	MED
097	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	MED
098	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	MED
099	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	MED
100	SEIZURES W MCC	MED
101	SEIZURES W/O MCC	MED
102	HEADACHES W MCC	MED
103	HEADACHES W/O MCC	MED
113	ORBITAL PROCEDURES W CC/MCC	SURG
114	ORBITAL PROCEDURES W/O CC/MCC	SURG
115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	SURG
116	INTRAOCULAR PROCEDURES W CC/MCC	SURG
117	INTRAOCULAR PROCEDURES W/O CC/MCC	SURG
121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	MED
122	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	MED

123	NEUROLOGICAL EYE DISORDERS	MED
124	OTHER DISORDERS OF THE EYE W MCC	MED
125	OTHER DISORDERS OF THE EYE W/O MCC	MED
129	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	SURG
130	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	SURG
131	CRANIAL/FACIAL PROCEDURES W CC/MCC	SURG
132	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	SURG
133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	SURG
134	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	SURG
135	SINUS & MASTOID PROCEDURES W CC/MCC	SURG
136	SINUS & MASTOID PROCEDURES W/O CC/MCC	SURG
137	MOUTH PROCEDURES W CC/MCC	SURG
138	MOUTH PROCEDURES W/O CC/MCC	SURG
139	SALIVARY GLAND PROCEDURES	SURG
146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	MED
147	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	MED
148	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	MED
149	DYSEQUILIBRIUM	MED
150	EPISTAXIS W MCC	MED
151	EPISTAXIS W/O MCC	MED
152	OTITIS MEDIA & URI W MCC	MED
153	OTITIS MEDIA & URI W/O MCC	MED
154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	MED
155	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	MED
156	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	MED
157	DENTAL & ORAL DISEASES W MCC	MED
158	DENTAL & ORAL DISEASES W CC	MED
159	DENTAL & ORAL DISEASES W/O CC/MCC	MED
163	MAJOR CHEST PROCEDURES W MCC	SURG
164	MAJOR CHEST PROCEDURES W CC	SURG
165	MAJOR CHEST PROCEDURES W/O CC/MCC	SURG
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	SURG
167	OTHER RESP SYSTEM O.R. PROCEDURES W CC	SURG
168	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	SURG
175	PULMONARY EMBOLISM W MCC	MED
176	PULMONARY EMBOLISM W/O MCC	MED
177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	MED
178	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	MED
179	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	MED
180	RESPIRATORY NEOPLASMS W MCC	MED
181	RESPIRATORY NEOPLASMS W CC	MED
182	RESPIRATORY NEOPLASMS W/O CC/MCC	MED
183	MAJOR CHEST TRAUMA W MCC	MED
184	MAJOR CHEST TRAUMA W CC	MED
185	MAJOR CHEST TRAUMA W/O CC/MCC	MED
186	PLEURAL EFFUSION W MCC	MED
187	PLEURAL EFFUSION W CC	MED
188	PLEURAL EFFUSION W/O CC/MCC	MED
189	PULMONARY EDEMA & RESPIRATORY FAILURE	MED
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	MED
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	MED
192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	MED
193	SIMPLE PNEUMONIA & PLEURISY W MCC	MED
194	SIMPLE PNEUMONIA & PLEURISY W CC	MED

195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	MED
196	INTERSTITIAL LUNG DISEASE W MCC	MED
197	INTERSTITIAL LUNG DISEASE W CC	MED
198	INTERSTITIAL LUNG DISEASE W/O CC/MCC	MED
199	PNEUMOTHORAX W MCC	MED
200	PNEUMOTHORAX W CC	MED
201	PNEUMOTHORAX W/O CC/MCC	MED
202	BRONCHITIS & ASTHMA W CC/MCC	MED
203	BRONCHITIS & ASTHMA W/O CC/MCC	MED
204	RESPIRATORY SIGNS & SYMPTOMS	MED
205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	MED
206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	MED
207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS	MED
208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	MED
215	OTHER HEART ASSIST SYSTEM IMPLANT	SURG
216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	SURG
217	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	SURG
218	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	SURG
219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	SURG
220	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	SURG
221	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	SURG
222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	SURG
223	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	SURG
224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	SURG
225	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	SURG
226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	SURG
227	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	SURG
228	OTHER CARDIOTHORACIC PROCEDURES W MCC	SURG
229	OTHER CARDIOTHORACIC PROCEDURES W CC	SURG
230	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	SURG
231	CORONARY BYPASS W PTCA W MCC	SURG
232	CORONARY BYPASS W PTCA W/O MCC	SURG
233	CORONARY BYPASS W CARDIAC CATH W MCC	SURG
234	CORONARY BYPASS W CARDIAC CATH W/O MCC	SURG
235	CORONARY BYPASS W/O CARDIAC CATH W MCC	SURG
236	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	SURG
239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	SURG
240	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	SURG
241	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	SURG
242	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	SURG
243	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	SURG
244	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	SURG
245	AICD GENERATOR PROCEDURES	SURG
246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	SURG
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	SURG
248	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	SURG
249	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	SURG
250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	SURG
251	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	SURG
252	OTHER VASCULAR PROCEDURES W MCC	SURG
253	OTHER VASCULAR PROCEDURES W CC	SURG
254	OTHER VASCULAR PROCEDURES W/O CC/MCC	SURG
255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	SURG
256	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	SURG

257	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	SURG
258	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	SURG
259	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	SURG
260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	SURG
261	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	SURG
262	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	SURG
263	VEIN LIGATION & STRIPPING	SURG
264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	SURG
265	AICD LEAD PROCEDURES	SURG
266	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	SURG
267	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	SURG
268	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	SURG
269	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	SURG
270	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	SURG
271	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	SURG
272	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	SURG
273	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	SURG
274	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	SURG
280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	MED
281	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	MED
282	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	MED
283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	MED
284	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	MED
285	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	MED
286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	MED
287	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	MED
288	ACUTE & SUBACUTE ENDOCARDITIS W MCC	MED
289	ACUTE & SUBACUTE ENDOCARDITIS W CC	MED
290	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	MED
291	HEART FAILURE & SHOCK W MCC	MED
292	HEART FAILURE & SHOCK W CC	MED
293	HEART FAILURE & SHOCK W/O CC/MCC	MED
294	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	MED
295	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	MED
296	CARDIAC ARREST, UNEXPLAINED W MCC	MED
297	CARDIAC ARREST, UNEXPLAINED W CC	MED
298	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	MED
299	PERIPHERAL VASCULAR DISORDERS W MCC	MED
300	PERIPHERAL VASCULAR DISORDERS W CC	MED
301	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	MED
302	ATHEROSCLEROSIS W MCC	MED
303	ATHEROSCLEROSIS W/O MCC	MED
304	HYPERTENSION W MCC	MED
305	HYPERTENSION W/O MCC	MED
306	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	MED
307	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	MED
308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	MED
309	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	MED
310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	MED
311	ANGINA PECTORIS	MED
312	SYNCOPE & COLLAPSE	MED
313	CHEST PAIN	MED
314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	MED
315	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	MED

316	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	MED
326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	SURG
327	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	SURG
328	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	SURG
329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	SURG
330	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	SURG
331	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	SURG
332	RECTAL RESECTION W MCC	SURG
333	RECTAL RESECTION W CC	SURG
334	RECTAL RESECTION W/O CC/MCC	SURG
335	PERITONEAL ADHESIOLYSIS W MCC	SURG
336	PERITONEAL ADHESIOLYSIS W CC	SURG
337	PERITONEAL ADHESIOLYSIS W/O CC/MCC	SURG
338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	SURG
339	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	SURG
340	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	SURG
341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	SURG
342	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	SURG
343	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	SURG
344	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	SURG
345	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	SURG
346	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	SURG
347	ANAL & STOMAL PROCEDURES W MCC	SURG
348	ANAL & STOMAL PROCEDURES W CC	SURG
349	ANAL & STOMAL PROCEDURES W/O CC/MCC	SURG
350	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	SURG
351	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	SURG
352	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	SURG
353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	SURG
354	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	SURG
355	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	SURG
356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	SURG
357	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	SURG
358	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	SURG
368	MAJOR ESOPHAGEAL DISORDERS W MCC	MED
369	MAJOR ESOPHAGEAL DISORDERS W CC	MED
370	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	MED
371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	MED
372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	MED
373	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	MED
374	DIGESTIVE MALIGNANCY W MCC	MED
375	DIGESTIVE MALIGNANCY W CC	MED
376	DIGESTIVE MALIGNANCY W/O CC/MCC	MED
377	G.I. HEMORRHAGE W MCC	MED
378	G.I. HEMORRHAGE W CC	MED
379	G.I. HEMORRHAGE W/O CC/MCC	MED
380	COMPLICATED PEPTIC ULCER W MCC	MED
381	COMPLICATED PEPTIC ULCER W CC	MED
382	COMPLICATED PEPTIC ULCER W/O CC/MCC	MED
383	UNCOMPLICATED PEPTIC ULCER W MCC	MED
384	UNCOMPLICATED PEPTIC ULCER W/O MCC	MED
385	INFLAMMATORY BOWEL DISEASE W MCC	MED
386	INFLAMMATORY BOWEL DISEASE W CC	MED
387	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	MED

388	G.I. OBSTRUCTION W MCC	MED
389	G.I. OBSTRUCTION W CC	MED
390	G.I. OBSTRUCTION W/O CC/MCC	MED
391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	MED
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	MED
393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	MED
394	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	MED
395	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	MED
405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	SURG
406	PANCREAS, LIVER & SHUNT PROCEDURES W CC	SURG
407	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	SURG
408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	SURG
409	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	SURG
410	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	SURG
411	CHOLECYSTECTOMY W C.D.E. W MCC	SURG
412	CHOLECYSTECTOMY W C.D.E. W CC	SURG
413	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	SURG
414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	SURG
415	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	SURG
416	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	SURG
417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	SURG
418	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	SURG
419	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	SURG
420	HEPATOBIILIARY DIAGNOSTIC PROCEDURES W MCC	SURG
421	HEPATOBIILIARY DIAGNOSTIC PROCEDURES W CC	SURG
422	HEPATOBIILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	SURG
423	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES W MCC	SURG
424	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES W CC	SURG
425	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	SURG
432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	MED
433	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	MED
434	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	MED
435	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS W MCC	MED
436	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS W CC	MED
437	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS W/O CC/MCC	MED
438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	MED
439	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	MED
440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	MED
441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	MED
442	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	MED
443	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	MED
444	DISORDERS OF THE BILIARY TRACT W MCC	MED
445	DISORDERS OF THE BILIARY TRACT W CC	MED
446	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	MED
453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	SURG
454	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	SURG
455	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	SURG
456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	SURG
457	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	SURG
458	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	SURG
459	SPINAL FUSION EXCEPT CERVICAL W MCC	SURG
460	SPINAL FUSION EXCEPT CERVICAL W/O MCC	SURG
461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	SURG
462	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	SURG

463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	SURG
464	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	SURG
465	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	SURG
466	REVISION OF HIP OR KNEE REPLACEMENT W MCC	SURG
467	REVISION OF HIP OR KNEE REPLACEMENT W CC	SURG
468	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	SURG
469	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	SURG
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	SURG
471	CERVICAL SPINAL FUSION W MCC	SURG
472	CERVICAL SPINAL FUSION W CC	SURG
473	CERVICAL SPINAL FUSION W/O CC/MCC	SURG
474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	SURG
475	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	SURG
476	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	SURG
477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	SURG
478	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	SURG
479	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	SURG
480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	SURG
481	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	SURG
482	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	SURG
483	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	SURG
485	KNEE PROCEDURES W PDX OF INFECTION W MCC	SURG
486	KNEE PROCEDURES W PDX OF INFECTION W CC	SURG
487	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	SURG
488	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	SURG
489	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	SURG
492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	SURG
493	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	SURG
494	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	SURG
495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	SURG
496	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	SURG
497	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	SURG
498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	SURG
499	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	SURG
500	SOFT TISSUE PROCEDURES W MCC	SURG
501	SOFT TISSUE PROCEDURES W CC	SURG
502	SOFT TISSUE PROCEDURES W/O CC/MCC	SURG
503	FOOT PROCEDURES W MCC	SURG
504	FOOT PROCEDURES W CC	SURG
505	FOOT PROCEDURES W/O CC/MCC	SURG
506	MAJOR THUMB OR JOINT PROCEDURES	SURG
507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	SURG
508	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	SURG
509	ARTHROSCOPY	SURG
510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	SURG
511	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	SURG
512	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	SURG
513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	SURG
514	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	SURG
515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	SURG
516	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	SURG
517	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	SURG
518	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	SURG
519	BACK & NECK PROC EXC SPINAL FUSION W CC	SURG

520	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	SURG
533	FRACTURES OF FEMUR W MCC	MED
534	FRACTURES OF FEMUR W/O MCC	MED
535	FRACTURES OF HIP & PELVIS W MCC	MED
536	FRACTURES OF HIP & PELVIS W/O MCC	MED
537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	MED
538	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	MED
539	OSTEOMYELITIS W MCC	MED
540	OSTEOMYELITIS W CC	MED
541	OSTEOMYELITIS W/O CC/MCC	MED
542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	MED
543	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	MED
544	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	MED
545	CONNECTIVE TISSUE DISORDERS W MCC	MED
546	CONNECTIVE TISSUE DISORDERS W CC	MED
547	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	MED
548	SEPTIC ARTHRITIS W MCC	MED
549	SEPTIC ARTHRITIS W CC	MED
550	SEPTIC ARTHRITIS W/O CC/MCC	MED
551	MEDICAL BACK PROBLEMS W MCC	MED
552	MEDICAL BACK PROBLEMS W/O MCC	MED
553	BONE DISEASES & ARTHROPATHIES W MCC	MED
554	BONE DISEASES & ARTHROPATHIES W/O MCC	MED
555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	MED
556	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	MED
557	TENDONITIS, MYOSITIS & BURSITIS W MCC	MED
558	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	MED
559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	MED
560	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	MED
561	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	MED
562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	MED
563	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	MED
564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	MED
565	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	MED
566	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	MED
570	SKIN DEBRIDEMENT W MCC	SURG
571	SKIN DEBRIDEMENT W CC	SURG
572	SKIN DEBRIDEMENT W/O CC/MCC	SURG
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	SURG
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	SURG
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	SURG
576	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	SURG
577	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	SURG
578	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	SURG
579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	SURG
580	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	SURG
581	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	SURG
582	MASTECTOMY FOR MALIGNANCY W CC/MCC	SURG
583	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	SURG
584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	SURG
585	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	SURG
592	SKIN ULCERS W MCC	MED
593	SKIN ULCERS W CC	MED
594	SKIN ULCERS W/O CC/MCC	MED

595	MAJOR SKIN DISORDERS W MCC	MED
596	MAJOR SKIN DISORDERS W/O MCC	MED
597	MALIGNANT BREAST DISORDERS W MCC	MED
598	MALIGNANT BREAST DISORDERS W CC	MED
599	MALIGNANT BREAST DISORDERS W/O CC/MCC	MED
600	NON-MALIGNANT BREAST DISORDERS W CC/MCC	MED
601	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	MED
602	CELLULITIS W MCC	MED
603	CELLULITIS W/O MCC	MED
604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	MED
605	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	MED
606	MINOR SKIN DISORDERS W MCC	MED
607	MINOR SKIN DISORDERS W/O MCC	MED
614	ADRENAL & PITUITARY PROCEDURES W CC/MCC	SURG
615	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	SURG
616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	SURG
617	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	SURG
618	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	SURG
619	O.R. PROCEDURES FOR OBESITY W MCC	SURG
620	O.R. PROCEDURES FOR OBESITY W CC	SURG
621	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	SURG
622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	SURG
623	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	SURG
624	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	SURG
625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	SURG
626	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	SURG
627	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	SURG
628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	SURG
629	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	SURG
630	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	SURG
637	DIABETES W MCC	MED
638	DIABETES W CC	MED
639	DIABETES W/O CC/MCC	MED
640	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	MED
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	MED
642	INBORN AND OTHER DISORDERS OF METABOLISM	MED
643	ENDOCRINE DISORDERS W MCC	MED
644	ENDOCRINE DISORDERS W CC	MED
645	ENDOCRINE DISORDERS W/O CC/MCC	MED
652	KIDNEY TRANSPLANT	SURG*
653	MAJOR BLADDER PROCEDURES W MCC	SURG
654	MAJOR BLADDER PROCEDURES W CC	SURG
655	MAJOR BLADDER PROCEDURES W/O CC/MCC	SURG
656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	SURG
657	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	SURG
658	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	SURG
659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	SURG
660	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	SURG
661	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	SURG
662	MINOR BLADDER PROCEDURES W MCC	SURG
663	MINOR BLADDER PROCEDURES W CC	SURG
664	MINOR BLADDER PROCEDURES W/O CC/MCC	SURG
665	PROSTATECTOMY W MCC	SURG
666	PROSTATECTOMY W CC	SURG

667	PROSTATECTOMY W/O CC/MCC	SURG
668	TRANSURETHRAL PROCEDURES W MCC	SURG
669	TRANSURETHRAL PROCEDURES W CC	SURG
670	TRANSURETHRAL PROCEDURES W/O CC/MCC	SURG
671	URETHRAL PROCEDURES W CC/MCC	SURG
672	URETHRAL PROCEDURES W/O CC/MCC	SURG
673	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	SURG
674	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	SURG
675	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	SURG
682	RENAL FAILURE W MCC	MED
683	RENAL FAILURE W CC	MED
684	RENAL FAILURE W/O CC/MCC	MED
685	ADMIT FOR RENAL DIALYSIS	MED
686	KIDNEY & URINARY TRACT NEOPLASMS W MCC	MED
687	KIDNEY & URINARY TRACT NEOPLASMS W CC	MED
688	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	MED
689	KIDNEY & URINARY TRACT INFECTIONS W MCC	MED
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	MED
691	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	MED
692	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	MED
693	URINARY STONES W/O ESW LITHOTRIPSY W MCC	MED
694	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	MED
695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	MED
696	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	MED
697	URETHRAL STRICTURE	MED
698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	MED
699	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	MED
700	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	MED
707	MAJOR MALE PELVIC PROCEDURES W CC/MCC	SURG
708	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	SURG
709	PENIS PROCEDURES W CC/MCC	SURG
710	PENIS PROCEDURES W/O CC/MCC	SURG
711	TESTES PROCEDURES W CC/MCC	SURG
712	TESTES PROCEDURES W/O CC/MCC	SURG
713	TRANSURETHRAL PROSTATECTOMY W CC/MCC	SURG
714	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	SURG
715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	SURG
716	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	SURG
717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	SURG
718	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	SURG
722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	MED
723	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	MED
724	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	MED
725	BENIGN PROSTATIC HYPERTROPHY W MCC	MED
726	BENIGN PROSTATIC HYPERTROPHY W/O MCC	MED
727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	MED
728	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	MED
729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	MED
730	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	MED
734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	SURG
735	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	SURG
736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	SURG
737	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	SURG
738	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	SURG

739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	SURG
740	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	SURG
741	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	SURG
742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	SURG
743	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	SURG
744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	SURG
745	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	SURG
746	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	SURG
747	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	SURG
748	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	SURG
749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	SURG
750	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	SURG
754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	MED
755	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	MED
756	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	MED
757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	MED
758	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	MED
759	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	MED
760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	MED
761	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	MED
765	CESAREAN SECTION W CC/MCC	MAT
766	CESAREAN SECTION W/O CC/MCC	MAT
767	VAGINAL DELIVERY W STERILIZATION &/OR D&C	MAT
768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	MAT
769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	MAT
770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	MAT
774	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	MAT
775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	MAT
776	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	MAT
777	ECTOPIC PREGNANCY	MAT
778	THREATENED ABORTION	MAT
779	ABORTION W/O D&C	MAT
780	FALSE LABOR	MAT
781	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	MAT
782	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	MAT
789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	MED
790	EXTREME IMMATURETY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	MED
791	PREMATURITY W MAJOR PROBLEMS	MED
792	PREMATURITY W/O MAJOR PROBLEMS	MED
793	FULL TERM NEONATE W MAJOR PROBLEMS	MED
794	NEONATE W OTHER SIGNIFICANT PROBLEMS	MED
795	NORMAL NEWBORN	MED
799	SPLENECTOMY W MCC	SURG
800	SPLENECTOMY W CC	SURG
801	SPLENECTOMY W/O CC/MCC	SURG
802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	SURG
803	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	SURG
804	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	SURG
808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	MED
809	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	MED
810	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	MED
811	RED BLOOD CELL DISORDERS W MCC	MED
812	RED BLOOD CELL DISORDERS W/O MCC	MED
813	COAGULATION DISORDERS	MED

814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	MED
815	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	MED
816	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	MED
820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	SURG
821	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	SURG
822	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	SURG
823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	SURG
824	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	SURG
825	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	SURG
826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	SURG
827	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	SURG
828	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	SURG
829	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	SURG
830	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	SURG
834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	MED
835	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	MED
836	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	MED
837	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	MED
838	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	MED
839	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	MED
840	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	MED
841	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	MED
842	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	MED
843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	MED
844	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	MED
845	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	MED
846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	MED
847	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	MED
848	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	MED
849	RADIOTHERAPY	MED
853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	SURG
854	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	SURG
855	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	SURG
856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	SURG
857	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	SURG
858	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	SURG
862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	MED
863	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	MED
864	FEVER	MED
865	VIRAL ILLNESS W MCC	MED
866	VIRAL ILLNESS W/O MCC	MED
867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	MED
868	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	MED
869	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	MED
870	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS	MED
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	MED
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	MED
876	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	SURG
880	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	MED
881	DEPRESSIVE NEUROSES	MED
882	NEUROSES EXCEPT DEPRESSIVE	MED
883	DISORDERS OF PERSONALITY & IMPULSE CONTROL	MED
884	ORGANIC DISTURBANCES & MENTAL RETARDATION	MED
885	PSYCHOSES	MED

886	BEHAVIORAL & DEVELOPMENTAL DISORDERS	MED
887	OTHER MENTAL DISORDER DIAGNOSES	MED
894	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	MED
895	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	MED
896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	MED
897	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	MED
901	WOUND DEBRIDEMENTS FOR INJURIES W MCC	SURG
902	WOUND DEBRIDEMENTS FOR INJURIES W CC	SURG
903	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	SURG
904	SKIN GRAFTS FOR INJURIES W CC/MCC	SURG
905	SKIN GRAFTS FOR INJURIES W/O CC/MCC	SURG
906	HAND PROCEDURES FOR INJURIES	SURG
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	SURG
908	OTHER O.R. PROCEDURES FOR INJURIES W CC	SURG
909	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	SURG
913	TRAUMATIC INJURY W MCC	MED
914	TRAUMATIC INJURY W/O MCC	MED
915	ALLERGIC REACTIONS W MCC	MED
916	ALLERGIC REACTIONS W/O MCC	MED
917	POISONING & TOXIC EFFECTS OF DRUGS W MCC	MED
918	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	MED
919	COMPLICATIONS OF TREATMENT W MCC	MED
920	COMPLICATIONS OF TREATMENT W CC	MED
921	COMPLICATIONS OF TREATMENT W/O CC/MCC	MED
922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	MED
923	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	MED
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	SURG
928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	SURG
929	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	SURG
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	MED
934	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	MED
935	NON-EXTENSIVE BURNS	MED
939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	SURG
940	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	SURG
941	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	SURG
945	REHABILITATION W CC/MCC	MED
946	REHABILITATION W/O CC/MCC	MED
947	SIGNS & SYMPTOMS W MCC	MED
948	SIGNS & SYMPTOMS W/O MCC	MED
949	AFTERCARE W CC/MCC	MED
950	AFTERCARE W/O CC/MCC	MED
951	OTHER FACTORS INFLUENCING HEALTH STATUS	MED
955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	SURG
956	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	SURG
957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	SURG
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	SURG
959	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	SURG
963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	MED
964	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	MED
965	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	MED
969	HIV W EXTENSIVE O.R. PROCEDURE W MCC	SURG
970	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	SURG
974	HIV W MAJOR RELATED CONDITION W MCC	MED
975	HIV W MAJOR RELATED CONDITION W CC	MED

976	HIV W MAJOR RELATED CONDITION W/O CC/MCC	MED
977	HIV W OR W/O OTHER RELATED CONDITION	MED
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	SURG
982	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	SURG
983	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	SURG
984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	SURG
985	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	SURG
986	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	SURG
987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	SURG
988	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	SURG
989	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	SURG
998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	**
999	UNGROUPABLE	**

* DRGs 001, 002, 005, 006, 007, 008, 010, 014, 016, 017 and 652 are organ transplants which require prior written approval.

** DRGs 998 & 999 are returned to the hospital for correct coding.

Section 15

COMMUNICATING WITH BLUE CROSS AND BLUE SHIELD OF LOUISIANA

Electronic Benefit Verification - iLinkBlue

You may verify benefits, inquire about claims status, and a whole lot more using iLinkBlue, (www.bcbsla.com/ilinkblue). Providers who access iLinkBlue can use the website to:

- Research Blue Cross patient eligibility
- Research coverage and deductible information
- Research paid and/or rejected claims and rejection reasons
- View and print Weekly Provider Payment Registers
- Check allowable charges

For electronic system help:



Call EDI Service Department at (225) 295-2085.

For electronic claims filing and/or accessing iLinkBlue help:



Email iLinkBlue.ProviderInfo@bcbsla.com



Call 1-800-216-BLUE (1-800-216-2583).

Provider Services Voice Response Telephone System Call Center

You may call Provider Services to obtain a member's claims status, eligibility, and deductible/coinsurance/copayment amounts or to check on the status of an authorization request. **Just call**



1-800-922-8866. Instructions are provided throughout the call to guide you through the steps to obtain the information you need.

Have your NPI, the member's Blue Cross ID number, the member's eight-digit date of birth and the date of service ready when you place your call, then listen carefully to the instructions.

Helpful Hints

- Speaker telephones and loud background noise will inhibit the performance of the voice response system.
- Speak numeric "zero," instead of alpha "O."
- The system will accept three efforts to identify provider and/or member contracts; after the third attempt, your call will be routed to the appropriate representative.
- Facility and professional providers must say or key their NPI.

Claim Status Hints

- If the telephone system is unable to match the date of service with the patient or provider's NPI, you will receive a fax notification stating that your request for information could not be processed via phone. Please call again and opt to speak to a representative for assistance with this policy.

- Fax back information should be received within 15 minutes of your request.
- Status information for contracts that begin with prefixes other than XU is not currently available.
- Claims must be paid or rejected in order to receive a claim status fax back.
- Claim Status Summaries are formatted to resemble your provider register.
- The summary will include the actual register date of your payment if you were paid.
- If benefits were paid to your patient, your summary will not reflect a date in the "Date Paid" field.
- You may inquire on up to ten dates of service per member.
- FEP (identified with an "R" in the first position of the contract number) must be keyed with a "0" in the last position of the contract number.

Benefit Summary Hints

- Benefit information on BlueCard® is available by calling the BlueCard Eligibility Line® at 1-800-676-BLUE (1-800-676-2583).
- Groups with non-standard or "special" benefits are routed to a representative for benefit information.
- Provider Services is specifically designed to provide in-network benefits only.
- Organize your Benefit Summary requests by products (for example, HMO) prior to beginning your request for benefit summaries.


The Provider Services telephone system is available for your convenience twenty-four hours a day, seven days a week. For information not offered by Provider Services, you will need assistance from a provider inquiry representative.

Customer Care Center

If your patients have questions about their healthcare benefits, you should tell them to call the number on their ID card. If they don't have their card, you may refer them to the Customer Care Center at 1-800-376-7741 or (225) 293-0625.

Preadmission Authorization

For admission authorization requests, please use our online authorization tool found on iLinkBlue or call our Authorization Unit at:

	Plan Approval	1-800-392-4085
	Federal Employee Program	1-800-334-9416
	Authorization Unit	(225) 295-2532 Fax
	Behavioral Health	1-800-991-5638

Provider Network Administration

If you need assistance with any of the material contained in this manual, contact Provider Network Administration at



network.administration@bcbsla.com



1-800-716-2299, option 4

Provider Relations Services

Provider Relations Representatives assist providers and their office staff and provide information about Blue Cross and its programs and procedures. To determine who your Provider Relations Representative is, see the Provider Representatives map at www.bcbsla.com/providers > Provider Tools. Please do not call your Provider Relations Representative with routine claim or benefit questions. You may obtain immediate answers to those questions through iLinkBlue or by calling the Provider Services at:



provider.relations@bcbsla.com



1-800-716-2299, option 4

Section 16

DEFINITIONS

THESE DEFINITIONS ARE DICTATED BY THE SUBSCRIBER/MEMBER BENEFITS

Above Allowable Amount

See Contractual Allowance.

Administrative Services Only (ASO)

An account that assumes full claims liability (self-insured) for funding the health Benefits contract with a third party (such as a Blue Cross and Blue Shield (BCBS) Plan) providing all or a portion of the administrative services that would be available under a regular health plan.

Allowable Charge

The lesser of the Billed Charge or the amount established by Plan, as the maximum amount allowed for provider services covered under the terms of the Member Contract/Certificate.

Alpha Prefix

A three-digit prefix to the Member's identification number that identifies the Blue Cross Plan or the national account in which the Member is enrolled. Authorization - a determination by Blue Cross regarding an admission, continued hospital stay, or other healthcare service for the purpose of determining Medical Necessity, appropriateness of the setting, or level of care. FEP members ID numbers will start with "R."

Authorization

A determination by Blue Cross regarding an admission, continued hospital stay, or other healthcare service or supply which, based on the information provided, satisfies the clinical review criteria requirement for medical necessity, appropriateness of the healthcare setting, or level of care and effectiveness. An authorization is not a guarantee of payment. Additionally, an authorization is not a determination about the member's choice of provider.

Benefit(s)

The amount for treatment, services or supplies to which a Member is entitled under the terms of a Member Contract/Certificate for Covered Services exclusive of applicable Deductible and Coinsurance/Copayment amounts.

Billed Charges

The total charges made by the Member Provider for all services and supplies provided to the Member.

Blue Advantage

Our Medicare Advantage network that is effective January 1, 2016, in the Baton Rouge, Lafayette and New Orleans areas only.

Blue Cross

Refers to Blue Cross and Blue Shield of Louisiana.

Charge Outlier Threshold

The amount calculated to determine if a claim meets one of two outlier criteria, e.g., three times the per diem amount. Member Providers should refer to the section regarding Contractual Outliers of their Member Provider Agreement Reimbursement Appendix for the exact details of their outlier provision.

Clean Claim

A claim that has no defect or impropriety (including lack of any required substantiating documentation) or particular circumstances requiring special or additional treatment that prevents timely payment from being made on the claim.

Coinsurance

The sharing of allowable charges for covered services. The sharing is expressed as a pair of percentages, a Plan percentage that we pay and a member percentage that they pay. Once the member has met any applicable deductible amount, the member's percentage will be applied to the allowable charges for covered services to determine the member's financial responsibility. The Plan's percentage will be applied to the allowable charges for covered services to determine the benefits provided.

Concurrent Review

The review of the medical appropriateness and Medical Necessity of continued inpatient care. It permits the concurrent review nurses to become aware of changes in the hospitalized Member's condition that necessitate additional length of stay, to identify potential discharge planning needs and to identify cases requiring outpatient case management.

Consumer Directed Health Care (CDHC)

A broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

As an umbrella term, CDHC encompasses multiple models and services including Consumer Directed Health Plans, high deductible health plans, member healthcare accounts, debit cards, member support tools, provider cost and profile information, e-business services and next generation networks.

Consumer Directed Health Plans (CDHP)

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

High deductible health plans vary in design (deductible thresholds, preventive coverage and more), and are offered and administered by a health insurance company, such as a Blue Cross Plan.

Contractual Allowance (Above Allowable Amount)

For Hospital Services, this is the difference between the Member Provider's Billed Charge and the Reimbursement Amount, which is not collectable from the Member. For professional services, this is the difference between the Billed Charge and the Allowable Charge that is not collectable from the Member for Covered Services.

Coordination of Benefits (COB)

Determining primary/secondary/tertiary liability between various healthcare Benefit programs and paying Benefits in accordance with established guidelines when Members are eligible for Benefits under more than one healthcare Benefits program.

Copayment (Co-pay)

The amount for which the Member is responsible and which may be collected directly from the Member at the time of service as the Member's share of payment, when applicable, in accordance with the Member Contract/Certificate.

Covered Services

Those Medically Necessary healthcare services for which Benefits are specified under a Member Contract/Certificate.

Current Procedural Terminology (CPT)

A system of terminology and coding developed by the American Medical Association that is used for describing, coding and reporting medical services and procedures.

Deductible

A specific amount of charges for Covered Services, usually expressed in dollars, that must be incurred by the Member before an obligation to Member arises under the Member Contract/Certificate to assume financial responsibility for all or part of the remaining Covered Services.

Diagnosis Related Groups (DRG)

A grouping of diseases and disorders into medically meaningful sets as developed by the Centers for Medicare and Medicaid Services (CMS). Each inpatient claim is classified into one of the possible DRGs by a computer program known as the "DRG grouper." Starting on July 1, 2014, the grouper system will use Discharge date or Statement "Through" date to group rather than Admission date. Inpatient discharges on or after October 1, 2015, will be processed under the DRG grouper system compliant with ICD-10 diagnosis and procedure code. The DRG grouper assigns a DRG using:

- Patient's principal diagnosis
- Patient's secondary diagnosis
- Surgical procedure(s) if applicable
- Patient's age
- Patient's sex
- Patient's discharge status
- Multiple diagnoses, complications or comorbidity

Elective Admission

That admission, whether for surgical or medical care, for which a reasonable delay will not affect the outcome of the treatment unfavorably.

Electronic Funds Transfer (EFT)

Allows payment to be sent directly to iLinkBlue enrolled providers' checking accounts. Weekly provider Payment Registers are viewed in iLinkBlue as enrollees no longer receive a Payment Register/Remittance Advice in the mail.

Electronic Submission of Claims (ESC)

A means of submitting claims data by computer systems via telephone lines or electronic media.

Emergency Admission

An admission to a hospital resulting from an Emergency Medical Condition.

Emergency Medical Condition

A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Experimental/Investigative Services

The use of any treatment, procedure, facility, equipment, device or supply not yet recognized by the National Association of Blue Cross and Blue Shield plans as accepted practice for treatment of the condition. NOTE: Blue Cross makes no payment for Experimental/Investigative services.

Explanation of Benefits (EOB)

A notice sent to the Member after a claim has been processed by Blue Cross that explains the action taken on that claim.

Federal Employee Program (FEP)

A healthcare Benefits plan designed for personnel employed by the Federal Government.

Flexible Spending Arrangement (FSA)

Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. FSAs can also be provided to cover childcare and transit expenses, but those accounts must be established separately from medical FSAs.

Grandfathered Plan

A health plan that an individual was enrolled in prior to March 23, 2010, and is still enrolled. Grandfathered plans are exempt from most changes required by PPACA. New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), otherwise known as HIPAA, was enacted as a broad congressional attempt at incremental healthcare reform. The "Administrative Simplification" section of that law requires the United States Department of Health and Human Services (DHHS) to develop standards and requirements for maintaining and transmitting health information.

Health Reimbursement Arrangement (HRA)

An employer-funded plan that reimburses employees for Qualified Medical Expenses (QMEs); an HRA is funded solely by the employer. Reimbursements for medical expenses, up to a maximum dollar amount for a coverage period, are not included in an employee's income. Unused funds can be rolled over annually but are owned by the employer and thus are not portable when the employee leaves the employer's company.

Health Savings Account (HSA)

A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified healthcare expenses of the account beneficiary who, for the months of which contributions are made to an HSA, is covered under a high-deductible plan. An HSA is employee-owned but can be funded by the employer and/or the employee. Unused funds are owned by the employee and thus are portable when the employee leaves the employer's company.

High Deductible Health Plan (HDHP)

A descriptive term relating to a broad category of health plans that feature higher annual deductibles than other traditional health plans. Deductibles typically exceed \$1000 for individual coverage and \$2000 for family coverage. This term encompasses those CDHP plans that are HSA qualified.

HMO Louisiana Select Network

A subset of HMO Louisiana providers who have signed a separate Agreement with PLAN to provide services to members with HMO Louisiana Select Network Contracts/certificates.

HMO Louisiana Select Network Provider

Any physician or group of physicians, or any facility, including but not limited to, a hospital, clinical laboratory, free-standing ambulatory surgery facility, skilled nursing facility, hospice, home health agency, or any other health care practitioner or provider of Medical Services who has entered into a HMO Louisiana Select Network contractual agreement with HMO Louisiana to provide covered services to members.

HSA Qualified High Deductible Health Plan

An individual or family health plan with minimum annual deductible and maximum out-of-pocket amounts indexed annually for inflation according to Internal Revenue Code (IRC) §223(c)(2) and IRC §223(g)(1).

Home Health Care

Health services rendered in the Member's place of residence by an organization licensed as a home health care agency by the appropriate state agency and approved by Plan. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed physician, in the individual's place of residence, home health services rendered by the appropriate health worker, including but not limited to physical therapist, speech therapist, occupational therapist, registered nurse, licensed practical nurse, or home health aide who meets the certification, registration and licensing requirements of the state in which services are rendered. In addition, the health worker shall be on the staff of or under contract with Member Provider.

Hospital-Based Physician

A physician who only provides services within the hospital and for whom the hospital files claims.

Hospital Services

Those non-transplant related inpatient and outpatient Hospital Services and supplies which are provided through the hospital. Hospital Services rendered during an inpatient admission include but are not limited to bed and board; Hospital Services rendered during an inpatient admission or for outpatient services include but are not limited to such nursing services and other related services, such use of hospital facilities as are ordinarily furnished by the hospital for the care and treatment of patients, and such drugs, biologicals, supplies, appliances and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of patients; and such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to patients either by such hospital or by others under such arrangements including but not limited to services performed by an organization or facility (related or unrelated to Member Provider and whether or not performed at Member Provider) without consideration of ownership of equipment, to include technical services such as EKG services, Computerized Axial Tomography (CAT) scans, Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) imaging, durable medical equipment, lab, radiology, diagnostic, lithotripsy, gamma knife, anatomical and clinical lab, etc. and ambulance services rendered in conjunction with EKG services, CAT scans, MRI and PET imaging, etc., while the Member is a patient at Member Provider.

Identification Card

The card issued to the Member identifying him/her as entitled to receive Benefits under a Member Contract/Certificate for services rendered by healthcare providers and for such providers to use in reporting to Blue Cross those services rendered to the Member.

Identification Number

The number assigned to the Member and all of his/her Blue Cross records. This number is a unique number selected at random, has a three-letter alpha-prefix in the first three positions and is noted on the Identification Card.

iLinkBlue: A secure Web portal available at no cost for healthcare providers, designed to help you quickly complete important functions such as claims entry, authorizations and billing information.

International Classification of Diseases, 10th Revision (ICD-10-CM)

A numerical classification descriptive of diseases, injuries and causes of death.

Medically Necessary/Medical Necessity

Healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- a. In accordance with nationally accepted standards of medical practice;
- b. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration and considered effective for the patient's illness, injury or disease; and
- c. Not primarily for the personal comfort or convenience of the patient, physician or other healthcare provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare Complementary (also referred to as Medicare Supplement)

A Benefit contract designed to supplement Medicare by covering certain hospital, medical and surgical services which are partially covered by Medicare. This Benefit design is provided through the BlueChoice 65 products.

Member

A participant (employee or dependent) covered under a subscriber contract.

Member Provider

A facility licensed as a hospital by the State of Louisiana Department of Health and Hospitals that has been selected by Plan for participation in its provider network and that has signed a Member Provider Agreement.

MS-DRG classification system

A restructure of the current 538 diagnosis-related groups (DRGs) to 745 MS-DRGs (severity-adjusted diagnosis related groups) to better recognize the severity of patient illness. The MS-DRGs more accurately capture resource utilization by splitting a large number of current DRGs into three different categories based on the presence or absence of diagnoses classified as “major complication or comorbidities” (MCC), “complications or comorbidities” (CC), or “without MCC/CC” (Non-CC).

The MS-DRGs were phased in over a two-year period. For the first year of the transition (2008), half of the relative weight for each MS-DRG were based on the current DRG relative weight and half was based on the new MS-DRG relative weight. For the second year (2009), the relative weights were based entirely on the MS-DRG relative weight.

Starting on July 1, 2014, the grouper system will use Discharge date or Statement “Through” date to group rather than Admission date. Inpatient discharges on or after October 1, 2015, will be processed under the DRG grouper system compliant with ICD-10 diagnosis and procedure code.

National Drug Code (NDC)

A unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

National Provider Identifier (NPI)

A 10-digit number unique to each provider that is issued by the Centers for Medicare and Medicaid Services (CMS). The NPI is required for providers to submit transactions to federal and state agencies, as well as file claims with private health plans.

Noncovered Service

A service and/or supply (not a Covered Service) for which there is no provision for either partial or total Benefit/payment under the Member Contract/Certificate.

Notification

A message sent to confirm, validate, acknowledge, or provide information from one entity to another.

Participating Plan

A Blue Cross and Blue Shield licensee participating in Blue Bank ownership and governance. Also means: A Blue Cross and Blue Shield licensee in whose service area a national account has employee and/or retiree locations, but in which the national account headquarters is not located unless otherwise agreed in accordance with National Account Program policies and provisions.

Patient Protection and Affordable Care Act (PPACA)

PPACA is legislation (Public Law 111-148) signed by President Obama on March 23, 2010. It is commonly referred to as the health care reform law.

Personal Savings Account (PSA)

A broad term used to represent the member’s portfolio of accounts: Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), Flexible Savings Account (FSA). This is also referred to as Health Care Accounts (HCA).

Plan

Blue Cross and Blue Shield of Louisiana; also referred to as Blue Cross or BCBSLA.

Preferred Provider

A physician, hospital or other participating provider who has a Preferred Provider agreement with Plan.

Private Duty Nursing Services

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending physician and require the technical skills of an RN or LPN in shifts of at least eight continuous hours.

Provider

A licensed or accredited hospital, medical supply or service vendor, or individual that provides medical care to a member.

Provider Payment Register/Remittance Advice

A claims summary identifying all claims paid or denied, along with payment, provided to the provider by either electronic means when set up with EFT or by mail when not set up with EFT.

Reimbursement Amount

The Allowable Charge amount negotiated between Plan and Member Provider except that it is the total compensation due Member Provider from both Plan and/or Member for both inpatient and outpatient Hospital Services, including Noncovered Services due from Member.

Skilled Nursing Services

Services provided to a Member who is within the skilled nursing unit of the hospital or services provided to a Member in an acute setting that do not meet an acute level of care as determined by Plan.

Sub-Acute Services

Services provided to a Member in an acute setting that do not meet an acute level of care as determined by Blue Cross, when a skilled nursing bed is not available.

Subscriber/Member

Employees or individuals and their enrolled dependents covered under a Subscriber Contract/Certificate who are entitled to receive healthcare Benefits as defined in and pursuant to the Subscriber Contract/Certificate.

Subscriber Contract/Certificate

A contract/certificate or health benefit plan that provides for payment in accordance with this Agreement to Member Provider and which is issued or administered by or through Blue Cross, its subsidiaries and affiliates and includes any national and regional group accounts of Blue Cross or any other Blue Cross Plan, Blue Shield Plan, or the Blue Cross and Blue Shield Association having a Benefit provision for which Blue Cross acts as the control plan, a participating plan or service plan in providing

those Benefits. It also includes any health plans or programs sponsored, provided, indemnified, or administered by other entities or persons who have made arrangements with Blue Cross, such as network access-only agreements, to access and utilize the Member Provider in connection with their managed care health plans or programs. Such entities or persons may avail themselves of the same access to service and related rights as Blue Cross, and such entities or persons shall be bound to the same payment responsibilities in regards to their Members as Blue Cross is for their respective Members under this Agreement. Member Provider will provide these services and look only to each joined entity or person for the Reimbursement Amount/Allowable Charge in the manner it would look to Blue Cross. The Subscriber Contract/Certificate or health benefit plan entitles Subscribers/Members to receive healthcare Benefits as defined in and pursuant to a Subscriber Contract/Certificate or health benefit plan.

Unbundled

Filing claims with two (2) or more reimbursement/medical codes to describe a procedure performed when a single, more comprehensive reimbursement/medical code exists that accurately describes the entire procedure.

Underwritten Business

Group or individual healthcare coverage where the Benefits are financed through premium payments to Plan, which assumes the financial risk.

Utilization Review

The program developed by Blue Cross to review and determine whether the medical services provided, or to be provided, are Medically Necessary and are Covered Services under the applicable Member Contract/Certificate.

SUMMARY OF CHANGES

Below is a summary of changes to the *Member Provider Policy & Procedures Manual*. Minor revisions not detailed in the summary include modifications to the text for clarity and uniformity, grammatical edits and updates to web links referenced in the document.

December 2016

Section 2: Network Overview

Office of Group Benefit Plans - Updated section

Blue Connect - Updated section

Section 5: Outpatient Acute Care Reimbursement

Outpatient Procedure Services - Updated CPT/HCPCS codes range

Diagnostic and Therapeutic Services - Update CPT/HCPCS codes range

Drug Screening Assays - Updated section

Not Separately Reimbursable Codes - Added section

Observation - Updated section

Pricing Flowchart for Outpatient Acute Care Reimbursement - Updated section

Service Exempt from the Multiple Procedure Discount - Updated code range

Section 7: Claims Submission & Payment

Serious Preventable Events and Present on Admission Indicators - Updated POA Indicators

Section 7-A: Electronic Claims Submission & Payment

Administrative Representative- Updated section

Section 8: Billing Guidelines

Ambulance Transport Benefit - Updated section

Behavioral Health - Updated section

Chiropractic and Therapy Services - Added section

Laboratory Billing Guidelines - Updated section

Section 13: Definitions

iLinkBlue - Added definition



www.bcbsla.com/providers

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