Provider Newsletter

Medicaid Managed Care
Dual Advantage

https://providers.healthybluela.com

December 2020

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Healthy Blue is the trade name of Community Care Health Plan of Louisiana, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

COVID-19 information from Healthy Blue

Healthy Blue is closely monitoring COVID-19 developments and how the novel coronavirus will impact our customers and provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) and the Louisiana Department of Health (LDH) to help us determine what action is necessary on our part. Healthy Blue will continue to follow LDH guidance policies.

For additional information, reference the *COVID-19 News and Updates* section of our **website**.

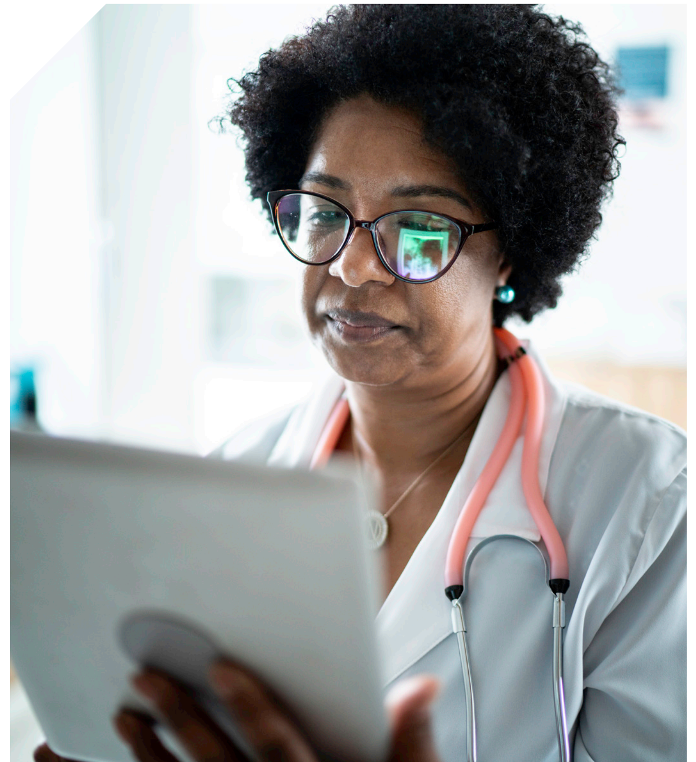
BLAPEC-1682-20/BLACARE-0163-20

Sign up to receive email from Healthy Blue

In order to communicate more efficiently with providers, Healthy Blue is now sending some bulletins, policy change notifications, prior authorization update information, educational opportunities and more to providers via email. Email is the quickest and most direct way to receive important information from Healthy Blue.

To receive email from Healthy Blue (including some sent in lieu of fax or mail), fill out our online form.

BLAPEC-2100-20



Digital transactions cut administrative tasks in half

Introducing the Healthy Blue *Digital Provider Engagement Supplement* to the provider manual

Using our secure provider portal or EDI submissions (via Availity*), administrative tasks can be reduced by more than 50% when filing claims with or without attachments, checking statuses, verifying eligibility, benefits and when submitting prior authorizations electronically. In addition, it could not be easier. Through self-service functions, you can accomplish digital transactions all at one time, all in one place. If you are not already registered, just go **here** for EDI or **here** for the secure provider portal (Availity).

Get payments faster

By eliminating paper checks, electronic funds transfer (EFT) is a digital payment solution that deposits payments directly into your account. It is safe, secure and will deliver payments to you faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the Availity Provider Portal or the *EDI 835* remittance, which meets all *HIPAA* mandates — eliminating the need for paper remittances.

Member ID cards go digital

Members who are transitioning to digital member ID cards, will find it is easier for them and you. The ID card is easily emailed directly to you for file upload, eliminating the need to scan or print. In addition, the new digital member ID card can be directly accessed through the secure provider portal via Availity. Providers should begin accepting the digital member ID cards when presented by the member.

Healthy Blue makes going digital easy with the *Digital Provider Engagement Supplement*

From our digital member ID cards, EDI transactions, application programming interfaces and direct data entry, we cover everything you need to know in the ***Digital Provider Engagement Supplement***, available on our provider website and on the secure Availity Portal. The supplement outlines our provider expectations, processes and self-service tools across all electronic channels, Medicare and Medicaid, including medical, dental and vision benefits.

The *Digital Provider Engagement Supplement* to the provider manual is another example of how Healthy Blue is using digital technology to improve the health care experience. We are asking providers to go digital with Healthy Blue no later than January 1, 2021, so we can realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration. Read the ***Provider Digital Engagement Supplement*** now and go digital with Healthy Blue.

** Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.*

BLA-NL-0263-20

Informal reconsideration/ peer-to-peer discussion

If our medical director denies coverage of a request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or servicing physician, and the member.

As a provider acting on behalf of a member, you have the right to discuss this decision with our medical director by calling our Health Care Management department at **1-877-440-4065, ext. 106-103-5145**.

Additional guidelines regarding peer-to-peer (P2P) discussions are below:

- For a prior authorization request, a provider, acting on behalf of the member, must submit the member's written consent to be eligible for P2P participation.
- Requests for P2Ps will be handled within one working day of the receipt of the request.
- If the P2P discussion is not completed within the specified time frame, the formal appeal process will need to be followed.
- We will not complete P2P discussions on retrospective-eligible, post-discharge hospitalizations. For retrospective-eligible, post-discharge adverse determinations, follow the formal appeal process.

The medical director will make two attempts to connect with the provider at the provider's specified contact number. If the provider fails to respond, the request for a P2P will be closed, and the provider's next course of action will be to follow the formal appeal process.

BLA-NL-0262-20

Coding spotlight: HEDIS MY 2021

HEDIS overview

The National Committee for Quality Assurance (NCQA) is a non-profit organization that accredits and certifies health care organizations. The NCQA establishes and maintains the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is a tool comprised of standardized performance measures used to compare managed care plans. The overall goal is to measure the value of health care based on compliance with HEDIS measures. HEDIS also allows stakeholders to evaluate physicians based on health care value rather than cost. This article will outline specific changes to the HEDIS measures as outlined by the NCQA. The changes are effective for the measurement year (MY) 2020 to 2021. It is important to note that the state health agency has the authority to determine which measures and rates managed care organizations should capture.

HEDIS data helps calculate national performance statistics and benchmarks and sets standards for measures in NCQA Accreditation.

Read more online.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

BLA-NL-0275-20

Resources to support your pregnant and postpartum patients and their families

Across the nation, too many women continue to experience pregnancy-related complications and death. More than 700 women die each year in the United States as a result of complications related to pregnancy or delivery.[1] Many of these deaths are preventable. In addition, significant racial and ethnic disparities exist in maternal morbidity and mortality. For example, Black/African American and American Indian/Alaska Native women are two to three times more likely to die from pregnancy-related complications compared to White women.[2] Healthy Blue recognizes your role at the front lines of defense to support your diverse pregnant and postpartum patients. We want to ensure you have the right tools and resources to help your patients understand their risks and key maternal warning signs.

The Centers for Disease Control and Prevention (CDC) recently launched the **Hear Her** campaign to raise awareness of pregnancy-related complications, risks and death. The Hear Her campaign aims to increase knowledge of the symptoms women should seek medical attention for during pregnancy and in the year after delivery, such as vision changes and chest pain. Resources are available for pregnant and postpartum women, partners, families and friends, and health care providers.

The Hear Her campaign reminds us of the importance of listening to women. As a health care provider, you have an opportunity to listen to pregnant women, engage in an open conversation to make certain their concerns are adequately addressed, and help your patients understand urgent maternal warning signs.

In addition, the Council on Patient Safety in Women's Health Care developed a tool to help women identify urgent maternal warning signs. The **Urgent Maternal Warning Signs tool** helps women recognize the symptoms they may experience during and after pregnancy that could indicate a life-threatening condition. The tool also provides additional information on the symptoms and conditions that place women at increased risk for pregnancy-related death.

If you have a pregnant member in your care who would benefit from case management, please call us at **1-844-521-6942**. Members can also call our 24/7 NurseLine at the number on their member ID card.

References

1 Centers for Disease Control and Prevention. (2020, August 13). *Reproductive Health: Maternal Mortality.* Retrieved from **https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html**.

2 Centers for Disease Control and Prevention. (2019, September 5). *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths.* Retrieved from **https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html**.

BLA-NL-0258-20

Notifications on the Availity Portal

Healthy Blue is now using the Notification Center on the Availity* Portal home page to communicate vital and time sensitive information. You will see a *Take Action* call out and a red flag in front of the message to make it easy to see new items requiring your attention.

We will use the *Notification Center* to update your organization if there are payment integrity requests for medical attachments or recommended training in the Custom Learning Center. Select the **Take Action** icon to access the custom learning recommended course.

There will also be a message posted in the *Notification Center* when a payment dispute decision is available. Selecting the **Take Action** icon will allow easy access to your appeals worklist for details.

Viewing the *Notification Center* updates should be included as part of your regular workflow so that you are aware of any outstanding action items.

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BLA-NL-0253-20

Provider Online Reporting registration

Background: Reports and information are available through Provider Online Reporting (POR) and can be accessed via the Availity Portal. Visit **https://www.availity.com** to register or log in.

POR registration:

1. Log in to **Availity**.
2. Choose **Payer Spaces** in the top menu bar.
3. Select the **Healthy Blue payer tile**.
4. On the *Applications* tab, select **Provider Online Reporting**.
5. Select the organization.
6. Choose **Submit**.

Note: First-time users accessing Payer Spaces will be asked to accept a Terms of Use Agreement. The agreement will appear for users once every 365 days.

On the *Welcome to Provider Online Reporting* page, select **Register/Maintain Organization**. Select **Register Tax ID(s)** for the applicable program to register the tax IDs. A pop-up window will display all tax ID(s) that need to be registered for the program. Check the box for each tax ID to be registered and select **Save**. You now have successfully completed the tax ID registration. After the registration has been completed, the status will change from *Register Tax ID(s)* to *Edit Tax ID(s)*.

Note: The practice may be participating in more than one program; the administrator must register each program that is listed.

Accessing POR

Use the navigation options on the left-hand side of the page to move around within the tool:

- The *Home* page in Provider Online Reporting will open. This page lists all programs for which the organization is eligible.
- The *Programs* page provides a description about the program your organization is participating in and includes helpful documents related to your program. Select a program using the drop-down arrow.
- The *Report Search* page launches the corresponding reporting application for your program. Select the appropriate program from the drop-down menu.
- Use the *Contact Us* page to submit questions about the POR application. Your question will be routed to the appropriate Healthy Blue contact.
- Select the **Notifications** page to view updates for programs as applicable.
- Use **Online Resources** under *Helpful Links* to view external websites that may be useful to your organization.

Note: Functionality is dependent upon specific program requirements.

What if I need assistance?

- If you have questions regarding the Availity Portal, contact Availity Client Services at **1-800-282-4548**.
- If you have questions about POR, use the *Contact Us* section of the application.
- If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-844-521-6942**.

BLAPEC-1636-20

Healthy Blue

Top claim denial reasons

In an effort to promote proper billing practices, Healthy Blue periodically shares top claim denial reasons for awareness.

Please see below for the top claim denial reasons for medical, inpatient (IP) hospital and outpatient (OP) hospital claims for Q3 2020. The most common claim denial reasons were *definite duplicate claim, deny pre-authorization not obtained, disallow — not allowed under contract* and *resubmit with applicable modifier.* The code description and reminder notes should assist in avoiding these denial reasons:

Top denial reasons		
Denial code	**Description**	**Reminder**
CDD	Definite duplicate claim	Prior to submitting a member's claim for the same date of service, make certain that you review your *Explanation of Payment (EOP)* to validate that the previously submitted claim has been paid or denied. If the previously submitted claim denied or requires correction, include the original claim number in field 64 of the *UB-04* and in field 22 of the *1500* form. The appropriate frequency code or resubmission code should be listed on the claim in field 4 of the *UB-04* and in field 22 of the *1500*. All service lines, including those that previously paid should be included.
Y3Z	Deny pre-authorization not obtained	Make certain the rendering provider is in-network. To determine if an outpatient service requires authorization, use the **pre-authorization tool** located on our website. For all services that require pre-authorization, make certain the details listed on the claim matches information on the approved authorization.
G18	Disallow — not allowed under contract	Make certain the rendering provider specialty is appropriate for the service being provided. To update a provider's specialty or have a provider credentialed, submit all required documents and licensure to lainterpr@healthybluela.com. You can also validate that you are contracted to provide specific services. Make certain that the service billed is listed on the applicable LA Medicaid Fee Schedule.
G99	Please resubmit with applicable modifier	Check the ***LA Medicaid Fee Schedule or the Specialized Behavioral Health Fee Schedule*** to review the CPT® code and required modifiers.

BLA-NL-0271-20

FDA approvals and expedited pathways used — new molecular entities (NMEs)

Healthy Blue reviews the activities of the Food and Drug Administration (FDA)'s approval of drugs and biologics on a regular basis to understand the potential effects for our providers and members.

The FDA approves new drugs and biologics using various pathways. Recent studies on the effectiveness of drugs and biologics going through different FDA pathways illustrates the importance of clinicians being aware of the clinical data behind a drug or biologic approval in making informed decisions.

Here is a list of the approval pathways the FDA uses for drugs/biologics:

- **Standard review** — The standard review process follows well-established paths to make sure drugs/biologics are safe and effective when they reach the public. From concept to approval and beyond, FDA performs these steps: reviews research data and information about drugs and biologics before they become available to the public; watches for problems once drugs and biologics are available to the public; monitors drug/biologic information and advertising; and protects drug/biologic quality. Follow this **link** to learn more about the standard review process.
- **Fast track** — Fast track is a process designed to facilitate the development and expedite the review of drugs/biologics to treat serious conditions and fill an unmet medical need. Follow this **link** to learn more about the fast track process.
- **Priority review** —A priority review designation means FDA's goal is to take action on an application within six months. Follow this **link** to learn more about the priority review process.
- **Breakthrough therapy** — This process is designed to expedite the development and review of drugs/biologics which may demonstrate substantial improvement over available therapy. Follow this **link** to learn more about the breakthrough therapy review process.
- **Orphan review** — This refers to the review of drugs that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. Follow this **link** to learn more about the orphan drug review process.
- **Accelerated approval** — These regulations allowed drugs/biologics for serious conditions that filled an unmet medical need to be approved based on a surrogate endpoint. To learn more about the accelerated approval process, follow this **link**.

Read more online.

BLA-NL-0269-20

Dual Advantage

COVID-19 information from Healthy Blue

View the **article** in the Medicaid section.

BLAPEC-1682-20/BLACARE-0163-20

2021 Medicare Advantage individual benefits and formularies

Summary of benefits, evidence of coverage and formularies for 2021 Healthy Blue Dual Advantage (HMO D-SNP) will be available **online**.

An overview of notable 2021 benefit changes will be available at **https://providers.healthybluela.com/la/pages/medicare-advantage** > 2020 D-SNP News and Announcements.

Please continue to check our **website** for the latest Healthy Blue Dual Advantage information.

BLACRNL-0037-20

Medical Policies and *Clinical Utilization Management Guidelines* update

The *Medical Policies, Clinical Utilization Management (UM) Guidelines* and *Third-Party Criteria* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed.

Please share this notice with other members of your practice and office staff.

To view a guideline, visit **https://provider.healthybluela.com/louisiana-provider/medical-policies-and-clinical-guidelines**.

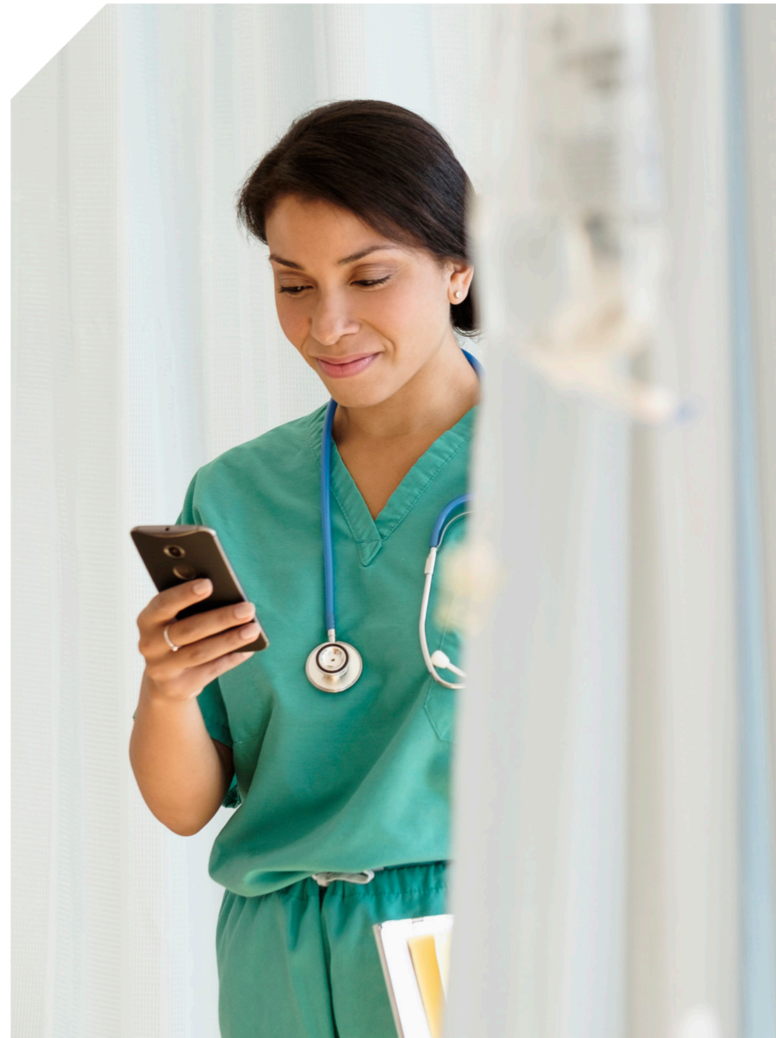
Updates

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive:

- MED.00134 — Noninvasive Heart Failure and Arrhythmia Management and Monitoring System:
  - Revised Investigational and Not Medically Necessary indications
- SURG.00156 — Implanted Artificial Iris Devices:
  - Revised Investigational and Not Medically Necessary indications
- SURG.00157 — Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis:
  - Revised Investigational and Not Medically Necessary indications
- CG-DME-07 — Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output:
- Revised Medically Necessary and Not Medically Necessary indications
- GENE.00052 — Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling:
  - Revised Medically Necessary indications
- SURG.00077 — Uterine Fibroid Ablation: Laparoscopic, Percutaneous or Transcervical Image Guided Techniques:
  - Expanded scope and revised Investigational and Not Medically Necessary indications
- SURG.00112 — Implantation of Occipital, Supraorbital or Trigeminal Nerve Stimulation Devices (and Related Procedures):
  - Revised scope, and Investigational and Not Medically Necessary indications
- CG-REHAB-12 — Rehabilitative and Habilitative Services in the Home Setting: Physical Medicine/Physical Therapy, Occupational Therapy and Speech-Language Pathology:
  - A new *Clinical UM Guideline* was created from content contained in CG-REHAB-04, CG-REHAB-05, CG-REHAB-06.
  - There are no changes to the guideline content.
  - Publish date is scheduled for December 8, 2020.
- The following AIM Specialty Health® (AIM)** *Clinical Appropriateness Guidelines* have been revised and will be effective on December 6, 2020.
  - Interventional Pain Management See August 16, 2020, version.)*
  - Chest Imaging (See August 16, 2020, version.)*
  - Oncologic Imaging (See August 16, 2020, version.)*
  - *Sleep Clinical Guidelines* (See August 16, 2020, version.)*

  To view AIM guidelines, visit the **AIM page**.

Healthy Blue



Medical Policies

On August 13, 2020, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Healthy Blue. These guidelines take effect December 6, 2020.

Clinical UM Guidelines

On August 13, 2020, the MPTAC approved several *Clinical UM Guidelines* applicable to Healthy Blue. These guidelines adopted by the medical operations committee for Healthy Blue Dual Advantage (HMO D-SNP) members on September 24, 2020. These guidelines take effect December 6, 2020.

Read more online.

*** AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue.*

BLACRNL-0041-20