Provider Newsletter

https://providers.healthybluela.com

Healthy Blue

Medicaid Managed Care
Dual Advantage

November 2020

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the *Provider Newsletter* via email?
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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

CAHPS education for providers

Consumer Assessment of Healthcare Providers and Systems (CAHPS)® is an annual standardized survey conducted to assess consumer experience with their health care services and health plan. Providers and their staff play a key role in the member experience. Several questions specific to the member's experience with their provider are included in the CAHPS survey. Education about the CAHPS survey, the importance of focusing on the patient experience and ways to improve the patient experience are included in the *Provider Orientation* and available by visiting the **https://providers.healthybluela.com**.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

BLA-NL-0250-20

Healthy Blue

Transition to AIM Specialty Health *Rehabilitative Services Clinical Appropriateness Guidelines*

Effective December 8, 2020, Healthy Blue will transition the clinical criteria for medical necessity review of certain outpatient rehabilitative services from our clinical guidelines for physical therapy CG-REHAB-04, occupational therapy CG-REHAB-05 and speech language pathology CG-REHAB-06 to AIM Specialty Health®* *Rehabilitative Service Clinical Appropriateness Guidelines*. These reviews will continue to be completed by the utilization management team.

Access and download a copy of the current and upcoming guidelines **here**.*

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

BLA-NL-0220-20

Updates to AIM Specialty Health *Musculoskeletal Program Clinical Appropriateness Guidelines*

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Specialty Health® (AIM)* musculoskeletal program joint surgery, spine surgery and interventional pain clinical appropriateness guidelines.

Read more online.

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BLA-NL-0215-20

Healthy Blue

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 and 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* to the provider manual, available by going to **https://providers.healthybluela.com/la/pages/communication-updates.aspx > Communications & Updates** > Provider Updates > Provider Digital Engagement, and on the secure **Availity Provider 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.

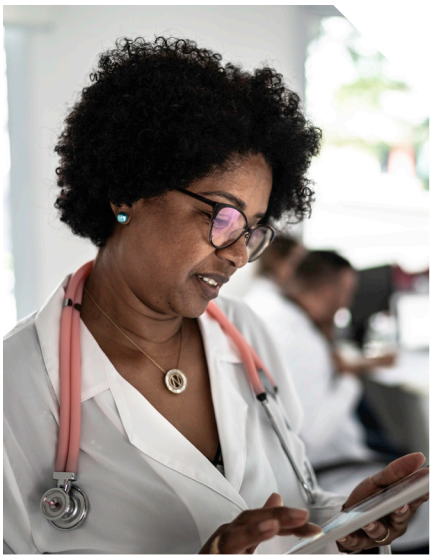
The *Digital Provider Engagement Supplement* to the provider manual is another example of how Healthy Blue is using digital technology to improve the health care experience. We are asking providers to go digital with Healthy Blue no later than January 1, 2021, so we can realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration. Read the *Provider Digital Engagement Supplement* now by going to **https://providers.healthybluela.com/la/pages/communication-updates.aspx** > Communications & Updates > Provider Updates > Provider Digital Engagement, 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

Healthy Blue

Attention: updated laboratory fee schedule



Effective January 1, 2021, Healthy Blue will update the *Reference Laboratory Fee Schedule* for Healthy Blue. This change is applicable to providers who are reimbursed, either in whole or in part, based on the fee schedule for laboratory services for Medicaid.

What is the impact of this change?

The actual impact to any particular provider will depend on the codes most frequently billed by that provider.

The updated fee schedule will be available on the **Availity Portal*** on the effective date of January 1, 2021.

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BLA-NL-0206-20/BLA-NL-0273-20

Coding spotlight: tips and best practices for compliance

Need for coding compliance

Coding compliance refers to the process of ensuring that the coding of diagnosis, procedures and data complies with all coding rules, laws and guidelines.

All provider offices and health care facilities should have a compliance plan. Internal controls in the reimbursement, coding, and payment areas of claims and billing operations are often the source of fraud and abuse, and have been the focus of government regulations.

Compliance plan benefits:

- More accurate payment of claims
- Fewer billing mistakes
- Improved documentation and more accurate coding
- Less chance of violating state and federal requirements including self-referral and anti-kickback statutes.

Compliance programs can show the provider practice is making an effort to submit claims appropriately and send a signal to employees that compliance is a priority.

Read more online.

BLA-NL-0252-20

Healthy Blue

Medical drug benefit *Clinical Criteria* updates

On June 20, 2019, the Pharmacy and Therapeutics (P&T) Committee approved the following *Clinical Criteria* applicable to the medical drug benefit for Healthy Blue. These policies were developed, revised or reviewed to support clinical coding edits.

Visit ***Clinical Criteria*** to search for specific policies. For questions or additional information, use this **email**.

Please see the explanation/definition for each category of *Clinical Criteria* below:

- New: newly published criteria
- Revised: addition or removal of medical necessity requirements, new document number
- Annual review: minor wording and formatting updates, new document number
- Updates marked with an asterisk (*): criteria may be perceived as more restrictive

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

Please note: The *Clinical Criteria* listed below applies only to the medical drug benefits contained within the member's medical plan. This does not apply to pharmacy services.

Effective date	Document #	*Clinical Criteria* title	New, revised, annual review
10/05/2020	ING-CC-0061*	GnRH Analogs for the treatment of non-oncologic indications	Revised
10/05/2020	ING-CC-0121	Gazyva (obinutuzumab)	Revised
10/05/2020	ING-CC-0124	Keytruda (pembrolizumab)	Revised
10/05/2020	ING-CC-0103	Faslodex (fulvestrant)	Revised
10/05/2020	ING-CC-0003*	Immunoglobulin	Revised
10/05/2020	ING-CC-0031*	Intravitreal Corticosteroid Implants	Revised

BLAPEC-1768-20

COVID-19 information from Healthy Blue

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

BLAPEC-1682-20/BLACARE-0163-20

Updates to AIM Specialty Health *Musculoskeletal Program Clinical Appropriateness Guidelines*

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

BLA-NL-0215-20

Medical drug *Clinical Criteria* updates

June 2020 update

On February 21, 2020, May 15, 2020, and June 18, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Healthy Blue. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the ***Clinical Criteria* web posting.**

BLCRNL-0035-20

The *Clinical Criteria* is publicly available on the provider website. Visit the ***Clinical Criteria* website** to search for specific policies.

For questions or additional information, use this **email**.

Healthy Blue

AIM Specialty Health Musculoskeletal program expansion update

As previously communicated, AIM Specialty Health® (AIM),* planned to expand their Musculoskeletal program to perform medical necessity reviews for certain elective surgeries of the small joint for Medicare Advantage members. However, this expansion has been postponed until further notice.

If you have questions about this communication or need assistance with any other item, please call the number on the back of the member ID card.

If you have questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com.

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

BLACRNL-0032-20

Update: Notice of changes to the AIM Specialty Health musculoskeletal program

As you know, AIM Specialty Health® (AIM)* administers the musculoskeletal program for Medicare Advantage members, which includes the medical necessity review of certain surgeries of the spine, joints and interventional pain treatment. For certain surgeries, the review also includes a consideration of the level of care.

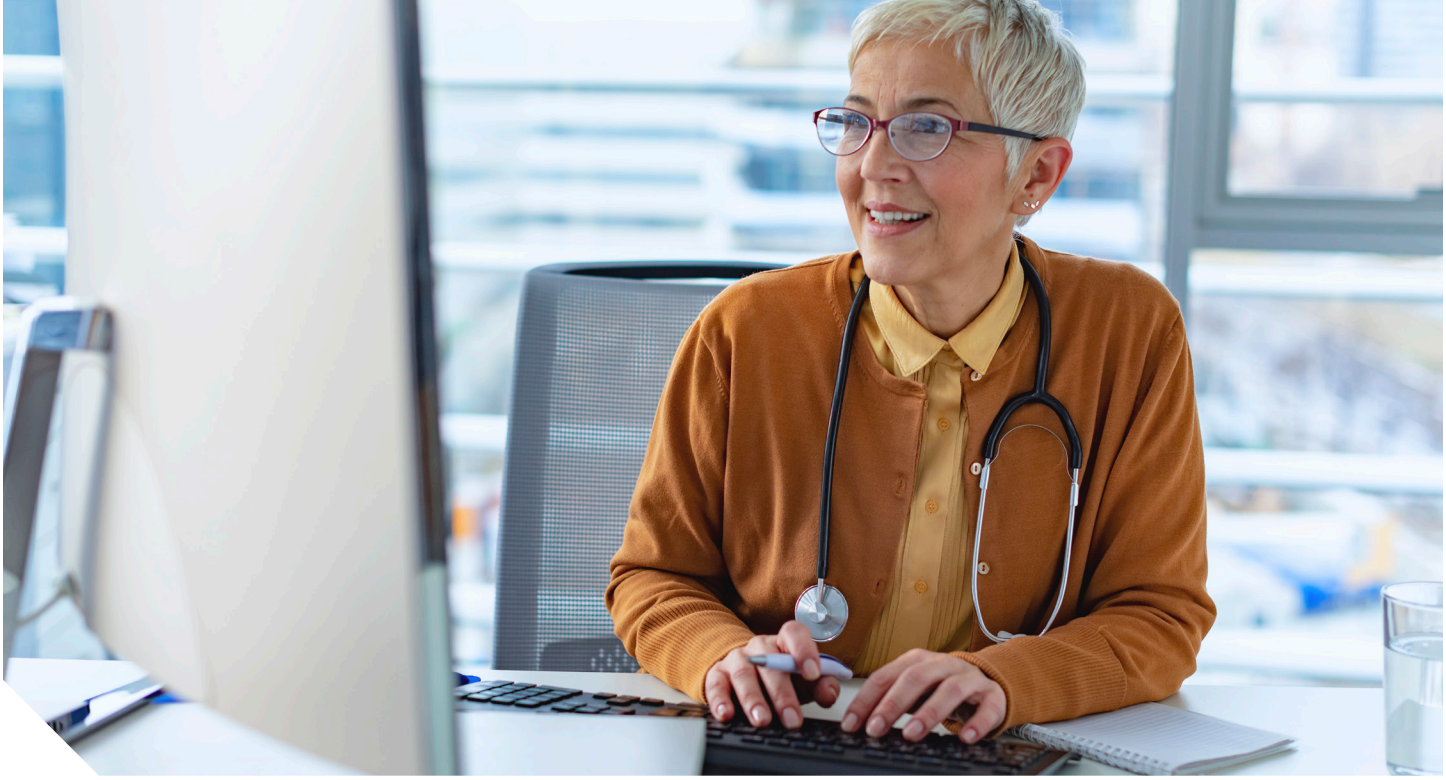
Effective December 1, 2020, two joint codes (29871 and 29892) will be incorporated into the AIM Level of Care Guideline for Musculoskeletal Surgery and Procedures. According to the clinical criteria for level of care, which is based on clinical evidence as outlined in the AIM guideline, it is generally appropriate to perform these two procedures in a hospital outpatient setting. To avoid additional clinical review for these surgeries, providers requesting prior authorization should either choose **hospital observation** admission as the site of service or **Hospital Outpatient Department (HOPD)**.

Read more online.

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue. Availity, LLC is and independent company providing administrative support services on behalf of Healthy Blue.*

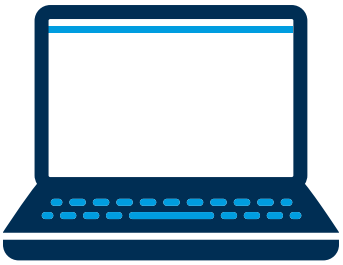
BLACRNL-0028-20

Healthy Blue



Provider Chat — a fast, easy way to get your questions answered

You now have a new option to have questions answered quickly and easily. With Healthy Blue, providers can have a real-time, online discussion through a new digital service, available through Payer Spaces on **Availity**.*



Provider Chat offers:

- Faster access to Provider Services for all questions.
- Real-time answers to your questions about prior authorization and appeals status, claims, benefits, eligibility, and more.
- An easy-to-use platform that makes it simple to receive help.
- The same high level of safety and security you have come to expect with Healthy Blue.

Chat is one example of how Healthy Blue is using digital technology to improve the health care experience, with the goal of saving valuable time. To get started, access the service through Payer Services on **Availity**.

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

BLACARE-0254-20

Healthy Blue

FDA approvals and expedited pathways used — new molecular entities

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

The FDA approves new drugs/biologics using various pathways of approval. Recent studies on the effectiveness of drugs/biologics going through these 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. To learn more about the Standard Review process, go **here**.
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. To learn more about the Fast Track process, go **here**.
Priority Review:	A Priority Review designation means FDA's goal is to take action on an application within six months. To learn more about the Priority Review process, go **here**.
Breakthrough Therapy:	A process designed to expedite the development and review of drugs/biologics that may demonstrate substantial improvement over available therapy. To learn more about the Breakthrough Therapy process, click **here**.
Orphan Review:	Orphan Review is the evaluation and development of drugs/biologics that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. To learn more about the Orphan Review process, click **here**.
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, click **here**.

New molecular entities approvals — January to August 2020

Certain drugs/biologics are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active ingredients that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product; these products frequently provide important new therapies for patients.

Healthy Blue reviews the FDA-approved NMEs on a regular basis. To facilitate the decision-making process, we are providing a list of NMEs approved from January to August 2020, along with the FDA approval pathway utilized.

BLACRNL-0039-20

Healthy Blue

Policy Reminder — Medicaid

Nurse Practitioner and Physician Assistant Services, Professional

(Effective 04/24/20)

Healthy Blue continues to allow reimbursement for services provided by nurse practitioner (NP) and physician assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- Service is considered a physician's service
- Service is within the scope of practice
- A payment reduction consistent with CMS reimbursement

Services furnished by the NP or PA should be submitted with their own NPI.

Note: This is a new policy structure, but not a change to processes or reimbursement.

This article is to inform you that there is now a separate and specific professional reimbursement policy to reference for Nurse Practitioner and Physician Assistant Services.

For additional information on the Nurse Practitioner and Physician Assistant Services professional policy, visit **https://providers.healthybluela.com**.

BLA-NL-0248-20

Policy Update — Dual Advantage

Nurse Practitioner and Physician Assistant Services, Professional

(Effective 04/24/20)

This update is to inform you that there is now a separate and specific professional reimbursement policy to reference for Nurse Practitioner and Physician Assistant Services.

Healthy Blue continues to allow reimbursement for services provided by nurse practitioner (NP) and physician assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- Service is considered a physician's service
- Service is within the scope of practice
- A payment reduction consistent with CMS

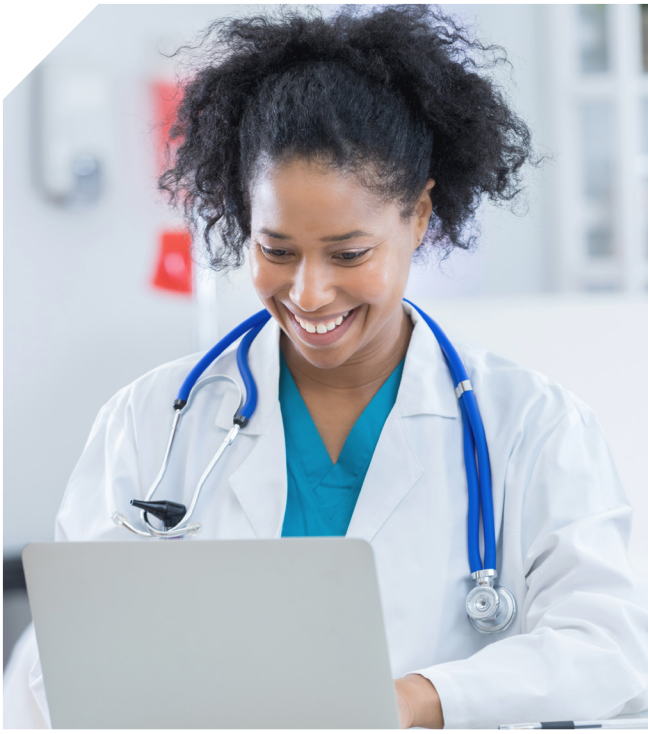
Services furnished by the NP or PA should be submitted with their own NPI.

For additional information, please review the Nurse Practitioner and Physician Assistant Services professional reimbursement policy at **https://providers.healthybluela.com**.

BLACRNL-0033-20

Policy Update — Dual Advantage

Emergency Department: Leveling of Evaluation and Management Services



Effective January 15, 2021, Healthy Blue classifies with an Evaluation and Management (E&M) code level the intensity/complexity of emergency department (ED) interventions a facility uses to furnish all services indicated on the claim. E&M services will be reimbursed based on this classification. Facilities must use appropriate *HIPAA*-compliant codes for all services rendered during the ED encounter. If the E&M code level submitted is higher than the E&M code level supported on the claim, we reserve the right to perform one of the following:

- Deny the claim and request resubmission at the appropriate level or request the provider submit documentation supporting the level billed.
- Adjust reimbursement to reflect the lower ED E&M classification.
- Recover and/or recoup monies previously paid on the claim in excess of the E&M code level supported.

Providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E&M service will be able to follow the dispute resolution process in accordance with the terms of their contract. Claims disputes require a statement providing the reason the intensity/complexity would require a different level of reimbursement, and the medical records which should clearly document the facility interventions performed and referenced in that statement.

For additional information, please review the Emergency Department: Leveling of Evaluation and Management Services reimbursement policy at **https://providers.healthybluela.com**.

BLACARE-0257-20

Healthy Blue