SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Member Provider Policy & Procedure Manual

5.1 GENERAL BILLING AND REIMBURSEMENT

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Member Provider Policy & Procedure Manual*. If Blue Cross and Blue Shield of Louisiana (Louisiana Blue) makes any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Member Provider Policy & Procedure Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Member Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. 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.

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

GENERAL BILLING AND REIMBURSEMENT

PROCEDURE AND DIAGNOSIS CODES AND GUIDELINES

Louisiana Blue uses Physicians' Current Procedural Terminology (CPT), ICD-10-CM and HCPCS codes for processing claims. **Participating providers should follow the coding guidelines published in the current edition of the CPT code book when submitting claims to Louisiana Blue and HMO Louisiana for processing. Louisiana Blue follows these coding guidelines unless otherwise identified in our policies.** 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 office 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 and 2; CPT and HCPCS. Inpatient procedures are found in the ICD-10-PCS coding book.

New CPT codes will be accepted as they become effective.

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 up to 12 (four per line) diagnosis codes on CMS-1500 and up to 26 diagnosis codes on UB-04 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.
- HIPAA regulations require valid ICD-10-CM diagnosis codes.
- 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.

DIAGNOSIS CODE SPECIFICITY

Louisiana Blue 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. 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 Louisiana Blue 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

Louisiana Blue 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 Louisiana Blue receive complete and accurately coded claims to properly indicate our members' health status.

It is best practice to submit all applicable diagnosis codes and CPT II codes on the original claim. However, providers can submit additional diagnosis codes on a supplemental claim form using CPT 99499. This code should be filed as a $0.01 charge.

DIAGNOSIS/PROCEDURE CODING

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

Volume 1	Tabular List
Volume 2	Instructions and Guidelines
Inpatient procedure codes are found in the ICD-10-PCS coding book.	

The diagnoses are classified by alphanumeric categories (the first character is always a letter and any additional characters are represented by a number or letter) with the addition of a fourth or seventh digit to provide specificity or more information regarding etiology, site or manifestations. The appropriate diagnosis code is found by using ICD-10-CM Volumes 1 and 2.

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 and 2, ICD-10-PCS, CPT and HCPCS.

New CPT and HCPCS codes will be accepted beginning Jan. 1 of each year.

REPORTING NATIONAL DRUG CODE 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 National Drug Codes (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 and outpatient hospital claims:

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

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format. If the NDC is not submitted in the correct format, the claim will be denied.

Revenue Code 250

For outpatient claims, when revenue code 250 is billed without an NDC and HCPCS/CPT code (when applicable) that line will not be reimbursed. This only applies to claims where Louisiana Blue is the primary payer.

For Hardcopy Claims

- On the CMS-1500 claim form, report the NDC in the shaded area of Block 24A. We follow the U.S. Centers for Medicare & Medicaid Services 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.

- On the UB-04 claim form, report the NDC and the quantity in Block 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 Compound Drugs

Compounded drugs are medications customized by a pharmacist to meet a specific patient need. This may include such things as altering the formulation or dosage. Following label instructions to mix pre-packaged products together is not considered a compounded drug.

When billing for a compounded drug, each specific drug in the compound is required to be billed on a separate line with the appropriate HCPCS drug procedure code and NDC information. Modifier KP should be billed for the first drug of a multiple-drug unit-dose formulation and Modifier KQ should be billed to represent the second or subsequent drug formulation.

The following information must be included when submitting a compound drug:

- NDC number for each drug
- Drug name(s)
- Quantity of each drug
- Total quantity of compound
- Units of measure
- Invoice

For Electronic Claims

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. 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 (Professional Only)

Select 24K to expand the claim line to report the NDC, Quantity and Measurement.

- NDC Code Field: Enter the 11-digit NDC code. No alpha characters, spaces or hyphens can be present.
- Quantity: Numeric value of quantity
- Measurement: Select the appropriate measurement from the drop-down menu
  - F2 – International Unit
  - GR – Gram
  - MG – Milligram
  - ML – Milliliter
  - UN – Unit

DRUG ALLOWABLE CHARGE

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

PROVIDER-PATIENT RELATIONSHIP

Coverage is not available for care provided to members outside of an established provider-patient relationship as defined by the Plan. The stipulation of a required provider-patient relationship does not apply to healthcare services provided in Urgent Care Centers, Emergency Room Departments, imaging services, pathology/laboratory services and/or services provided while the member (patient) is in a facility.

ELIGIBLE CHARGES

Eligible charges are defined as total charges billed on a claim less denied charges, including but not limited to claims editing and medical policy.

INPATIENT ACUTE CARE REIMBURSEMENT

- Inpatient billings should include any charges for inpatient hospital services while the member is a patient at your hospital. If a member is admitted as inpatient and requires medically necessary services not otherwise available at the inpatient facility, the inpatient hospital lacking the needed services is responsible for the costs of the other services. Subcontracted services should not be billed as they are included in the inpatient reimbursement of the hospital lacking the needed services.
- 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 non-covered service under the member contract/certificate.
- If a provider is reimbursed according to MS-DRG reimbursement methodology with transfer adjustments, then an adjustment will take place in one of two scenarios. If length of stay (LOS) is more than one day less than the geometric mean length of stay (GMLOS) for that MS-DRG and either:
    1. A transfer is made to the acute facility (based on the discharge status).
    2. A transfer is made to the post-acute facility based on the discharge status and MS-DRG is applicable for post-acute transfer adjustment. The specific MS-DRG's are identified by a post-acute indicator of "Yes" in CMS IPPS Table 5 Final Rule.

- Louisiana Blue will use the contracted rate, the payment processing methodology and other provisions in effect at the time of the patient admission as the basis for payment.
- Claims are grouped to a DRG based on discharge date.
- Louisiana Blue will notify the hospital of any rate or reimbursement methodology changes no later than 60 days prior to the effective date of the contract renewal.

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 eligible 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 used to group each claim to a specific MS-DRG. Each MS-DRG is assigned to a reimbursement category. CMS sets the payment rate for each MS-DRG case based on the average resources used to treat patients with that condition. The MS-DRGs and the corresponding reimbursement categories are listed in the MS-DRG Type of Service Listing section of this manual. Louisiana Blue will notify the Member Provider of any changes in MS-DRG type of service classifications.

Louisiana Blue uses the current version of the MS-DRG grouper system that recognizes the differences in patient severity. It is updated annually on Oct. 1 or as soon as it is available. The updated grouper is effective Oct. 1 and uses the discharge date to determine the DRG grouping.

Reduced Reimbursement for Delayed Services

The per diem reimbursement amount for inpatient hospital services will be reduced by 50% 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.

REFER MEMBERS TO NETWORK PROVIDERS

As a participating provider in our networks, you agree to assist us in our efforts to keep our members' costs down. One way to do that is to refer our members — your patients — to providers in their network.

This is important because members may pay significant costs when using a provider not in their network. The amounts that some nonparticipating providers charge for their services are higher than the negotiated allowable charges participating providers have agreed to accept. When seeing a nonparticipating provider, the member may be responsible for the difference between the allowed amount and the billed charge.

In the interest of affordable, quality care for your patients, it is important that you refer your Louisiana Blue patients to providers in their network. To confirm if a provider is participating, please consult our online directories.

Note: Providers who repeatedly refer members to nonparticipating providers could be subject to an overall reimbursement rate reduction by a certain percentage as determined by Louisiana Blue in its sole discretion and in accordance with applicable law.

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 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. Louisiana Blue 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 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 (45388). In this scenario Modifier 33 is appended to 45388 to 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 screening colonoscopies.

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. Claim lines submitted with both the LT and RT modifiers will be considered incorrectly billed. Modifier 50 is not applicable to radiology services. For radiology services, please bill the procedures on separate lines with Modifier RT and LT.

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

1. The primary bilateral procedures are reimbursed at 150% of the allowable charge.
2. The secondary bilateral procedures are reimbursed at 75% 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% of allowable charge and the remaining procedures at 50% of allowable charge.

Modifier 52 - Partially Reduced or Eliminated Procedures

- Modifier 52 - used when services were modified mid-procedure at the physician's discretion such that the service furnished is less than usually required. Outpatient facility reduced services will be reimbursed at 50% of the allowable charge.

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

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

Modifier AS - Billing for Surgical Assistant Services on UB-04

Modifier AS should not be submitted on the UB-04 claims form. If facilities submit Modifier AS on the UB-04 form, the assistant at surgery service will be denied. For guidelines on submitting Modifier AS on the CMS-1500 claims form, refer to the *Professional Provider Office Manual*, available online on our Provider page.

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 components 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.

CHARGE MASTER INCREASE

Louisiana Blue requires facility providers to give a 30-day advance notice of all changes and updates to services on the charge master. The provider can submit a letter that defines the net increase of the charges, the effective date and any exceptions (e.g., if charge increase is only applicable to certain codes or services) or a Charge Increase Worksheet in the format referenced below. Louisiana Blue may request the provider submit a Charge Increase Worksheet in addition to a letter if more details are needed.

Charge Increase Worksheet Sample

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			220	Rev Code 12	CPT 12	$ 120.00	$ 26,400.00	$ 120.00	$ 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%

Example Only

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			28	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			190	Rev Code 12	CPT 12	$ 120.00	$ 22,800.00	$ 120.00	$ 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%

Example Only

Charge Increase Worksheet.xls

Failure to furnish timely charge master changes may result in delays to agreed-upon reimbursement adjustments. Notice of charge master changes should be mailed to Provider Contracting at the address found on our Quick Reference Guide.

OUTPATIENT PROCEDURE SERVICES

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 Ambulatory Payment Classification (APC) program and other applicable Medicare programs; however, the payment methodology is based on the existing Louisiana Blue outpatient methodology.

Outpatient Procedure Services include most services contained within the surgery section of CPT code book as well as significant procedures defined in the Medicine Section such as cardiac catheterizations.

Louisiana Blue edits the hospital's outpatient coding upon claims submission for accuracy and internal consistency. Such editing may require Louisiana Blue 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 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 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 eligible charge or the appropriate discounted Outpatient Procedures Reimbursement Schedule amount. If multiple procedures are performed, the primary procedure is reimbursed based on 100% of the discounted Outpatient Procedures Reimbursement Schedule amount and the secondary procedure(s) are reimbursed based on 50% of the discounted Outpatient Procedures Reimbursement Schedule amount. Select procedures are exempt from the multiple procedure discount and will be reimbursed at 100% of the discounted Outpatient Procedures Reimbursement Schedule. The total reimbursement amount for the claim is the lesser of the eligible 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 eligible 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's 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 post-service 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 preoperative services should be included on the bill in conjunction with the procedure performed

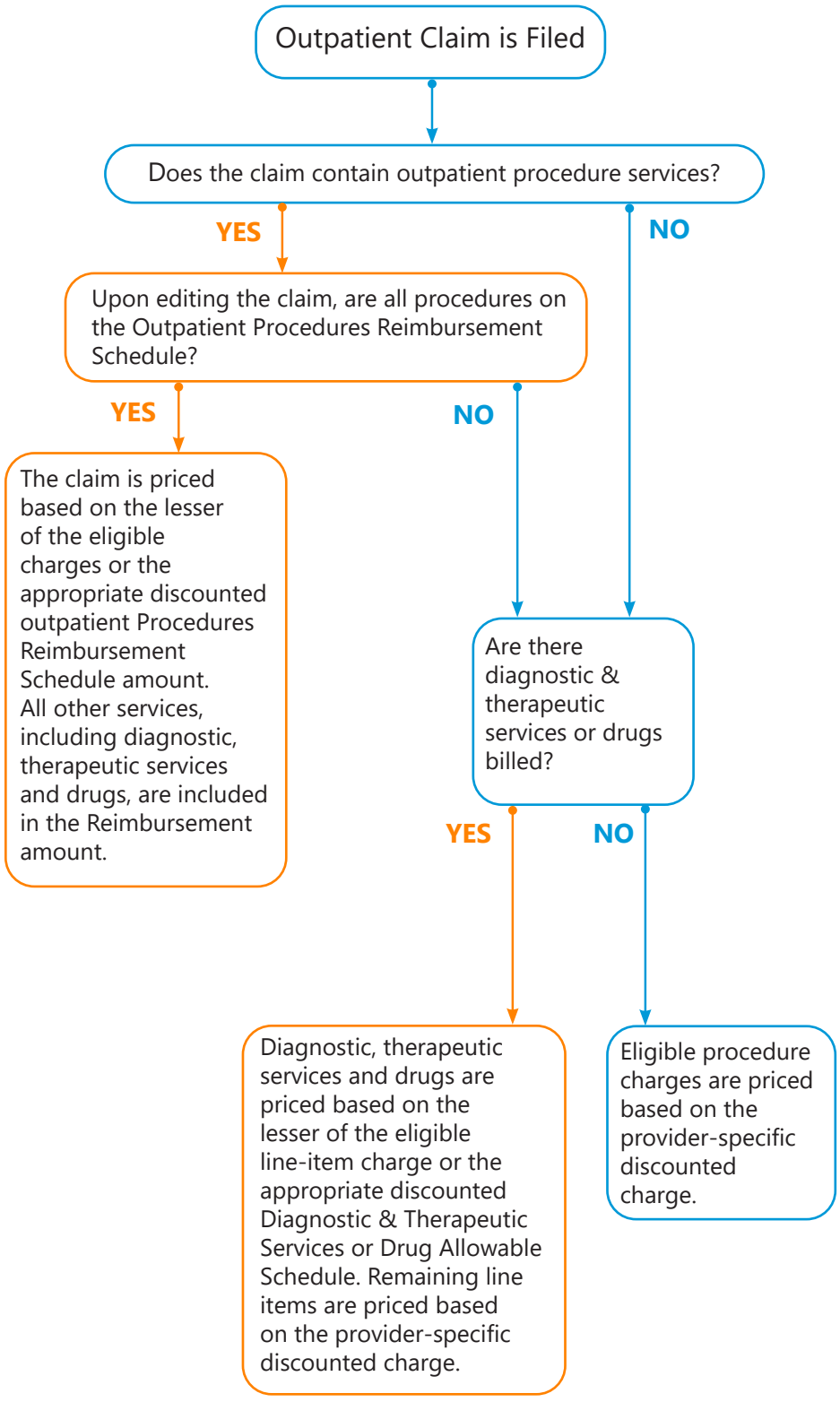
Outpatient Procedure Services do not include the following:

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

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.

PRICING FLOWCHART FOR OUTPATIENT ACUTE CARE REIMBURSEMENT



INPATIENT PAYMENT METHODOLOGY EXAMPLES

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)
Louisiana Blue Payment	$4,000

Member liability and the Louisiana Blue 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

Member Liability	($1,300)
Louisiana Blue Payment	$4,200

Member liability and the Louisiana Blue 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% 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)
Louisiana Blue Payment	$25,070

Member liability and the Louisiana Blue 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 Louisiana Blue 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)
Louisiana Blue Payment	$4,200

Member liability and the Louisiana Blue 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)
Louisiana Blue Payment	$4,200

Member liability and the Louisiana Blue 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 ($6,250 - $5,500).

Note: The per diem outlier provision does not apply to case rate reimbursement.

6) 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:

Louisiana Blue	$15,400**
Member	$ 600
Total	$16,000

This amount is calculated as follows: [(Billed Charges) - (Case Rate X 3)].55
**This amount is calculated as follows: [(Case Rate) + (Outlier)] - (Member Liability)

Member liability and the Louisiana Blue 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).

7) MS-DRG with Outlier and Post-acute Transfer Payment Example (if applicable per provider contract)

Given:

Base Rate	$8,500
DRG	218
Weights	MCARE2017
DRG Weight	5.6679
Length of Stay	3 days
GMLOS	5.4 days
Discharge Status	62
Billed Charges	$200,500
Outlier	3x / 30%

Allowable:

Base Allow = Base Rate X Weight = $8,500 X 5.6679 =	$48,177.15
Outlier Amount = (Billed Charges – 3 X Base Allow) X 30% =	$16,790.57
Base + Outlier =	$64,967.72
Transfer Adjustment = (Base + Outlier) X ((LOS + 1)/GMLOS) =	$64,967.72 X (4/5.4) = $48,124.24

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 (Louisiana Blue payment + member liability).

OUTPATIENT CODE UPDATES

Louisiana Blue may expand the Outpatient Procedures Reimbursement Schedule for new codes developed by the American Medical Association subsequent to the production of this manual.

NEW CODES

Louisiana Blue 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 the new code and similar codes in comparison to the provider's current allowable charges for these similar codes to develop a fair payment for the new service.

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 the medical director for final determination of allowable charges.

NOT SEPARATELY REIMBURSABLE CODES

Certain codes will deny because the services these represent are included in the reimbursement of other services. Also, Louisiana Blue does not reimburse separately for codes such as miscellaneous codes, 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 specifically outlined in a Louisiana Blue billing guideline. These services are not separately reimbursed and are not billable to our members because Louisiana Blue considers these services to be included in other services billed for that member.

INVALID PROCEDURE CODES

Louisiana Blue may determine that certain CPT/HCPCS codes are not valid for submission and may choose to require a different code to be billed to represent those services (e.g., 97140 should be used for dry needling instead of 20560 or 20561).

Unless Louisiana Blue gives specific written billing instructions to use the following codes, they are considered invalid for Louisiana Blue purposes.

- HCPCS codes when an equivalent or similar CPT code exists describing the same service or procedure (e.g., CPT drug screen codes 80320-80377 should be billed instead of HCPCS codes G0480-G0483).
- Medicaid codes T1000-T9999
- C1000-C9999 for providers other than hospitals and ambulatory surgical centers.

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 they will be reimbursed at 100% of the reimbursement amount.

32553	38207	38243	62369	0512T
33276	38208	38999	62370	0686T
36440	38209	43755	67028	0888T
36450	38210	49411	91020	C1726
36455	38211	50686	91030	C9728
36456	38212	51101	91132	C9780
36460	38213	51703	91299	C9792
36511	38214	51784	92242	G0277
36512	38215	53660	92950	G0563
36513	38228	54240	92960	
36514	38230	55876	92961	
36516	38232	62252	0263T	
36522	38241	62367	0264T	
38206	38242	62368	0265T	

Note: This list is subject to change as medical codes are updated and deleted.

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 Louisiana Blue 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 glycemic control
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures
- Latrogenic pneumothorax with venous catheterization
- Surgical site infection following cardiac implantable electronic device (CIED)

Note: The conditions listed above are consistent with the U.S. Centers for Medicare & Medicaid Services' (CMS) 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

Note: The events above are consistent with CMS' 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.

Note*: 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 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.

Louisiana Blue 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 our Chief Medical Officer within 30 days of the occurrence.

Please DO NOT report Never Events 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 principal 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.

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, the hospital must immediately notify Louisiana Blue and shall refund any payment received within 30 days of discovery or receipt of payment.

If Louisiana Blue 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, Louisiana Blue 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.

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

Note: 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.

NONPARTICIPATING 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 nonparticipating 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 Plan issuing the member certificate.

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, durable medical equipment (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 facility 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 Louisiana Blue 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 inpatient, the Member Provider should bill Louisiana Blue for that service. The other facility should not bill Louisiana Blue separately for the services rendered.

For example, a member, who is an inpatient at ABC Hospital, needs hyperbaric oxygen therapy, but ABC Hospital does not have the necessary equipment. Therefore, ABC Hospital sends the member to XYZ Hospital. Once the procedure is completed, the member returns to ABC Hospital. In this case, ABC Hospital should bill Louisiana Blue for the hyperbaric oxygen therapy. XYZ Hospital should not bill Louisiana Blue or the member.

At least annually, Member Providers should furnish Louisiana Blue 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.

OBSERVATION

Louisiana Blue reimburses charges for outpatient procedure services rendered to a member classified by the facility as observation status according to the Member Provider Agreement Reimbursement Appendix. The CPT/HCPCS procedure code range available in this manual defines outpatient procedure services. Louisiana Blue reimburses charges for outpatient services in which an outpatient procedure was NOT performed on a member classified by the facility as observation status according to the lesser of:

1. The Member Provider Agreement Reimbursement Appendix for Outpatient Services, which limits the payment for observation services to a maximum of 48 hours of observation. Claims are system reviewed and adjusted as needed. Or;
2. The contracted inpatient reimbursement (the facility must follow inpatient billing guidelines).

The hour count commences when outpatient services begin, which is when the member arrives at the facility for treatment, not when the observation status begins.

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

Observation Stay Medical Policy Reviews

Louisiana Blue will review services provided during an observation stay against applicable medical policies prior to claims payment. Services that are not medically necessary or investigational will not be reimbursed, and these services are not billable to the member.

Observation stays do not require prior authorization. Providers are encouraged to request a pre-determination review of medical policy services that will be performed during an observation stay prior to the service(s) being rendered. To initiate a request, access the Louisiana Blue Authorizations tool through iLinkBlue (www.lablue.com/ilinkblue) under the "Authorizations" menu option.

Carelon Medical Benefits Management (Carelon) reviews a subset of Louisiana Blue medical policies, but not in the observation setting. If Carelon reviews and denies a service related to medical policy in a setting other than observation, Louisiana Blue will not reimburse the same service even though performed in the observation setting. If your original plan of care includes services with applicable medical policy and criteria that are now planned for the observation setting, contact Louisiana Blue directly.

If you would like to review specific medical policy coverage guidelines, access our medical policy index on iLinkBlue (www.lablue.com/ilinkblue) under the "Authorizations" section. Policies are listed in alpha order or you may search by keyword, procedure code, policy name or policy number.

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 in this section. 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 48 hours or longer will be reimbursed according to the observation guidelines listed above.

Emergency room visit(s) on the same day with a subsequent admission for a clinically associated diagnosis should be filed with the inpatient hospital claim. Multiple emergency room visits on the same day billed on the same claim will be reviewed for validity.

Admissions Through the Emergency Room/Observations

When a patient is in observation status or in the emergency room affiliated with the acute care facility and is subsequently admitted to the affiliated acute facility, the observation and/or emergency room record should become part of the affiliated acute facility admission record and the associated charges should be included when billing the inpatient claim. This is the case for one or multiple emergency room visits in the same day or across two days.

Thus, if there is a subsequent inpatient admission, the emergency room visit(s) and/or observation should be filed with the inpatient hospital claim and will be included in the inpatient stay. The statement covered period indicated on the UB-04 claim form should reflect the "from" date when the services were first provided, rather than the date when the patient was admitted in the acute facility. The admission date should reflect the date when the patient was admitted in the acute facility. 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.

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 Louisiana Blue. Louisiana Blue will use the contracted rate, the payment processing methodology and other provisions in effect at the time of the patient admission as the basis for payment. 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.

Louisiana Blue allows the following codes for skilled nursing facility outpatient services. Skilled nursing facilities shall indemnify and hold harmless both Louisiana Blue and member(s) for any billed charges for CPT/HCPCS not listed herein.

92507	92611	97110	97163	97533
92508	92626	97112	97164	97535
92522	97014	97116	97165	97537
92523	97024	97140	97166	97542
92524	97032	97150	97167	97760
92526	97033	97161	97168	G0283
92610	97035	97162	97530	

PHYSICIAN REIMBURSEMENT

Reimbursement Amount/Allowable Charge

Louisiana Blue 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 Louisiana Blue, 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 Louisiana Blue 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. Louisiana Blue 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. 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 an independent contractor. These 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.

MEMBER COST SHARE

Deductibles, coinsurance and copayments are the member's cost share toward all services. As a participating provider, you have agreed to not waive these amounts. When the charge for an office visit is less than the member's cost share, providers should collect the actual charge. If you collect any amount above the copayment for covered services, you must refund the member the excess amount collected within 30 days of notification of the overpayment. Payments made by Louisiana Blue members should not incur credit card access or convenience fees.