Helpful Tips: Avalon - Lab Management Program for BCBSOK Members

Effective November 1, 2022, BCBSOK implemented a program with Avalon Healthcare Solutions for claims for certain outpatient laboratory services provided to many of our commercial members in Oklahoma. The information below is intended to help answer provider questions and provide additional details around this program.

The program helps reduce over-testing, lower cost variability, and drive high quality care, all of which are good for member health. Implementation of the Lab Benefit Management Program supports a value-driven approach to outpatient laboratory services as part of a broader, ongoing commitment to drive accessible, quality, affordable care for our members.

Key points:

Prior to ordering or performing a laboratory service, providers should review our Lab Benefit Management Program Clinical Payment and Coding Policies (CPCPs) to determine if any specific criteria apply to the test(s) ordered. These policies can be found at https://www.bcbsok.com/provider/standards/standards-requirements/cpcp/avalon.

New or revised BCBSOK clinical payment and coding policies (CPCPs) can be found on the BCBSOK website. These policies provide billing, coding, and documentation guidelines that you may find useful in your practice or facility. Please visit this site regularly to ensure you are up to date on any changes or new policies. These policies can be accessed on the *Clinical Payment and Coding Policies page* https://www.bcbsok.com/provider/standards/standards-requirements/cpcp/avalon of our website.

The Lab Benefit Management Program may include:
- Outpatient laboratory claims with dates of service beginning **November 1, 2022**
- Claims for services performed in an outpatient setting (typically office, hospital outpatient or independent laboratory)
- Any claims that meet criteria relevant to one or more of the Lab Benefit Management Program CPCPs

Provider resources:

Avalon Healthcare Solutions has developed a Trial Claim Advice Tool which allows providers to input the procedure codes and diagnoses to view a preliminary determination of how the claim may be reviewed. Responses consider information entered through the tool for the date of service entered and historical claims finalized through the previous business day. Claims not yet finalized won't be considered.
- The Trial Claim Advice Tool does not guarantee approval, coverage, or reimbursement of services.
- Responses consider information entered through the tool for the date of service entered and historical claims finalized through the previous business day.

How to access the Tool:
- To access the Trial Claim Advice Tool, log on to Availity® Essentials.
- To get to the Trial Claim Advice Tool, use the single sign-on feature via the BCBS-branded Payer Spaces section within the Availity portal.
- If you're not a registered Availity user, register on the Availity website at no charge. For registration help, call Availity Client Services at 800-282-4548.

Frequently Asked Questions

1. What is the Avalon - Lab Benefit Management Program?

Avalon Healthcare Solutions is a comprehensive laboratory benefits manager that has helped payers, physicians, and consumers across 15 states with more than 45 million insureds since 2016 optimize the use of diagnostic laboratory tests. The Lab Benefit Management Program will help reduce over-testing, lower cost variability, and drive high quality care. Through the Lab Benefit Management Program, BCBSOK implemented payment related claim edits to identify claims that do not comply with the criteria contained within relevant Lab Benefit Management Program CPCPs.

2. How can providers access the Clinical Payment and Coding Policies?

Providers can access the CPCPs at the link below:
https://www.bcbsok.com/provider/standards/standards-requirements/cpcp/avalon

3. Which members are included in the Avalon - Lab Benefit Management Program?

At this time, BCBSOK fully insured, commercial and out of area (BlueCard) members as well as BCBSOK HMO membership are included in the Lab Benefit Management Program. Additional membership may be added in the future as we continue our focus on improving lab utilization.

4. What types of policy rules are in scope for the Avalon - Lab Benefit Management Program?

The Avalon - Lab Benefit Management Program review process includes, but is not limited to the following*:

- Mutually exclusive procedures.
- Unit limits on a single date of service (within and across claims).
- Unit limits over a period (e.g., 15 units permitted per 3 months).
- Frequency between procedures (e.g., minimum of 14 days between tests).
- Services not reimbursable with the diagnosis billed on the claim.

*Refer to the list of policies for further details

5. What places of service are included?

The Avalon - Laboratory Management Program will apply to the following outpatient places of service (POS):

- POS 11 (Physician Office)
- POS 19 (Off-Campus Outpatient Hospital)
- POS 22 (On-Campus Outpatient Hospital)*

*Note: Outpatient Hospital Laboratory Services billed on institutional claims with Bill Types 130 through 149 are treated as POS 22

- POS 81 (Independent Laboratory)

6. What type of claims apply?

All claims with laboratory and pathology services *except for ER/Inpatient/Observation claims* will be included in the Avalon - Lab Benefit Management Program. Refer to the list of CPCPs at the link below for further details. https://www.bcbsok.com/provider/standards/standards-requirements/cpcp/avalon

7. Is there a tool providers can use to understand the impact to a claim?

Avalon Healthcare Solutions has developed a Trial Claim Advice Tool which allows providers to input the procedure codes and diagnoses to view a preliminary determination of how the claim may be reviewed. Responses consider information entered through the Trial Claim Advice Tool for the date of service entered and historical claims finalized through the previous business day. Claims not yet finalized won't be considered.

How it works:

The Trial Claim Advice Tool simulates the claim edits, provides information on the decision types and descriptions, and will help providers familiarize themselves with the Lab Benefit Management Program. The Trial Claim Advice Tool considers information entered for the date of service, claims finalized through the prior business day, and applicable CPCPs to offer a simulation of the outcome of claims, using inputs that a provider would have when ordering a lab test, including:

- Subscriber ID
  - *when inputting subscriber ID, you must include a total of 15 characters, i.e. 3 character alpha-numeric prefix plus 12 digits for the ID #.*
    - *If the ID # is less than 12 digits, you will add zeros after the 3 character alpha-numeric prefix to equal 12 digits; example, member's card lists subscriber ID as YUP123456789; when inputting subscriber ID into the Tool, include 000 <u>after</u> the alpha-numeric prefix to make the ID # 12 digits; example YUP000123456789*
- Patient Date of birth (DOB)
- Procedure code
- Diagnosis code
- Date of service
- Number of units and,
- Provider's participation status

The Trial Claim Advice Tool cannot be used to obtain a guarantee of approval, coverage, or reimbursement. Providers are not required to use the Trial Claim Advice Tool before ordering a lab test. Rather, the Trial Claim Advice Tool is a helpful guide to providers that offers a simulation of claim adjudication. Becoming familiar with the Trial Claim Advice Tool will help providers mitigate some of the challenges they could experience through the Lab Benefit Management Program.

How to access the Tool:

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8. How can a provider know if a patient received a test from another provider within a frequency limitation? e.g. HBA1C

The best approach to understanding what test(s) your patient may have received is to ask your patient and/or collaborate care with your patient's other providers on their behalf. Also, accessing the Trial Claim Advice Tool referenced above can help identify potential claim outcomes as the Trial Claim Advice Tool considers information entered in the Tool for the date of service and historical claims finalized through the previous business day.

9. How can providers be aware of labs ordered by other providers?

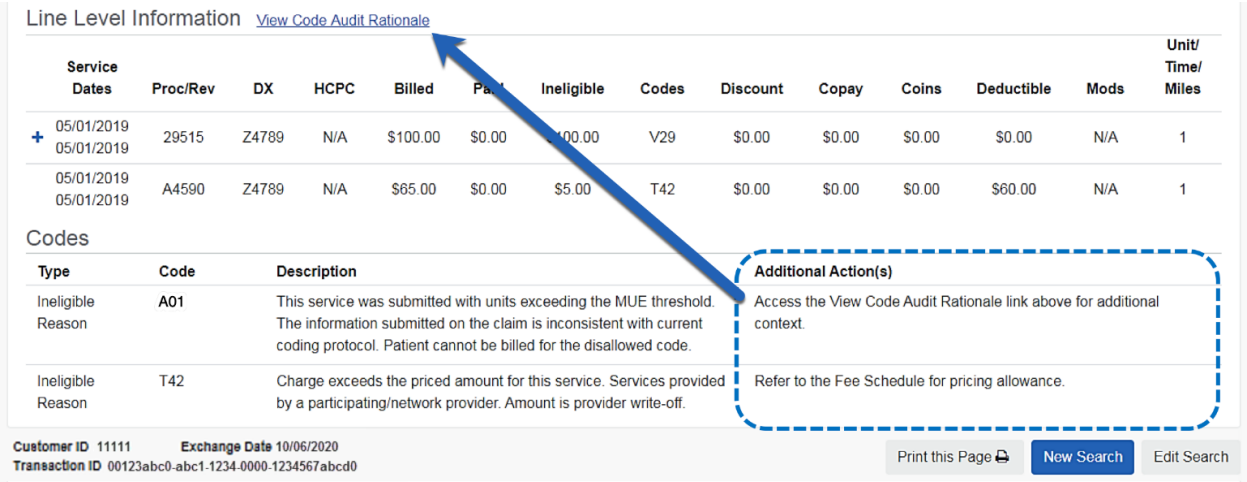
Potential claim outcomes provided by Avalon Healthcare Solutions' Trial Claim Advice Tool considers information entered in the tool for the date of service and historical claims finalized through the previous business day.

10. Will the Provider Claim Summaries (PCS)/Remittance Advice include the applicable denial message?

Yes. PCS/835 – Remittance Advice messages have been updated to reference the reason denial and applicable Clinical Payment and Coding Policy.

11. Where can I find more information regarding a claim denial?

Providers can use the Claim Status Tool for additional insight into the Code Audit Rationale and Description of the ineligible reasons codes provided on a claim. Please see the user guide link below for detailed instructions and ensure you click on the *View Code Audit Rationale* link.
https://www.bcbsok.com/docs/provider/ok/claims/status/claim-status-tool.pdf



12. Once I understand why a claim denied, what steps can I take if I disagree?

If a provider notices that certain billing patterns do not align with the Lab Benefit Management Program, the provider can use the Trial Claim Advice Tool to gain a better understanding of the application of CPCPs in those instances and adjust their billing practices accordingly.

Providers may submit a corrected claim to address errors that result in non-payment. Please see the link below for more information on submitting corrected claims.
https://www.bcbsok.com/docs/provider/ok/claims/tips/submitting-replacement-corrected-claims-ok.pdf

13. If a claim edit results in a denial, can the member be billed?

The BCBSOK provider agreement sets forth the circumstances under which a provider may bill a member. BCBSOK encourages providers to review and understand the CPCP criteria. It's BCBSOK's position that members should not be required to compensate providers for testing that does not meet our reimbursement criteria as outlined in the referenced Avalon - Lab Benefit Management Program CPCPs. Email provider inquiries or call the Provider Contract Support Unit at 1-800-722-3730, Option 2, for information regarding your provider agreement. Your inquiry will be routed to a professional provider representative.

14. What if the test performed is eligible according to the Avalon - Lab Benefit Management Program CPCP policy?

If you have already reviewed the policy to confirm the test billed is eligible for reimbursement according to the criteria outlined in the policy, then you should carefully review the information submitted on the claim for accuracy. Claim processing is dependent on the accuracy of the information (i.e. diagnosis code, procedure code, place of service, units, etc.) submitted on the claim. If there was incorrect information submitted on the claim, then you may file a **corrected** claim for reconsideration. Corrected claims must be filed using the appropriate claim frequency code to avoid a duplicate denial. It is the responsibility of the provider to ensure the medical record documentation supports all coding submitted on the claim. Please see the link below for more information on submitting corrected claims.
https://www.bcbsok.com/docs/provider/ok/claims/tips/submitting-replacement-corrected-claims-ok.pdf

15. Will the Avalon - Lab Benefit Management Program result in a significant increase in denials?

The Avalon - Lab Benefit Management Program aims to reduce non-reimbursable testing through provider coding and education. This should lead to testing and ordering that is appropriate, and, subsequently minimize denials where possible. The CPCPs are based on criteria developed by specialized professional societies and national guidelines including the CMS Provider Reimbursement Manual. The CPCPs and claim edits also align with American Medical Association (AMA) Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) or Current (HCPCS) coding and ICD-10 diagnosis coding guidelines, other laboratory and pathology coding guidelines, National Committee for Quality Assurance (NCQA) standards, and federal and state mandated benefits, offers, and coverages. As such, the Lab Benefit Management Program does not require providers to fundamentally change the way they order lab tests.

16. Will the Avalon - Lab Benefit Management Program increase the provider's administrative burden?

No, BCBSOK does not anticipate an increase in administrative burden for our providers. The Lab Benefit Management Program does not require providers to change the way they order lab tests, as it aligns with AMA CPT and HCPCS coding and ICD-10 diagnosis coding guidelines, other laboratory and pathology coding guidelines, NCQA standards, and federal and state mandated benefits. The Avalon - Lab Benefit Management Program edits use information submitted on the provider's claim. The rationale for denial(s) are included on the Provider Claim Summary (PCS)/Remittance Advice. The PCS/835 – Remittance Advice messages are displayed in Availity's Claim Status Tool under the *View Code Audit Rationale* link.