BlueCross BlueShield of Oklahoma

Reminder - New Laboratory Management Program for BCBSOK Members effective November 1, 2022

Summary

Effective November 1, 2022, Blue Cross and Blue Shield implemented its new program with Avalon Health 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 detail around this program.

The new program will:

- Help our members access the right care at the right time and in the right setting
- Better prepare you to submit claims for covered services reflecting quality, affordable care delivery to our members

See below for **key points and provider resources** to help you prepare.

Policy Updates- What you need to know.

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

Affected Claims

Our new 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 policies referenced in this document

Frequently Asked Questions

Overview

1. Who is Avalon?

Avalon Healthcare Solutions is the industry leading comprehensive laboratory benefits manager (LBM) helping payers, providers and consumers optimize the cost-effective use of diagnostic laboratory tests. We are working with Avalon to offer a suite of laboratory management services. Our goals are to:

- Increase access, quality, and affordability of lab care.
- Enable providers to navigate policy adherence with claim simulation tools.
- Enhance the patient healthcare experience.

Through this working relationship, the plan will have the ability to help members get the right test at the right time in the right setting.

2. What is the benefit of the new Laboratory Management program?

We are implementing this program with new Clinical Payment and Coding Policies (CPCPs). Through this arrangement we will have the ability to help members get the right test at the right time.

Our Laboratory Management Program promotes testing consistent with industry guidelines, which helps to drive quality and cost-effective medical care for our members.

Policy Administration

3. Where can I access the new policies?

You can access our new and revised Clinical Payment and Coding Policies (CPCPs) for BCBSOK at the link below:

- OKLAHOMA - BCBSOK Clinical Reimbursement Policies effective Nov. 1, 2022.

4. What types of policy rules are in scope for the Laboratory Management Program?

The Laboratory 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

Routine Testing Management Questions

5. Is there a tool available to understand the impacts to a claim?

Avalon 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, we encourage you to sign up before the November 2022 program activation in order to gain access to the Trial Claim Advice Tool*. Register on the Availity website today, at no charge. For registration help, call Availity Client Services at 800-282-4548.

6. How is a provider supposed to know if a patient received a test from another provider within a frequency limitation? E.G. HbA1c

The best approach would be to ask the patient and/or collaborate care with other providers on the member's behalf. Also, potential claim outcomes provided by Avalon's Trial Claim Advice Tool consider information entered in the tool for the date of service, claims finalized through the prior business day.

7. What places of service are included?

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

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)

8. What type of claims apply?

All claims with laboratory and pathology services, except for ER/Inpatient/Observation claims. Refer to the list of policies for further details.

9. Which members are impacted?

Primarily our fully insured, commercial and out of area (Bluecard) members of BCBSOK as well as HMO membership for BCBSOK. We will likely add on additional membership over time as we continue our focus on improving lab utilization.

10. Will Blue Cross and Blue Shield provide the language for Provider Claim Summaries (PCS)/remittance Advice?

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

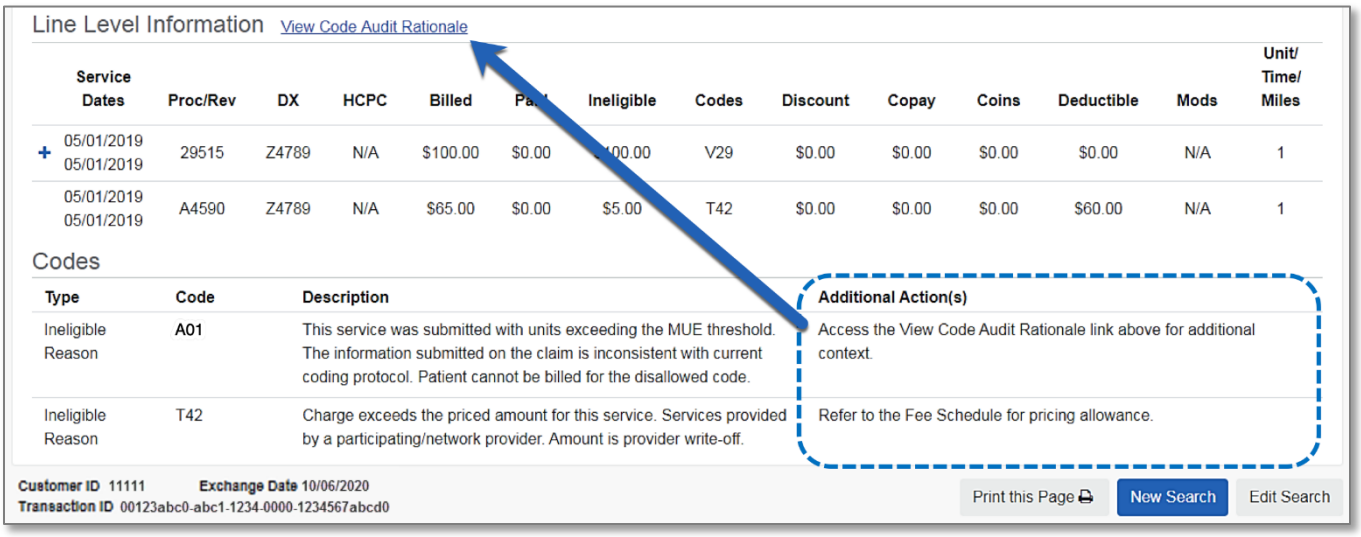
11. Will providers have awareness of labs ordered by other providers?

Potential claim outcomes provided by Avalon's Trial Claim Advice Tool consider information entered in the tool for the date of service, claims finalized through the prior business day.

12. Where can I find more information on why my claim denied?

Providers can use the Claim Status Plus 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 View Code Audit Rationale link.

Claim Status Tool User Guide



13. What do I do if my claim is denied, but the test performed is covered, according to the Laboratory Benefit Management Program CPCP policy?

If you have already reviewed the policy to confirm the test billed is eligible for reimbursement according to the coverage 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 should 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.

Submitting Replacement Corrected Claims