BlueCross BlueShield of Montana

Avalon Trial Claim Advice Tool – Lab Benefit Management Program for Members

Frequently Asked Questions

1. What is the Avalon Lab Benefit Management program?

Avalon Healthcare Solutions is an industry leading comprehensive laboratory benefits manager helping payers, providers, and consumers optimize the cost-effective use of diagnostic laboratory tests. The LBM program helps reduce over-testing (including fraud, waste, and abuse), lowers cost variability, and drives high quality care. Through the LBM program, Blue Cross and Blue Shield of Montana implemented reimbursement related claim edits to identify claims that do not comply with the criteria contained within relevant Clinical Payment and Coding Lab Policies.

2. Where can I access these policies?

You can access the CPCPLABs for BCBSMT through Availity® Essentials.

3. What types of policy rules are in scope for the laboratory management program?

The LBM 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*

4. What is the Trial Claim Advice Tool?

The Trial Claim Advice Tool allows providers to input the procedure codes and diagnoses to view a preliminary determination of how a 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 included.

- The Trial Claim Advice Tool does not guarantee approval, coverage, or reimbursement of services.

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 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.

5. How will a provider 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 and historical claims finalized through the prior business day.

6. What places of service are included?

The LBM 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)

7. What claims are subject to the LBM program?

The LBM Program applies to outpatient laboratory services provided to our fully-insured commercial members. The LBM program does not apply to laboratory services provided in an emergency room, hospital observation, or hospital inpatient setting. At this time, the LBM program does not apply to government programs members. Refer to the applicable CPCPLABs for further details.

8. Which Members are impacted?

The LBM program applies to fully insured commercial and out of area (BlueCard®) members of BCBSMT. We will likely add on additional membership over time as we continue our focus on improving lab utilization.

9. Will BCBSMT provide the language for Provider Claim Summaries or Remittance Advice?

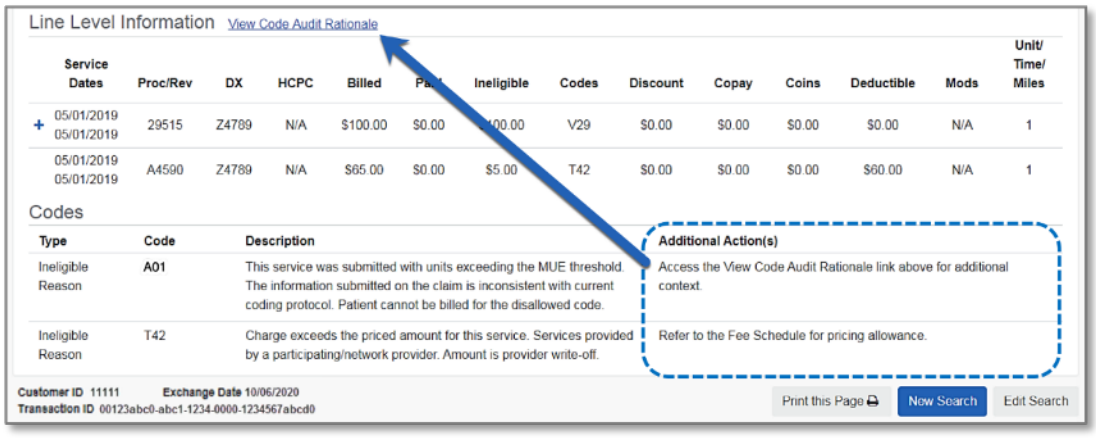
Yes. PCS/835 – Remittance Advice messages have been updated to reflect the reason and applicable CPCPLAB policy.

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

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

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

Providers can use the Claim Status Plus/Trial Claims Advice tool for additional insight into the Code Audit Rationale and Description of the ineligible reason codes provided on a claim. Please see Claim Status Tool User Guide for detailed instructions and ensure you click on View Code Audit Rationale link.



12. What do I do if my claim was denied but the test performed is covered according to the CPCPLAB policy?

If you have already reviewed the CPCPLAB 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 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.

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

The BCBSMT provider agreement sets forth the circumstances under which a provider may bill a member. BCBSMT encourages providers to review and understand the CPCPLAB criteria. Our members are not required to compensate any participating provider for a test that is unnecessary.

14. Will the LBM Program result in a significant increase in denials?

The Avalon - Lab Benefit Management Program aims to reduce unnecessary testing through provider correct coding and education. This should lead to testing and ordering that is appropriate and subsequently minimize denials where possible. The CPCPLABs are based on criteria developed by specialized professional societies and national guidelines including the CMS Provider Reimbursement Manual. The CPCPLAB policies and claim edits also align with American Medical Association Current Procedural Terminology and Healthcare Common Procedure Coding System or coding and ICD-10 diagnosis coding guidelines, other laboratory and pathology coding guidelines, National Committee for Quality Assurance 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.