Blue Cross and Blue Shield of Louisiana

FACILITY WORKSHOP

Fall 2023

Blue Cross and Blue Shield of Louisiana
HMO Louisiana

Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

To serve Louisianians as the statewide leader in offering access to affordable health care by improving quality, value and customer experience.

Welcome

Today we will review the following:

- ✓ Being in the Network
- ✓ Identifying Your Patients
- ✓ Verifying Your Patient's Benefits
- ✓ Authorizations
- ✓ Policies and Procedures
- ✓ Blue Distinction
- ✓ Billing Guidelines
- ✓ Claims
- ✓ iLinkBlue
- ✓ Medical Records
- ✓ Supporting Your Needs

BEING IN THE NETWORK

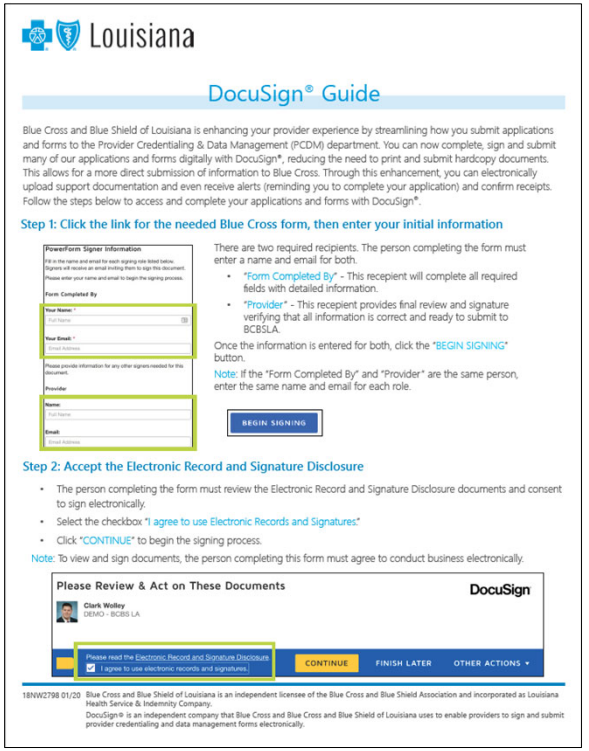
Credentialing

Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

Complete, sign and submit applications and forms to the Provider Credentialing & Data Management (PCDM) Department digitally with **DocuSign**.

It allows you to electronically upload support documentation and even receive reminder alerts to complete submission and confirm receipt.

What is DocuSign?
As an innovator in e-signature technology, DocuSign helps organizations connect and automate how various documents are prepared, signed and managed.



Louisiana

DocuSign® Guide

Blue Cross and Blue Shield of Louisiana is enhancing your provider experience by streamlining how you submit applications and forms to the Provider Credentialing & Data Management (PCDM) department. You can now complete, sign and submit many of our applications and forms digitally with DocuSign®, reducing the need to print and submit hardcopy documents. This allows for a more direct submission of information to Blue Cross. Through this enhancement, you can electronically upload support documentation and even receive alerts (reminding you to complete your application) and confirm receipts. Follow the steps below to access and complete your applications and forms with DocuSign®.

Step 1: Click the link for the needed Blue Cross form, then enter your initial information

There are two required recipients. The person completing the form must enter a name and email for both.

- "Form Completed By" - This recepient will complete all required fields with detailed information.
- "Provider" - This recepient provides final review and signature verifying that all information is correct and ready to submit to BCBSLA.

Once the information is entered for both, click the "BEGIN SIGNING" button.

Note: If the "Form Completed By" and "Provider" are the same person, enter the same name and email for each role.

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

- The person completing the form must review the Electronic Record and Signature Disclosure documents and consent to sign electronically.
- Select the checkbox "I agree to use Electronic Records and Signatures"
- Click "CONTINUE" to begin the signing process.

Note: To view and sign documents, the person completing this form must agree to conduct business electronically.

Please Review & Act on These Documents

DocuSign

Clark Wolley
DEMO - BCBS LA

Please read the Electronic Record and Signature Disclosure
I agree to use electronic records and signatures

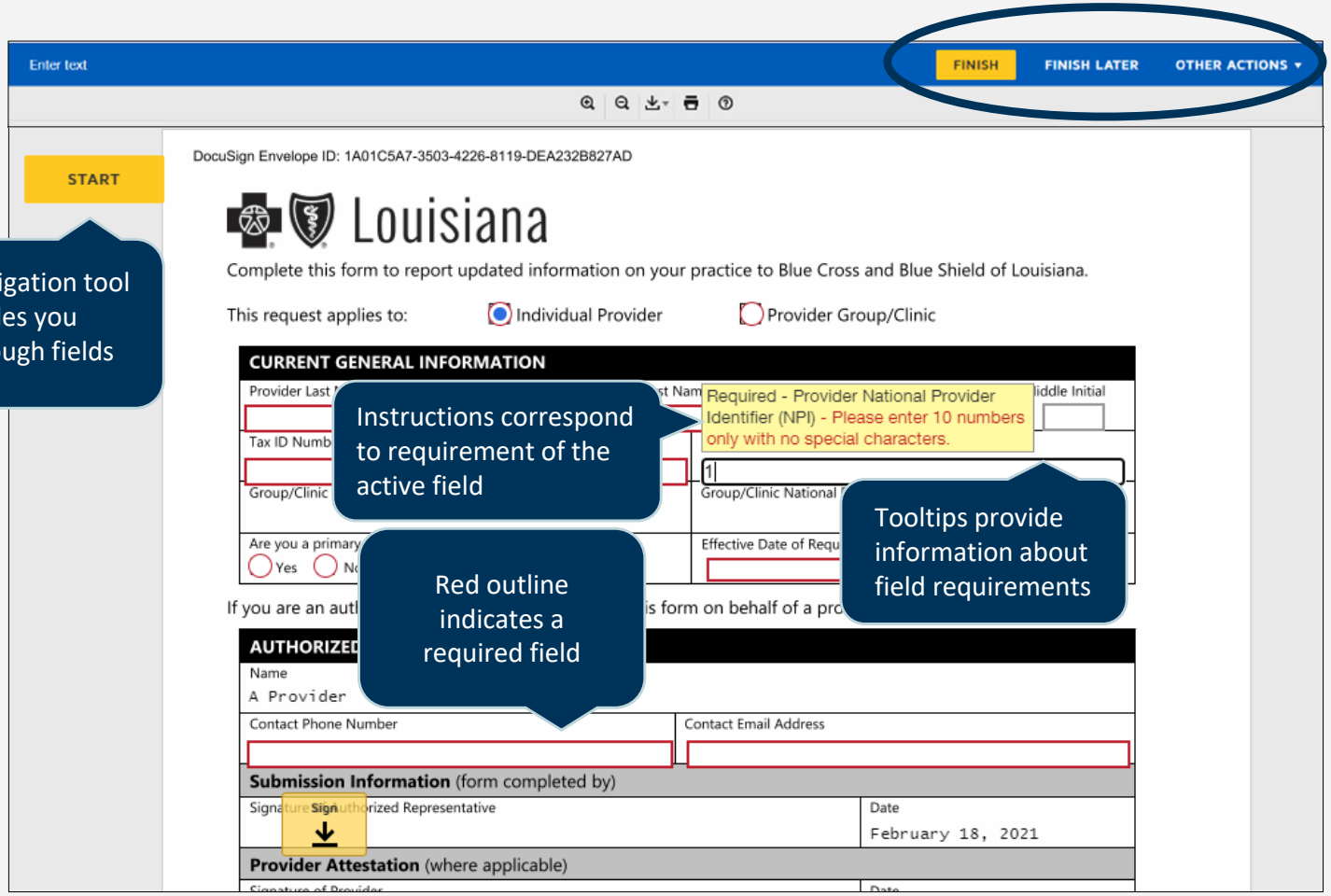
CONTINUE FINISH LATER OTHER ACTIONS

18NW2798 01/20 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

DocuSign® is an independent company that Blue Cross and Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

A DocuSign guide is available online at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals, then look under the "Join Our Networks" tab.

Easily Complete Forms with DocuSign



Find our *DocuSign Guide* at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Join Our Networks.

Credentialing Process

Since 1996, we have been dedicated to fully credentialing providers who apply for network participation.

- Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC).
- To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Blue Cross Blue Shield Association.
- Providers will remain non-participating in our networks until a signed agreement is received by our contracting department.
- The credentialing committee approves credentialing twice per month.

Inquire about your initial credentialing status by contacting our Provider Credentialing & Data Management (PCDM) Department at **PCDMstatus@bcbsla.com**.

Facility Network Availability

The following facility types must meet certain criteria to participate in our networks:

- Ambulance Service
- Ambulatory Surgical Center
- Birthing Centers
- Cardiac Cath Lab (Outpatient)
- Diagnostic Services
- Dialysis Facility
- DME Supplier
- Emergency Medicine Physician Groups
- Home Health Agency
- Home Infusion
- Hospice
- Hospitals
- IOP/PHP Psych/CDU
- Laboratory
- Lithotripsy/Orthotripsy
- Nursing Home
- Radiation Center
- Residential Treatment
- Retail Health Clinic
- Skilled Nursing Facility
- Sleep Lab/Center
- Specialty Pharmacy
- Urgent Care Clinic

View the *Credentialing Criteria* for these facility types at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Credentialing Process.

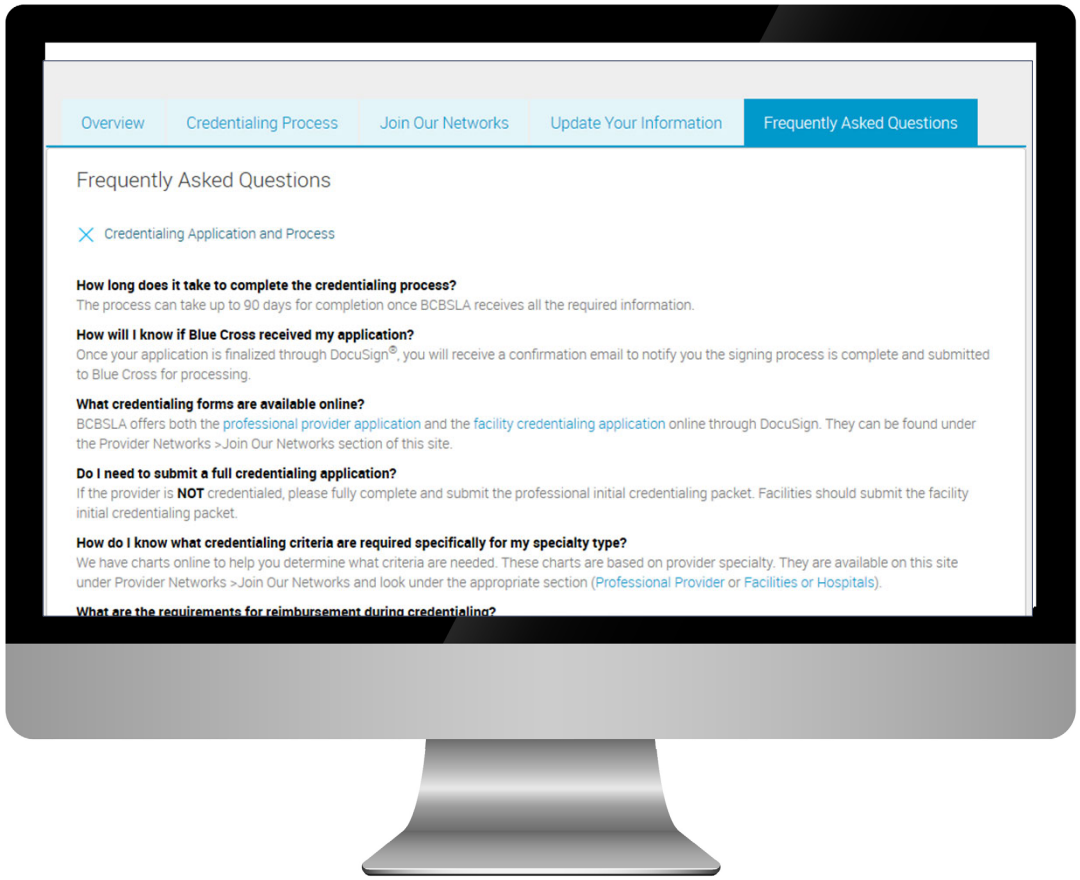
Hospital Based Providers

A hospital-based provider is defined as a provider that **only** sees patients as a result of their being admitted or directed to the hospital.

- The classification as a hospital-based provider applies for the hospital location only and NOT for any other practice locations outside the hospital.
- Hospital-based providers can be allowed to participate in our networks without credentialing requirements. We do not list those providers in the directory and allow the hospital's credentialing to stand.

A provider is **NOT considered hospital-based** if they have patients referred directly to them from another physician or organization or if the member can make an appointment with the physician.

Frequently Asked Questions



A list of FAQs is available at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Frequently Asked Questions.

Recredentialing

Blue Cross Recredentialing Process

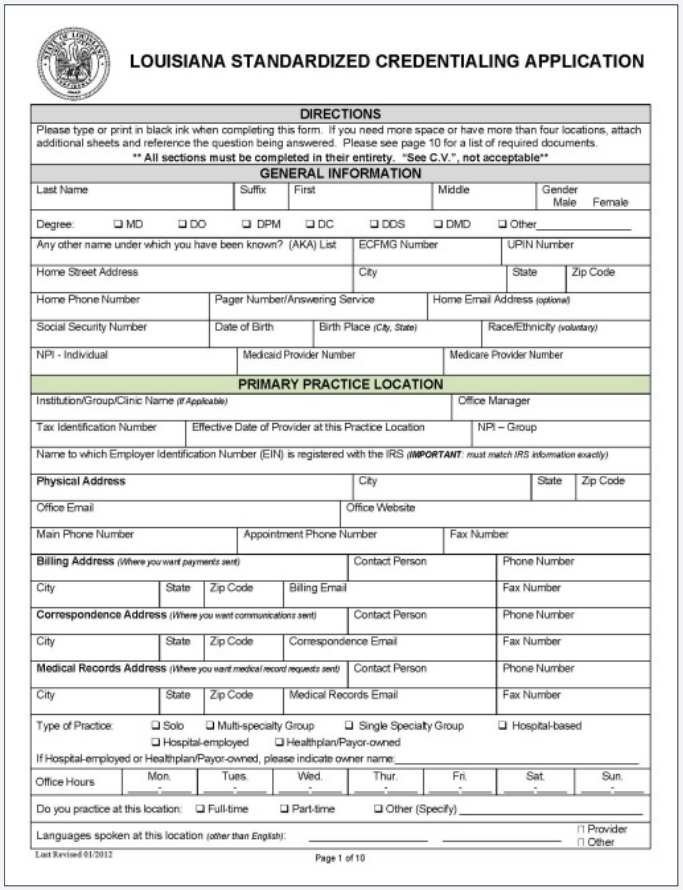
- Network providers must be approved through our **recredentialing** process **every three years** from the last credentialing acceptance date.
- Blue Cross is partnered with SymplrCVO to recredential our network providers.
- Blue Cross sends* recredentialing applications to providers approximately six months prior to the recredentialing due date.
- Instructions are included on how to return completed forms. SymplrCVO or Blue Cross will complete the verification process.
- The Credentialing Committee reviews all recredentialing applications.

**The provider's correspondence record information is used when sending recredentialing applications.*

If you have questions during the process, you may email **recredentialing@vhpla.com** or call (318) 807-4755.

Required Recredentialing Documents

The Louisiana Standardized Credentialing Application (LSCA) or the CAQH Application are accepted recredentialing documents.



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.

** All sections must be completed in their entirety. "See C.V.", not acceptable**

GENERAL INFORMATION

Last Name | Suffix | First | Middle | Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number

Home Street Address | City | State | Zip Code

Home Phone Number | Pager Number/Answering Service | Home Email Address (optional)

Social Security Number | Date of Birth | Birth Place (City, State) | Race/Ethnicity (voluntary)

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name (If Applicable) | Office Manager

Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

Billing Address (Where you want payments sent) | Contact Person | Phone Number

City | State | Zip Code | Billing Email | Fax Number

Correspondence Address (Where you want communications sent) | Contact Person | Phone Number

City | State | Zip Code | Correspondence Email | Fax Number

Medical Records Address (Where you want medical record requests sent) | Contact Person | Phone Number

City | State | Zip Code | Medical Records Email | Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

Office Hours | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun.

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location (other than English): _____ _____ ❑ Provider ❑ Other

Last Revised 01/2012

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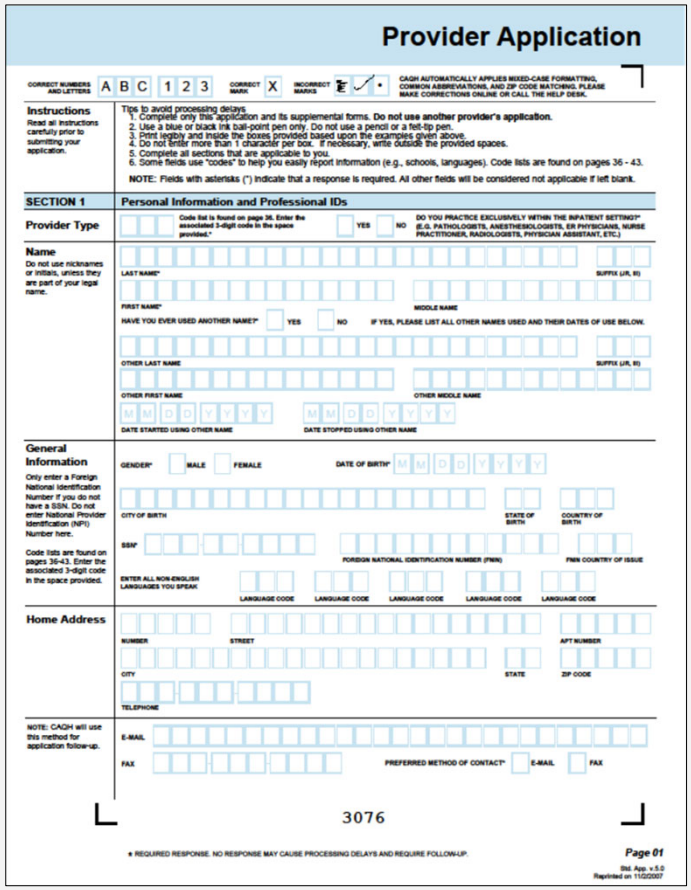


Provider Application

CORRECT NUMBERS AND LETTERS A B C 1 2 3 | CORRECT MARK X | INCORRECT MARKS | CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type — Code list is found on page 36. Enter the associated 3-digit code in the space provided.* | YES | NO | DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* | SUFFIX (JR, III)

FIRST NAME* | MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME | SUFFIX (JR, III)

OTHER FIRST NAME | OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (MMDDYYYY) | DATE STOPPED USING OTHER NAME (MMDDYYYY)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE | DATE OF BIRTH* (MMDDYYYY)

CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH

SSN* | FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) | FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK: LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address

NUMBER | STREET | APT NUMBER

CITY | STATE | ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX | PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 01

Std. App. v 5.0 Reprinted on 11/2007

Required Recredentialing Supporting Documentation for Facilities

The following documents must be submitted with your recredentialing application:

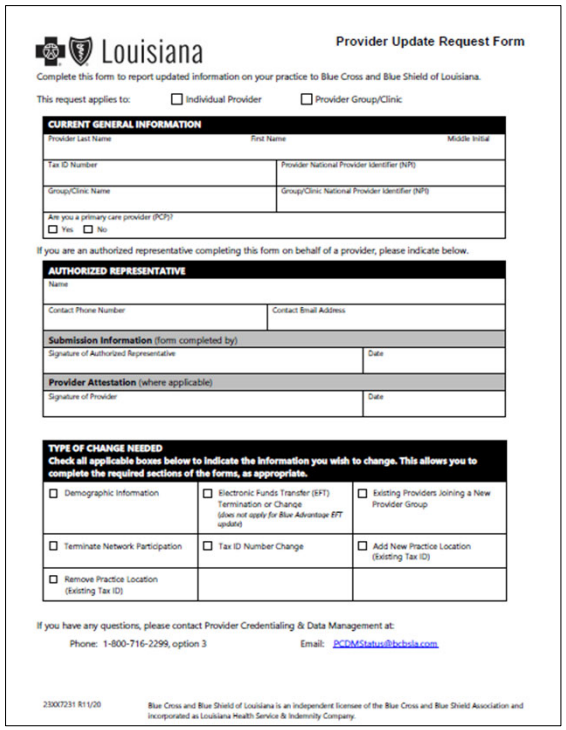
- Completed credentialing form
- Completed attachment(s), as applicable
- Copy of state license
- Copy of W-9
- Copy of Malpractice Liability Certificate (copy of policy declarations page)

If information is missing from submitted recredentialing application, the provider is then contacted by a recredentialing specialist with a deadline to return the needed information. If not received timely, then provider may be terminated from the network.

Data Management

How to Update Your Information

This allows us to keep our directories current, contact you when needed as well as disperse payments. These forms are in DocuSign format, allowing you to easily submit them to Blue Cross electronically.



Louisiana

Provider Update Request Form

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana.

This request applies to: ☐ Individual Provider ☐ Provider Group/Clinic

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Group/Clinic Name | Group/Clinic National Provider Identifier (NPI)

Are you a primary care provider (PCP)? ☐ Yes ☐ No

If you are an authorized representative completing this form on behalf of a provider, please indicate below.

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

Submission Information (form completed by)

Signature of Authorized Representative | Date

Provider Attestation (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.

☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change *(does not apply for Blue Advantage EFT update)*	☐ Existing Providers Joining a New Provider Group
☐ Terminate Network Participation	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

If you have any questions, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 3 Email: PCDMStatus@bcbsla.com

23007231 R11/20

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Provider Update Request Form – to update information such as:

- Demographic Information – for updating contact information
- Existing Providers Joining a New Provider Group – if you are joining an existing provider group or clinic or adding new providers to your group
- Add Practice Location – to add a practice location(s)
- Remove Practice Location – to remove a practice location(s)
- Tax Identification Number (TIN) Change – to change your Tax ID number
  - TIN changes require new contracts to be issued. Our contracting dept should be notified in advance of this change.
- Terminate Network Participation – to terminate existing network participation or an entire provider record
- EFT Term/Change Request – to change your electronic funds transfer (EFT) information or to cancel receiving payments via this method

Submit these forms online at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Update Your Information.

Provider Update Request Form

- Indicate on the Provider Request Form the type of change you are requesting.
- You will **only** need to fill out the section of this form that needs updating. Filling out the entire form is not required.

TYPE OF CHANGE **Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.**		
☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change (*does not apply for Blue Advantage EFT update*)	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

Provider Directory

Keeping your information up to date with us is extremely important to help our members find you.

We publish demographic information in our online provider directory. The directory is available on our website at **www.bcbsla.com**.

- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
- Information about telehealth services

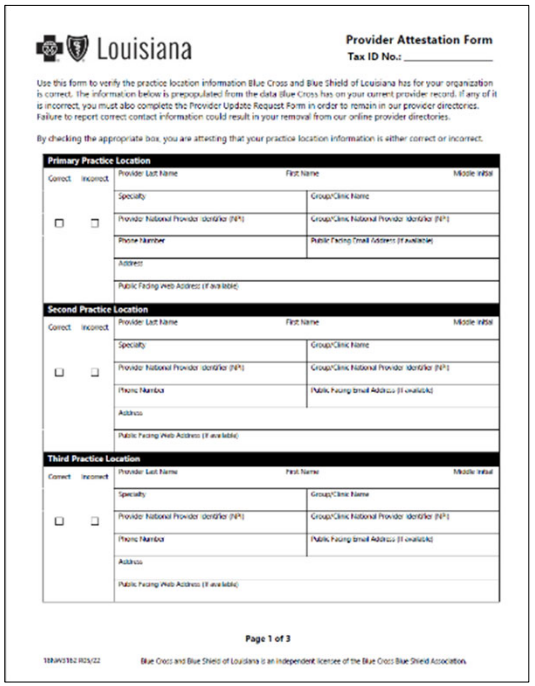
For professional providers to be listed in our directories, they must be available to schedule patients' appointments a **minimum of 8 hours per week** at the location listed.

It is the contractual responsibility of all participating providers keep their information current with Blue Cross. To report changes in your information, use the **Provider Update Request Form**. Our Provider Credentialing & Data Management Department will work with you to help ensure your information is current and accurate.

Provider Attestation Form

The Provider Attestation Form is prepopulated with the information we have on file. Providers must verify and attest to the accuracy of the information.

- In compliance with the federal Consolidated Appropriation Acts (CAA), our PCDM Department sends out a Provider Attestation Form every 90 days to all providers listed in our online provider directories. Providers must review their information as it appears in our directories and attest that it is still accurate.
- If any information is incorrect, you must complete and return our Provider Update Request Form. This allows us to update your published information in our directories. A link to the update form is included within the attestation form.



Louisiana

Provider Attestation Form

Tax ID No.: _____

Use this form to verify the practice location information Blue Cross and Blue Shield of Louisiana has for your organization is correct. The information below is prepopulated from the data Blue Cross has on your current provider record. If any of it is incorrect, you must also complete the Provider Update Request Form in order to remain in our provider directories. Failure to report correct contact information could result in your removal from our online provider directories.

By checking the appropriate box, you are attesting that your practice location information is either correct or incorrect.

Primary Practice Location

Correct | Incorrect | Provider Last Name | First Name | Middle Initial

Specialty | Group/Clinic Name

Provider National Provider Identifier (NPI) | Group/Clinic National Provider Identifier (NPI)

Phone Number | Public Facing Email Address (if available)

Address

Public Facing Web Address (if available)

Second Practice Location

Correct | Incorrect | Provider Last Name | First Name | Middle Initial

Specialty | Group/Clinic Name

Provider National Provider Identifier (NPI) | Group/Clinic National Provider Identifier (NPI)

Phone Number | Public Facing Email Address (if available)

Address

Public Facing Web Address (if available)

Third Practice Location

Correct | Incorrect | Provider Last Name | First Name | Middle Initial

Specialty | Group/Clinic Name

Provider National Provider Identifier (NPI) | Group/Clinic National Provider Identifier (NPI)

Phone Number | Public Facing Email Address (if available)

Address

Public Facing Web Address (if available)

Page 1 of 3

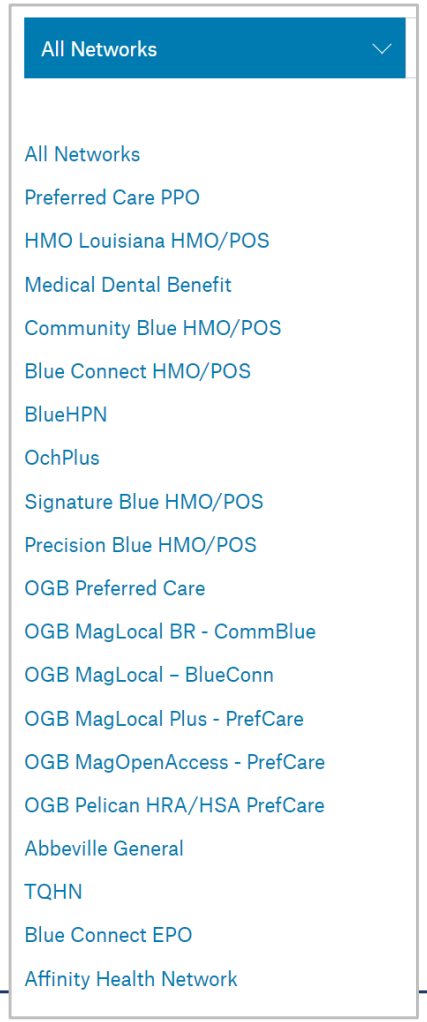
Blue Cross and Blue Shield of Louisiana is an Independent licensee of the Blue Cross Blue Shield Association.

Providers who do not complete and submit the attestation form will be removed from our online provider directories.

IDENTIFYING YOUR PATIENTS

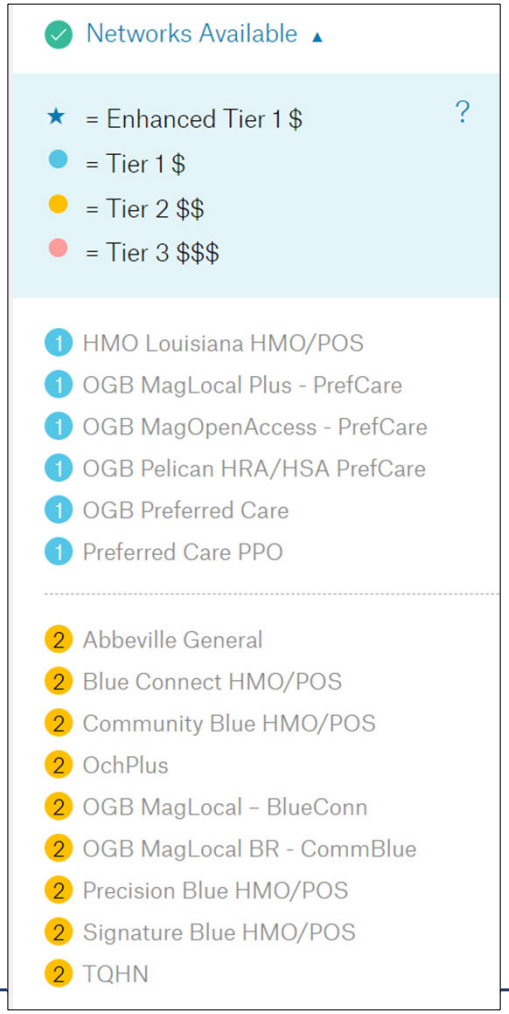
Knowing Your Networks

Blue Cross offers many networks. All providers do not participate in all networks. In order to maximize benefits for your patients, you need to know which networks you participate in. This information can be found online at **www.bcbsla.com** >Find a Doctor or Drug >Local Provider Directory.



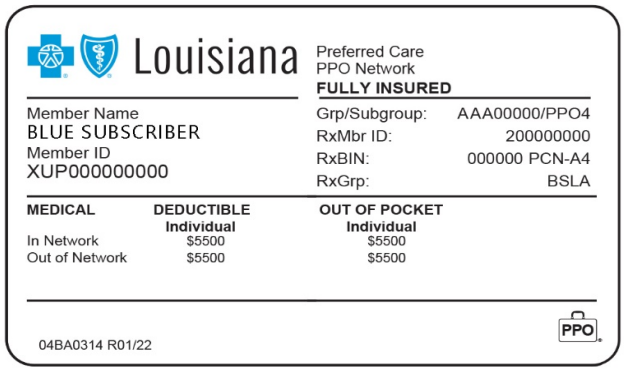
Some of our networks have tiered benefits.

Indicators are included in our online directories.



Preferred Care PPO

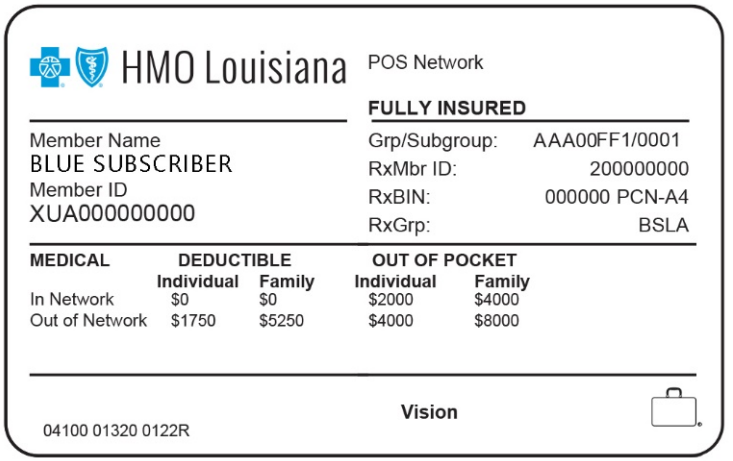
- Our Preferred Care PPO Network is available statewide.
- Members with PPO benefits receive the highest level of benefits when they receive services from PPO providers.



Louisiana

HMO, Louisiana Inc.

- Our HMO Louisiana, Inc. network is available statewide.
- HMO Louisiana members have one of two styles of benefits: HMO or HMO Point of Service (POS).
- HMO members receive **no benefits** while HMO POS members receive a **lower level** of benefits when using providers not in the HMO Louisiana Network.


HMO Louisiana POS Network

FULLY INSURED

Member Name
BLUE SUBSCRIBER
Member ID
XUA000000000

Grp/Subgroup: AAA00FF1/0001
RxMbr ID: 200000000
RxBIN: 000000 PCN-A4
RxGrp: BSLA

MEDICAL	DEDUCTIBLE		OUT OF POCKET	
	Individual	Family	Individual	Family
In Network	$0	$0	$2000	$4000
Out of Network	$1750	$5250	$4000	$8000

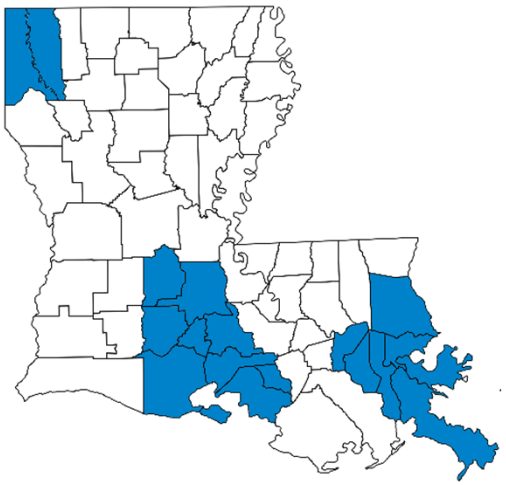
Vision

04100 01320 0122R

HMO Louisiana

Blue Connect

- **Prefixes XUF, XUG, XUU and XUV**
- Blue Connect is an HMO POS product currently available to groups and individuals residing in 17 parishes.
- Members may **not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Blue Connect Network.



New Orleans area

Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes

Lafayette area

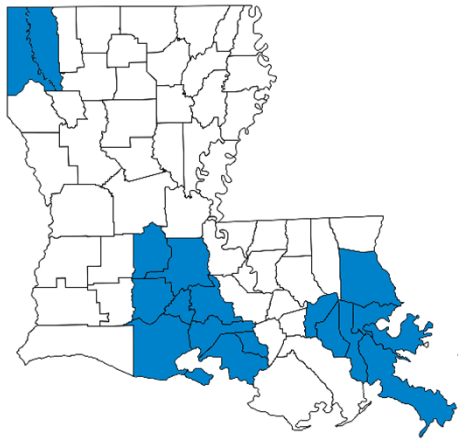
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

Shreveport area

Bossier and Caddo parishes

Blue High-Performance Network

BlueHPN is an HMO product currently available to groups and individuals residing in the following parishes:



Lafayette area

Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

New Orleans area

Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes

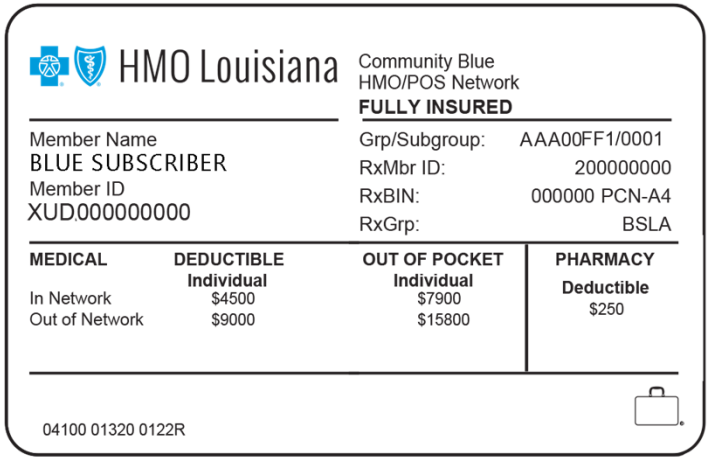
Shreveport area

Bossier and Caddo parishes

BlueHPN members are identifiable by the BlueHPN in a **suitcase logo** in the bottom right-hand corner of the card.

Community Blue

- **Prefixes XUD, XUJ and XUT**
- Community Blue is an HMO POS product currently available to groups and individuals residing in four parishes:

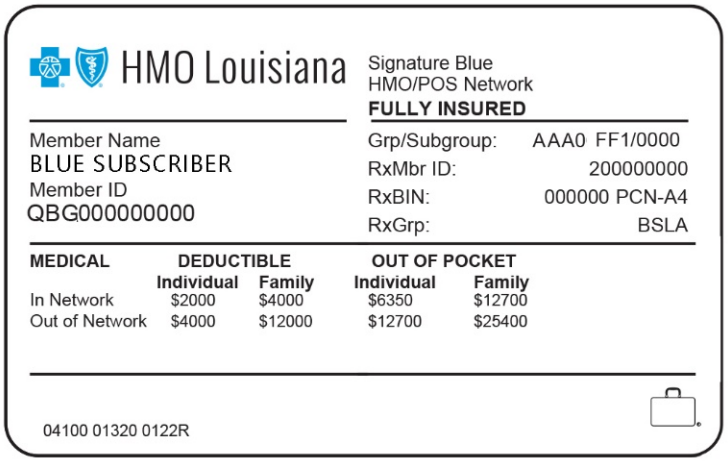


Baton Rouge area

Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Signature Blue

- **Prefixes QBB, QBE, QBG and QBS**
- Signature Blue is an HMO POS product that is available to groups and individuals residing in two parishes.



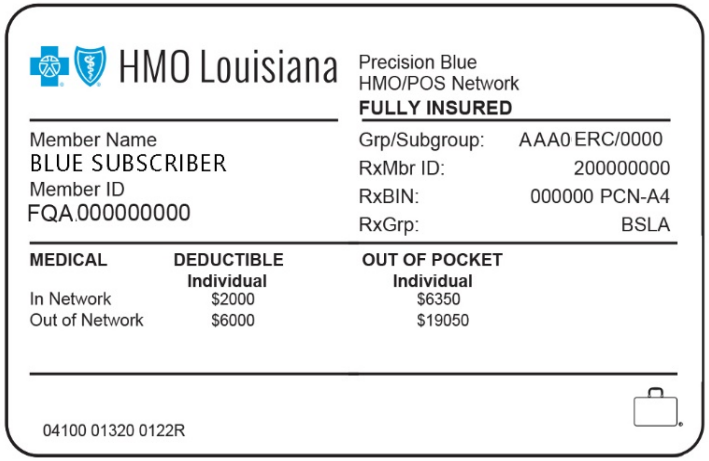
New Orleans area:

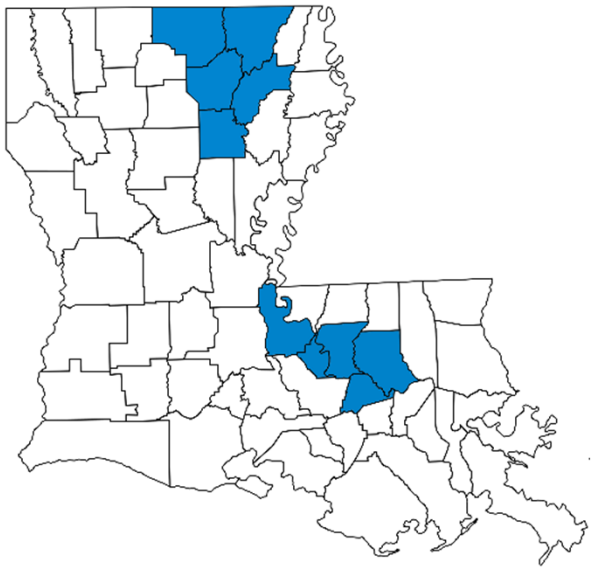
Jefferson and Orleans parishes

Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Signature Blue Network.

Precision Blue

- **Prefixes: FQA, FQT or FQW**
- Precision Blue is an HMO POS product currently available to groups and individuals residing in ten parishes.





Baton Rouge area

Ascension, East Baton Rouge, Livingston, Pointe Coupee and West Baton Rouge parishes

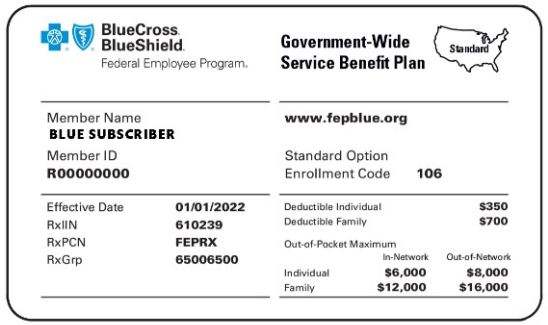
Greater Monroe/ West Monroe area

Caldwell, Morehouse, Ouachita, Richland and Union parishes

Federal Employee Program

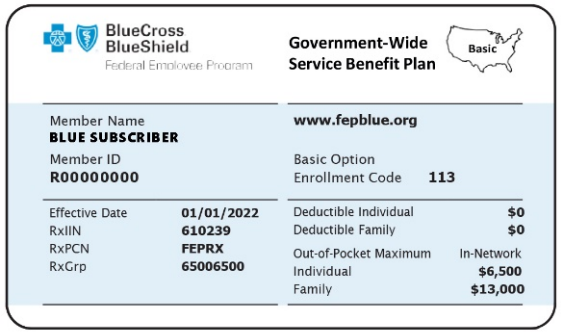
- **Prefix: R (followed by 8 digits)**
- The **Federal Employee Program (FEP)** provides benefits to federal employees and their dependents. These members use the Preferred Care PPO Network.
- FEP members have three benefit plan options:
  - Standard Option, Basic Option and FEP Blue Focus.

Standard



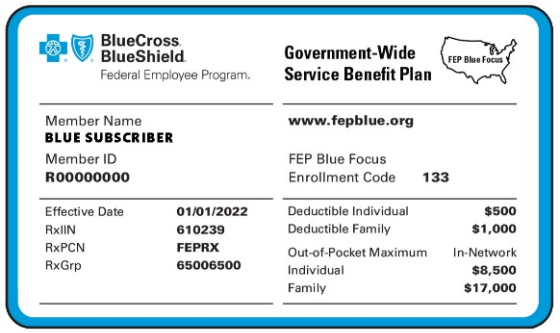
In-network benefits
Out-of-network benefits

Basic



In-network benefits
No out-of-network benefits

Blue Focus



Limited in-network benefits
No out-of-network benefits

Office of Group Benefits

Prefixes: OGS, LZB or LXS

Blue Cross administers benefits for Office of Group Benefits (OGB) state of Louisiana employees, retirees and dependents. There are five member-benefit plans currently available to OGB members:

Pelican HRA 1000 (Active Employees & Retirees with and without Medicare)

- Prefix: OGS
- Consumer-driven health plan with health reimbursement arrangement.
- Uses our OGB Preferred Care PPO provider network.

Pelican HRA 775 (Active Employees Only)

- Prefix: OGS
- Consumer-driven health plan with health savings account.
- Uses our OGB Preferred Care PPO provider network.

Magnolia Local (Active Employees & Retirees with and without Medicare)

- Uses our Blue Connect (prefix: LZB) or Community Blue (prefix: LXS) provider networks.
- HMO POS
- There are no benefits for services performed by out-of-network providers.

Magnolia Local Plus (Active Employees & Retirees with and without Medicare)

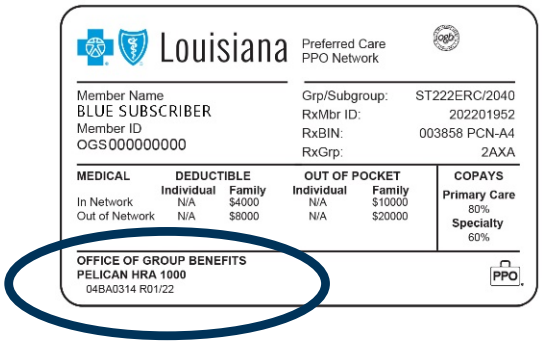
- Prefix: OGS
- HMO benefit design that uses our OGB Preferred Care PPO provider network.
- There are no benefits for services performed by out-of-network providers.

Magnolia Open Access (Active Employees & Retirees with and without Medicare)

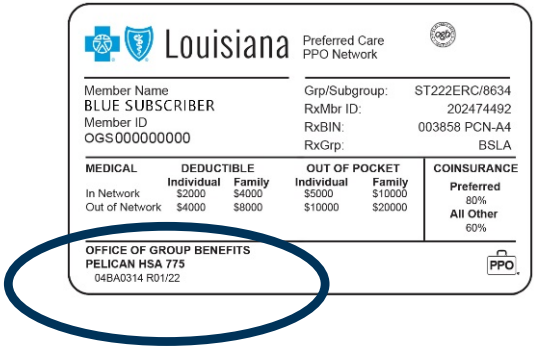
- Prefix: OGS
- PPO benefit plan
- Uses our OGB Preferred Care PPO provider network.

Sample OGB Member ID Cards

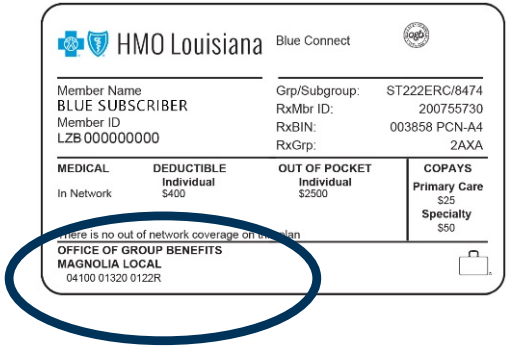
Pelican HRA 1000



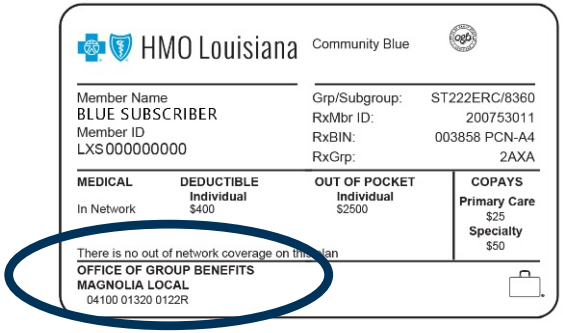
Pelican HRA 775



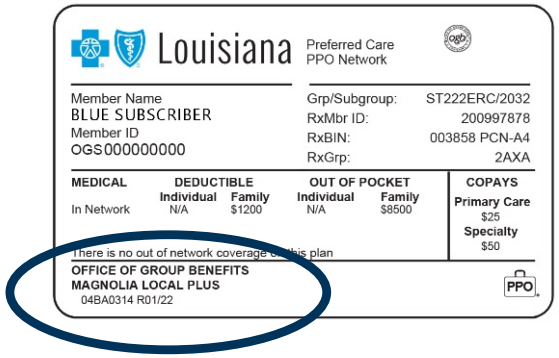
Magnolia Local Blue Connect



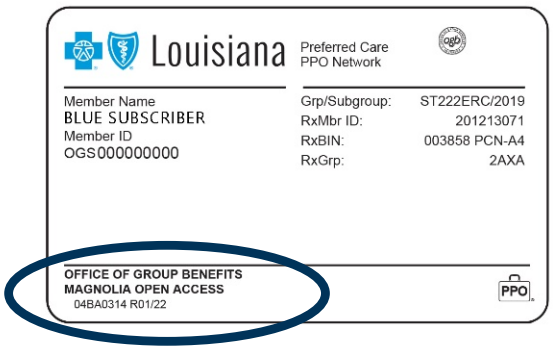
Magnolia Local Community Blue



Magnolia Local Plus



Magnolia Open Access



For more information about our OGB benefit plans as well as important plan requirements, view the *OGB Speed Guide*, available at **www.bcbsla.com/providers** >Resources >Speed Guides.

Blue Advantage Networks

- **Prefixes: PMV and MDV**
- Blue Advantage (HMO) and Blue Advantage (PPO) are our Medicare Advantage products currently available to Medicare-eligible members statewide.
- Blue Advantage HMO members **must use** Blue Advantage network providers except for select situations such as emergency care.
- Blue Advantage PPO allows members access to services provided by out of network providers however, cost sharing may be greater when covered services are obtained out of network.

BlueCard® Program

- BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan service area.
- The main identifiers for BlueCard members are the prefix and the "suitcase" logo on the member ID card. The suitcase logo provides the following information about the member:

- The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic.

- The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

- The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product.

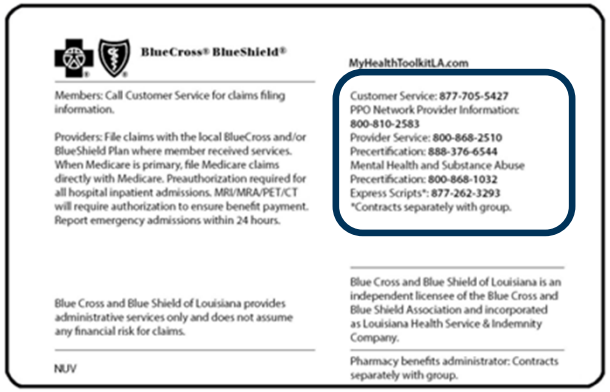
- The BlueHPN suitcase logo indicates the member is enrolled in a Blue High Performance Network$_{SM}$ (Blue HPN) product.

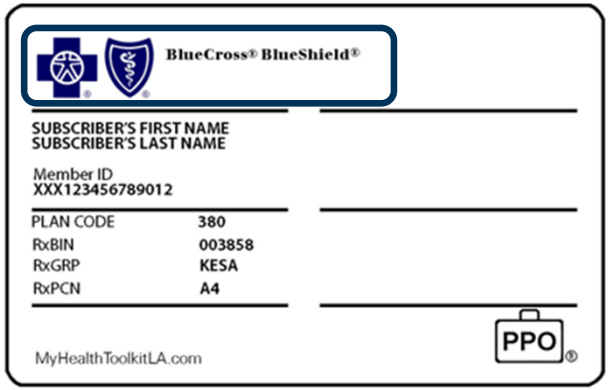
Note: BlueCard authorizations are handled through each member's home plan.

National Alliance

(South Carolina Partnership)

- National Alliance groups are administered through BCBSLA's partnership agreement with Blue Cross and Blue Shield of South Carolina (BCBSSC).
- Our taglines are present on the member ID cards; however, customer service, provider service and precertification are handled by BCBSSC.
- Claims are processed through the BlueCard program.



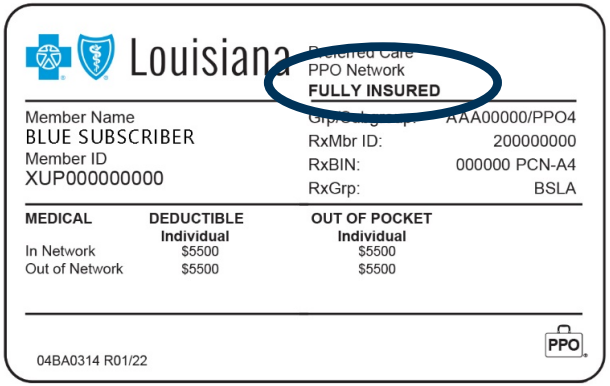


This list of prefixes is available on iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

Fully Insured vs. Self-funded

FULLY INSURED

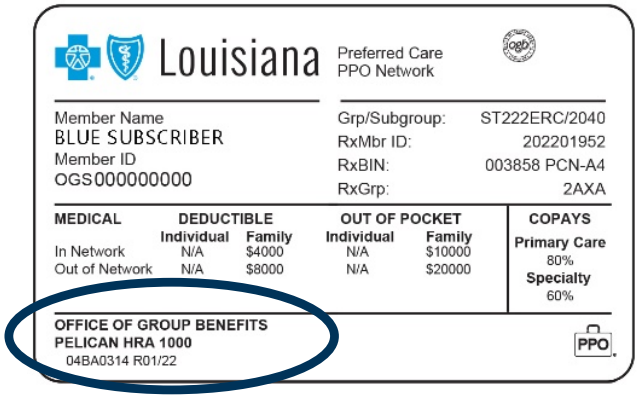
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.


Louisiana
PPO Network
FULLY INSURED
Member Name
BLUE SUBSCRIBER
Member ID
XUP000000000
RxMbr ID: 200000000
RxBIN: 000000 PCN-A4
RxGrp: BSLA
MEDICAL | DEDUCTIBLE Individual | OUT OF POCKET Individual
In Network | $5500 | $5500
Out of Network | $5500 | $5500
04BA0314 R01/22
PPO

"Fully Insured" notation

SELF FUNDED

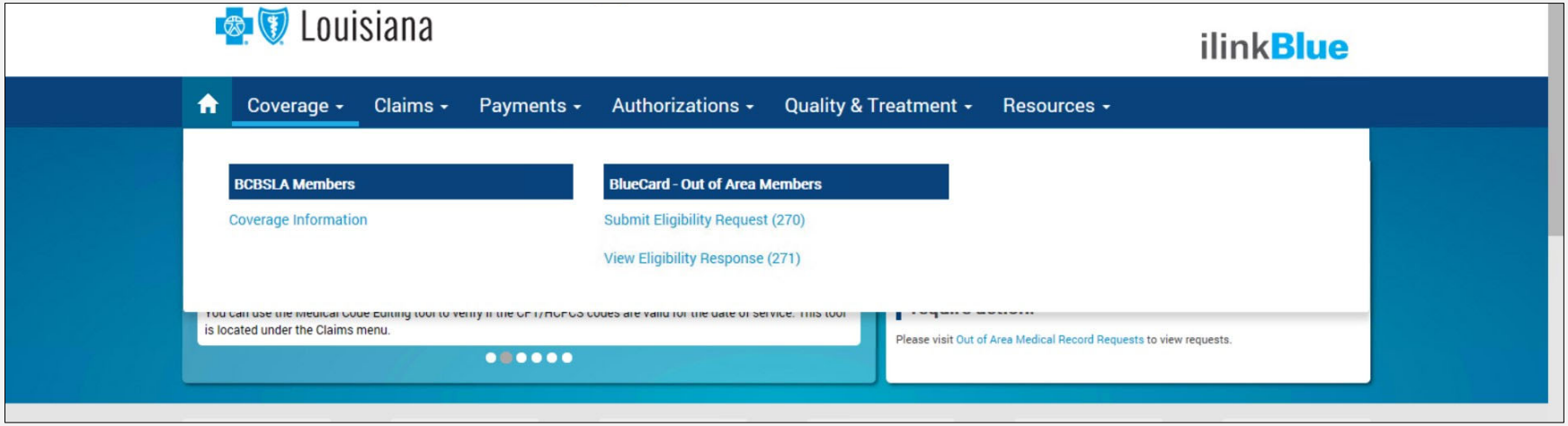
Group policies issued by Blue Cross/HMOLA but claims payments are funded by the employer group, not Blue Cross/HMOLA.


Louisiana
Preferred Care
PPO Network
Member Name
BLUE SUBSCRIBER
Member ID
OGS000000000
Grp/Subgroup: ST222ERC/2040
RxMbr ID: 202201952
RxBIN: 003858 PCN-A4
RxGrp: 2AXA
MEDICAL | DEDUCTIBLE Individual | DEDUCTIBLE Family | OUT OF POCKET Individual | OUT OF POCKET Family
In Network | N/A | $4000 | N/A | $10000
Out of Network | N/A | $8000 | N/A | $20000
COPAYS
Primary Care 80%
Specialty 60%
OFFICE OF GROUP BENEFITS
PELICAN HRA 1000
04BA0314 R01/22
PPO

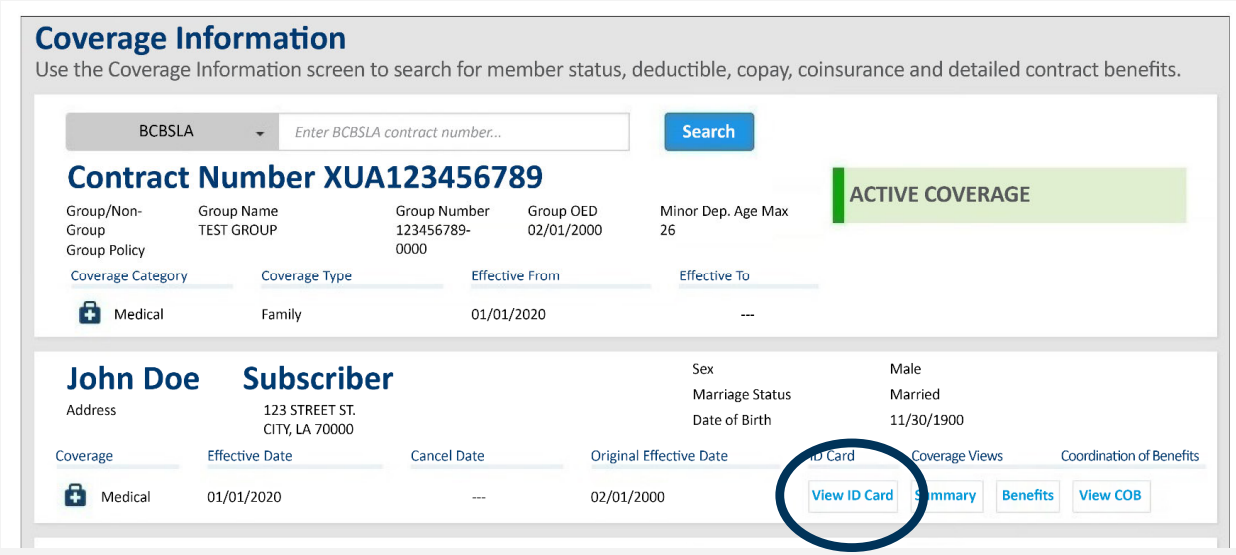
- **"Fully Insured" NOT noted**
- **Self-funded group name listed**

The benefit, limitation, exclusion and authorization **requirements often vary for self-funded groups**. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (**www.bcbsla.com/ilinkblue**).

Digital ID Cards in iLinkBlue



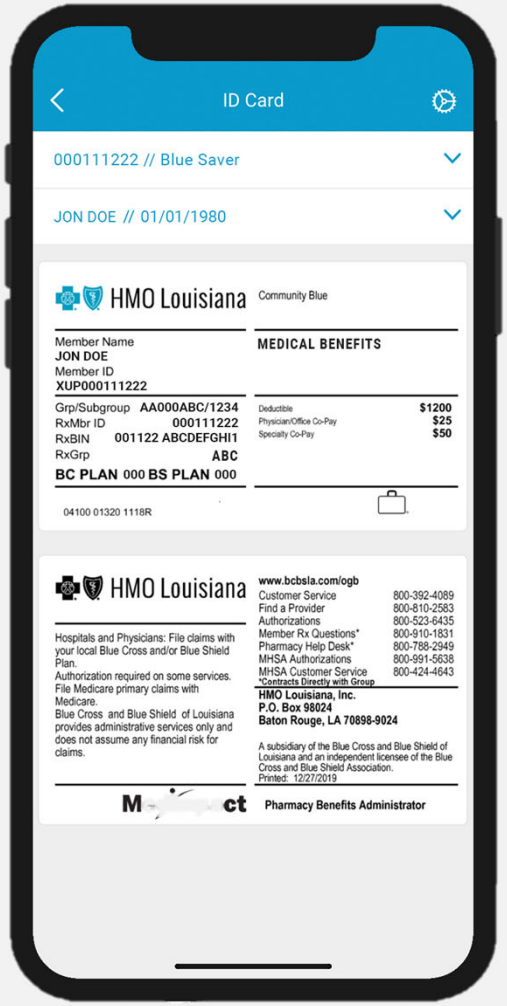
Digital ID cards can be accessed through iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Coverage Information" menu option, then click "View ID Card."



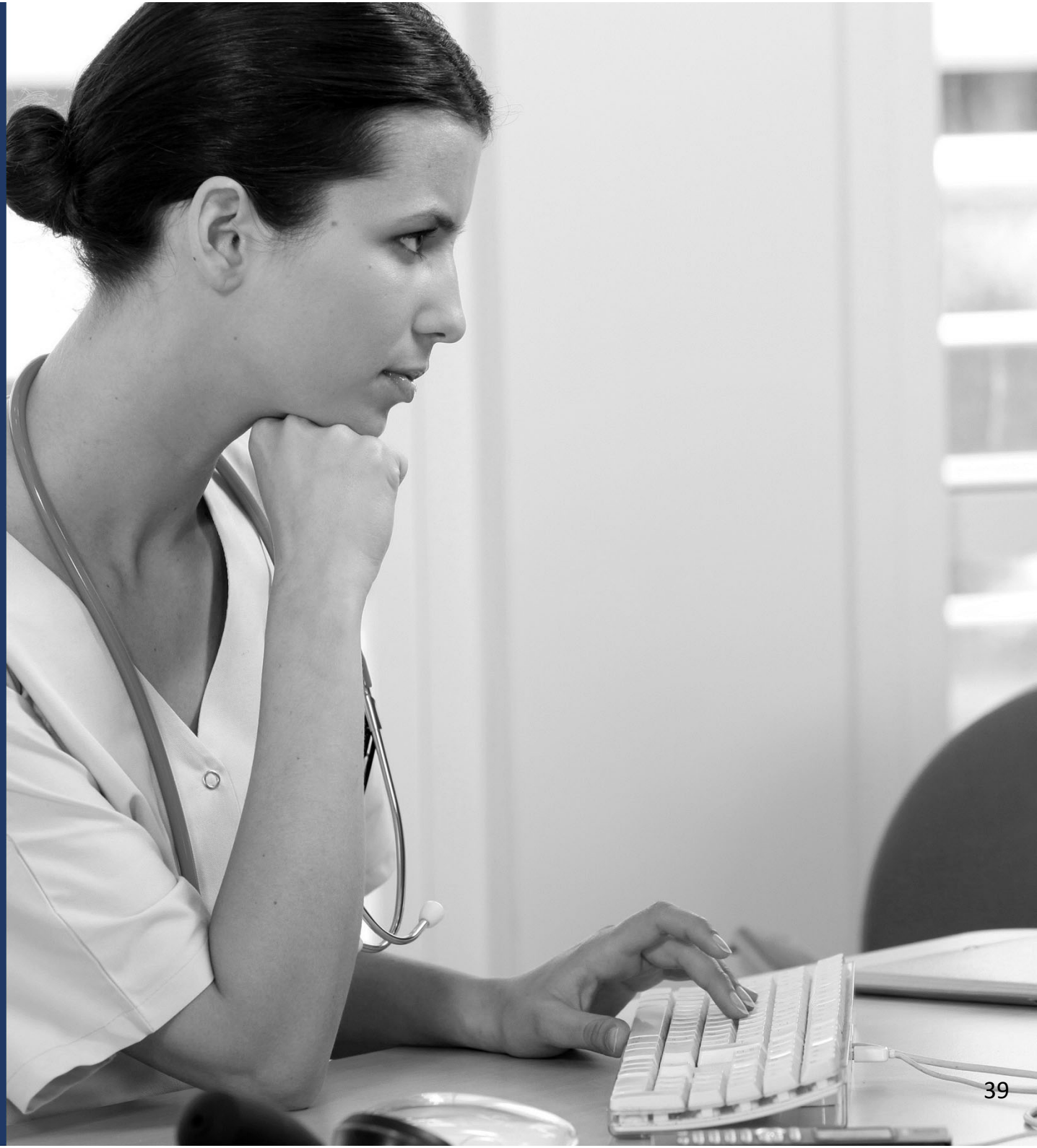
Digital ID Cards

Our members may also access their cards through their smartphone, via the Blue Cross mobile app or through our online member portal:

- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available.
- To access through the Blue Cross member portal, log into the online member account at **www.bcbsla.com**. There, click on “My ID Card” and use the drop-down menu to choose from ID cards available. These cards can be downloaded as PDFs and saved.



VERIFYING YOUR PATIENTS' BENEFITS



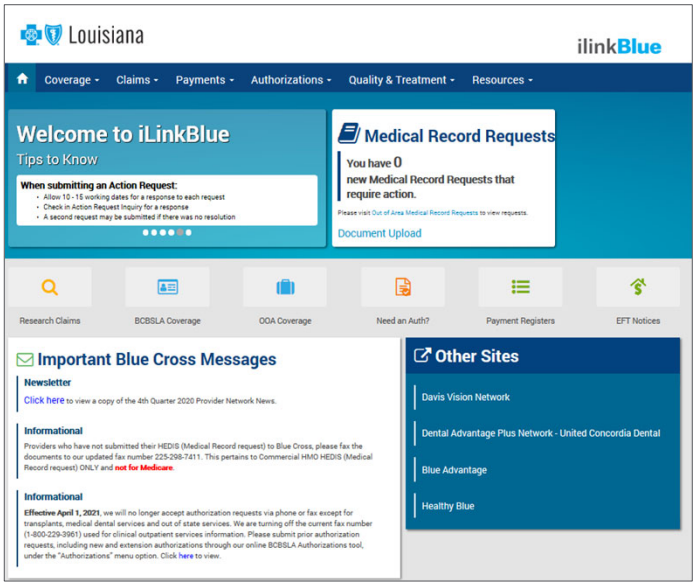
iLinkBlue

iLinkBlue offers user-friendly navigation to allow easy access to many secure online tools:

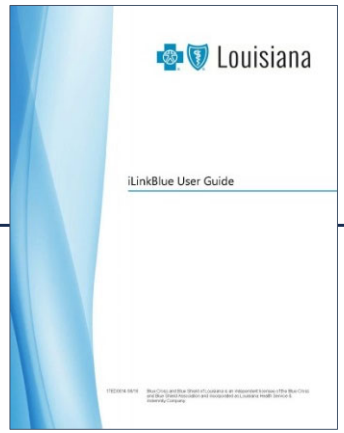
- Coverage & Eligibility
- Benefits
- Coordination of Benefits (COB)
- Claims Status (BCBSLA, FEP and Out of Area)
- Medical Code Editing
- Payment Registers/EFT Notifications
- Allowables Search
- Authorizations
- Medical Policy
- 1500 Claims Entry

ilinkBlue

www.bcbsla.com/ilinkblue

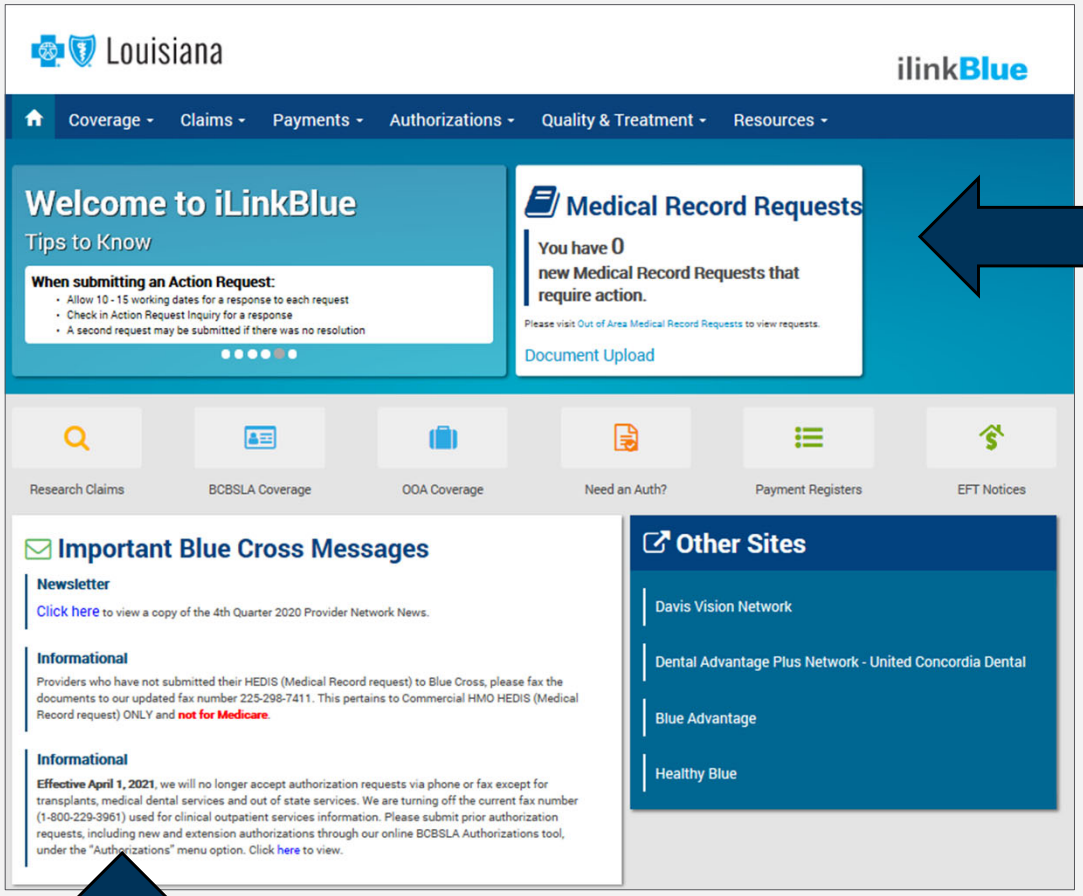


For iLinkBlue training and education, contact **provider.relations@bcbsla.com**.



Use our *iLinkBlue User Guide* to help navigate all of the features in iLinkBlue. It is available online at **www.bcbsla.com/providers** >Resources.

iLinkBlue Landing Page

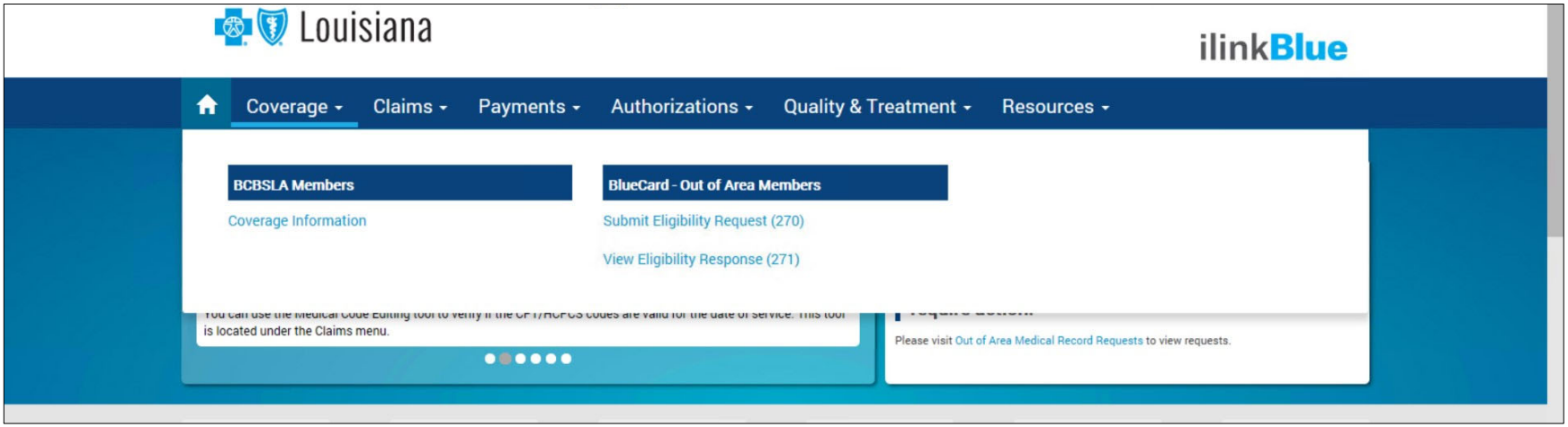


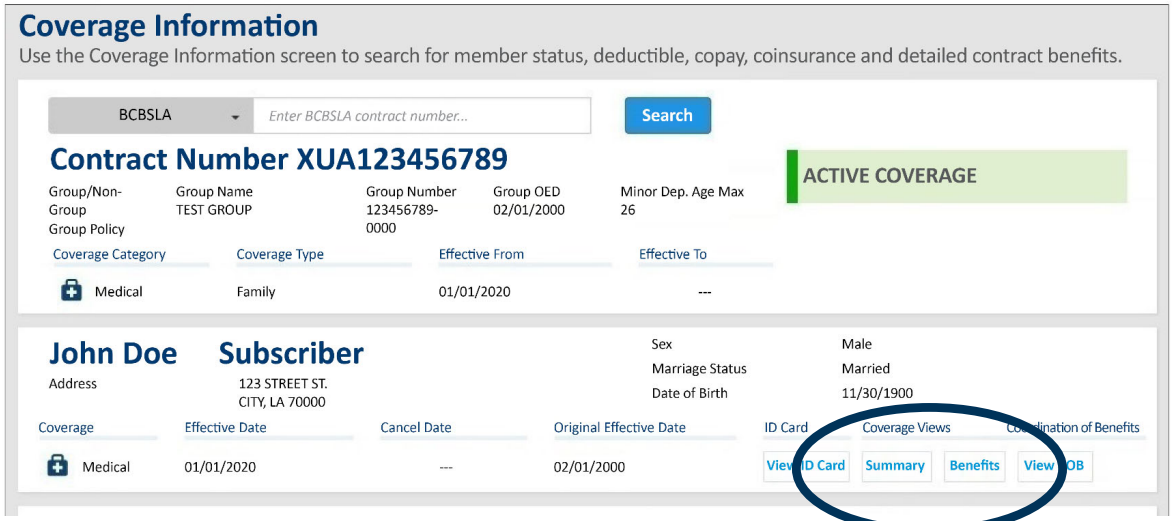
The main landing page has an alert box for when there are BlueCard® (out-of-area) medical record requests for your patients.

There is a message board on the main landing page. This area contains informational and alert posts such as:

- Upcoming events
- New features
- System outages
- Holiday notices
- And other important bulletins

Verifying Benefits in iLinkBlue



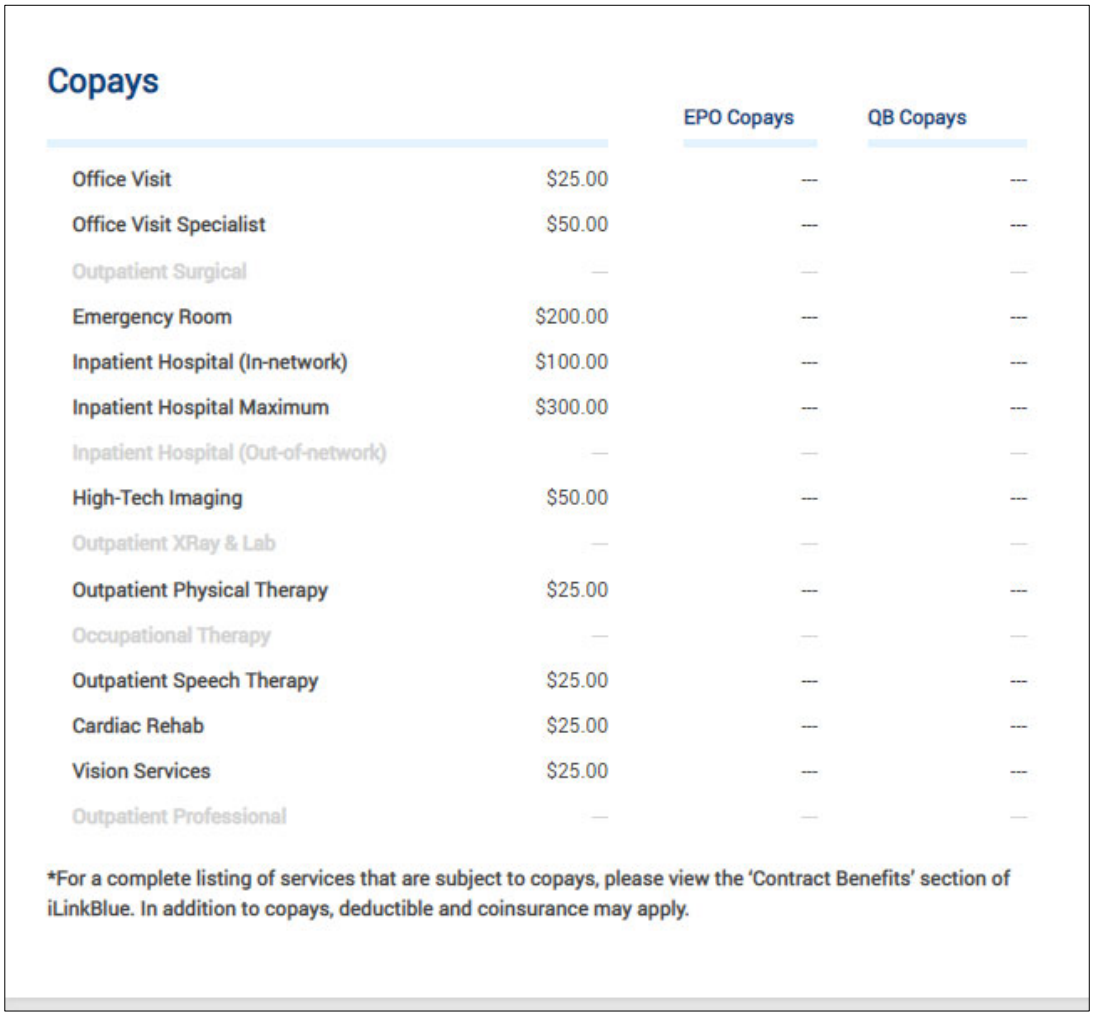


Easily verify your patient's benefits using iLinkBlue. Go to **www.bcbsla.com/ilinkblue** >Coverage >Coverage Information, then click on "Summary" and/or "Benefits."

Summary of Benefits - Copays

On the Summary page you will see a list of your patient's different copays.

- Office Visits
- Office Visit Specialist
- Emergency Room
- Inpatient Hospital (in-network)
- Inpatient Hospital Maximum
- High-Tech Imaging
- Outpatient Physical Therapy
- Outpatient Speech Therapy
- Cardiac Rehab
- Vision Services



Copays

		EPO Copays	QB Copays
Office Visit	$25.00	---	---
Office Visit Specialist	$50.00	---	---
Outpatient Surgical	---	---	---
Emergency Room	$200.00	---	---
Inpatient Hospital (In-network)	$100.00	---	---
Inpatient Hospital Maximum	$300.00	---	---
Inpatient Hospital (Out-of-network)	---	---	---
High-Tech Imaging	$50.00	---	---
Outpatient XRay & Lab	---	---	---
Outpatient Physical Therapy	$25.00	---	---
Occupational Therapy	---	---	---
Outpatient Speech Therapy	$25.00	---	---
Cardiac Rehab	$25.00	---	---
Vision Services	$25.00	---	---
Outpatient Professional	---	---	---

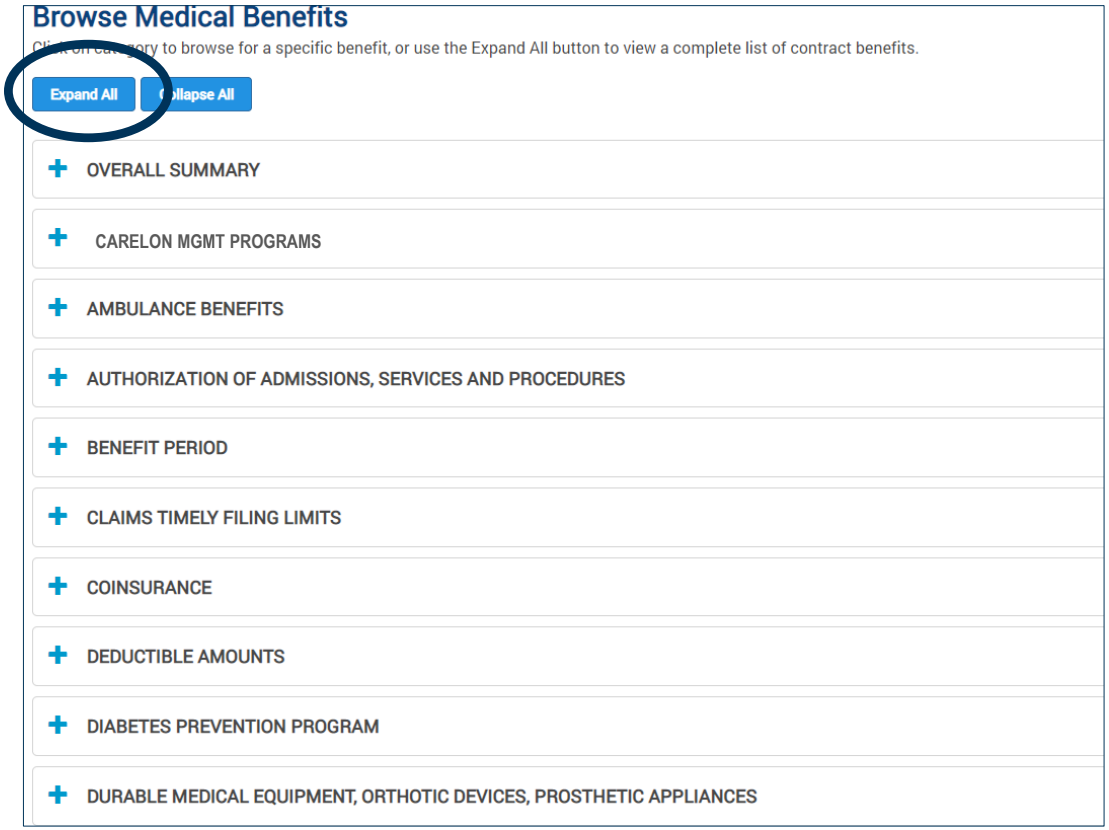
*For a complete listing of services that are subject to copays, please view the 'Contract Benefits' section of iLinkBlue. In addition to copays, deductible and coinsurance may apply.

Go to **www.bcbsla.com/ilinkblue** >Coverage >Coverage Information, then click on "Benefits."

Benefits

It is important to understand your patient's medical benefits. The Benefits page shows different types of benefits, including:

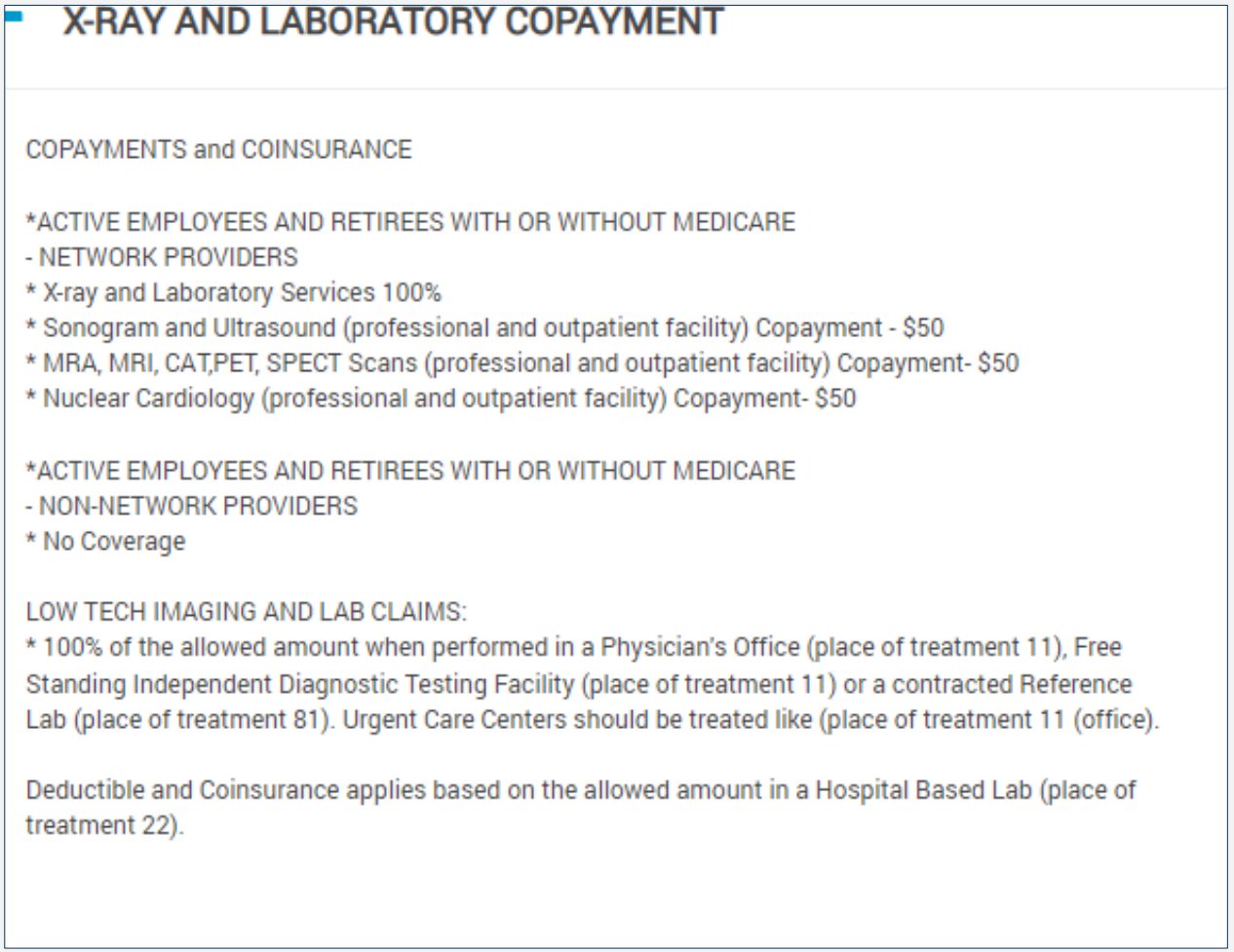
- Overall Summary
- Carelon Mgmt Programs
- Ambulance Benefits
- Authorizations
- Benefit Period
- Claims Timely Filing Limits
- Coinsurance
- Deductible Amounts
- Diabetes Prevention Program
- Durable Medical Equipment
- Office Copays
- Etc.



Go to **www.bcbsla.com/ilinkblue** >Coverage >Coverage Information, then click on "Benefits."

Additional Copays

All additional copays are listed on the Benefits page.



X-RAY AND LABORATORY COPAYMENT

COPAYMENTS and COINSURANCE

*ACTIVE EMPLOYEES AND RETIREES WITH OR WITHOUT MEDICARE
- NETWORK PROVIDERS
* X-ray and Laboratory Services 100%
* Sonogram and Ultrasound (professional and outpatient facility) Copayment - $50
* MRA, MRI, CAT,PET, SPECT Scans (professional and outpatient facility) Copayment- $50
* Nuclear Cardiology (professional and outpatient facility) Copayment- $50

*ACTIVE EMPLOYEES AND RETIREES WITH OR WITHOUT MEDICARE
- NON-NETWORK PROVIDERS
* No Coverage

LOW TECH IMAGING AND LAB CLAIMS:
* 100% of the allowed amount when performed in a Physician's Office (place of treatment 11), Free Standing Independent Diagnostic Testing Facility (place of treatment 11) or a contracted Reference Lab (place of treatment 81). Urgent Care Centers should be treated like (place of treatment 11 (office).

Deductible and Coinsurance applies based on the allowed amount in a Hospital Based Lab (place of treatment 22).

Go to **www.bcbsla.com/ilinkblue** >Coverage >Coverage Information, then click on "Benefits."

Other Copays

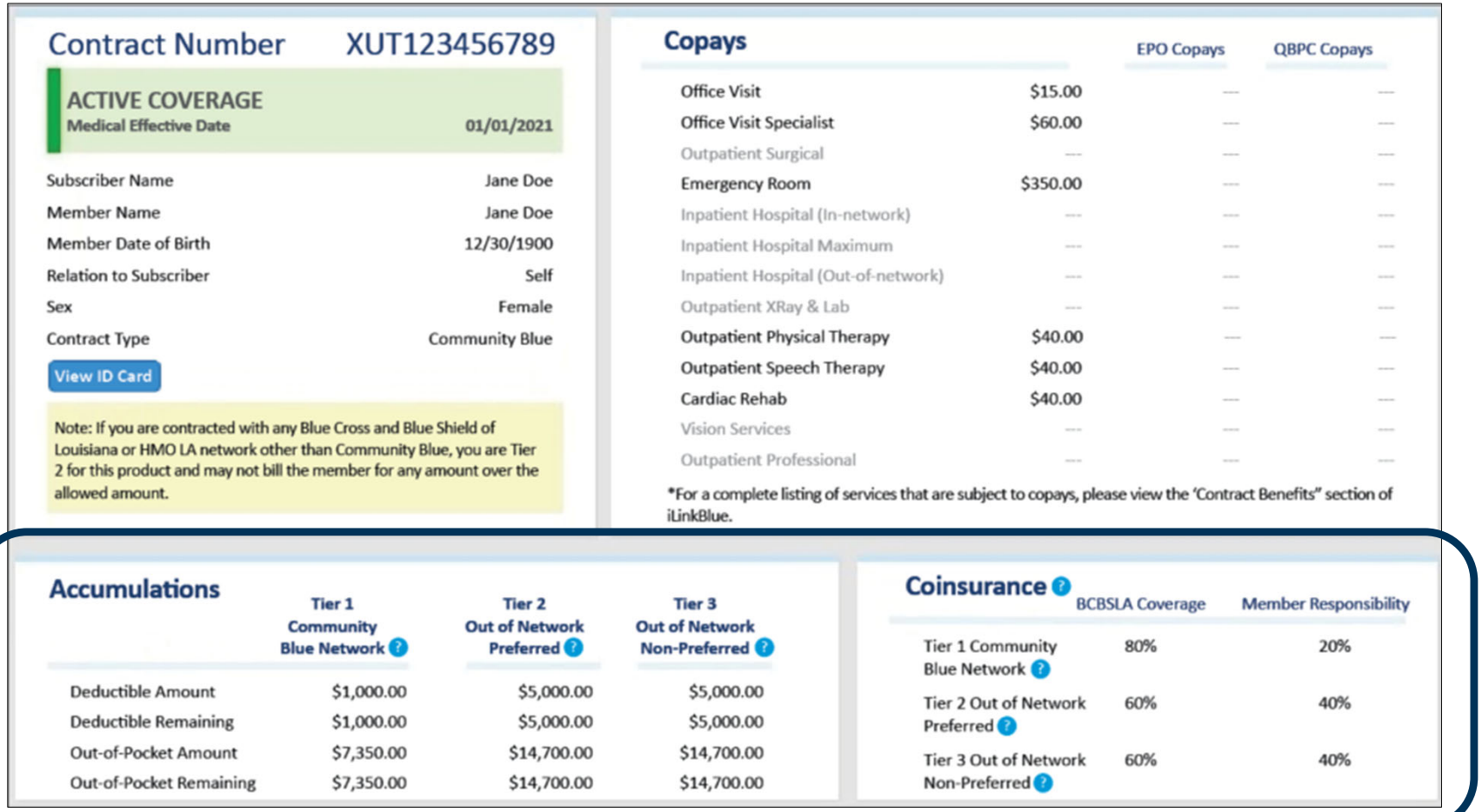
OTHER COPAYS

COPAYMENTS for NETWORK PROVIDERS
Ground Ambulance Services Copayment - $50 per day per Provider
Ambulatory Surgical Center and Outpatient Surgical Facility Copayment - $100 per surgical visit
Autism Spectrum Disorders (ASD) - $25 PCP / $50 Specialist
Bariatric Surgery Facility - $2,500 Facility Copayment
Cardiac Rehabilitation Copayment - $25 PCP / $50 Specialist
Cardiac Rehabilitation Outpatient Facility Copayment - $50 per visit
Chemotherapy Radiation Therapy Office Copayment - $25 per visit
Day Rehabilitation Programs Copayment - $25 per visit
Diabetic / Nutritional Counseling Copayment (Clinics and Outpatient Facilities) - $25 per visit
High-Tech Imaging Outpatient Copayment - $50 per visit
Inpatient Facility Copayment - $100 per day, $300 maximum per Admission
Massage Therapy (Outpatient) Copayment - $25 per visit
Mental Health / Substance Use Inpatient Treatment and Intensive Outpatient Programs Copayment - $100 per day, $300 maximum per Admission
Mental Health /Substance Use Disorder Outpatient Treatment Copayment - $25 per visit
Newborn (Ill / Sick) Facility Copayment - $100 per day, $300 maximum per Admission
Nurse Practitioner Copayment - $25 per visit
Occupational Therapy (Outpatient) Copayment - $25 per visit
Office Primary Care Physician Copayment - $25 per visit
Office Specialist Copayment - $50 per visit
Physical Therapy (Outpatient) Copayment - $25 per visit
Pregnancy Care Copayment - $90 per pregnancy
Retail Health Clinic Copayment - $25 per visit
Skilled Nursing Facility Copayment - $100 Copayment per day, $300 maximum per Admission
Sonograms and Ultrasounds (Outpatient) Copayment - $50 per visit
Speech Therapy (Outpatient) Copayment - $25 per visit
Urgent Care Center Copayment - $50 per visit
Vision Care (Non-Routine) Exam Copayment - $25 PCP / $50 Specialist

ALL PROVIDERS
Air Ambulance Services Copayment - $250 per day per Provider
Emergency Ground Ambulance Services Copayment - $50 per day per Provider (Emergency Medical Transportation only)
Emergency Medical Services Copayment (Hospital / Facility charge) - $200 per visit

Tiered Benefits

Some members' benefits include **tiered benefit levels**. Accumulations will show deductibles and coinsurance depending on the provider's network participation. The provider must participate in the member specific select network to be considered a Tier 1 provider.



Contract Number XUT123456789

ACTIVE COVERAGE
Medical Effective Date 01/01/2021

Subscriber Name	Jane Doe
Member Name	Jane Doe
Member Date of Birth	12/30/1900
Relation to Subscriber	Self
Sex	Female
Contract Type	Community Blue

View ID Card

Note: If you are contracted with any Blue Cross and Blue Shield of Louisiana or HMO LA network other than Community Blue, you are Tier 2 for this product and may not bill the member for any amount over the allowed amount.

Copays

		EPO Copays	QBPC Copays
Office Visit	$15.00	---	---
Office Visit Specialist	$60.00	---	---
Outpatient Surgical	---	---	---
Emergency Room	$350.00	---	---
Inpatient Hospital (In-network)	---	---	---
Inpatient Hospital Maximum	---	---	---
Inpatient Hospital (Out-of-network)	---	---	---
Outpatient XRay & Lab	---	---	---
Outpatient Physical Therapy	$40.00	---	---
Outpatient Speech Therapy	$40.00	---	---
Cardiac Rehab	$40.00	---	---
Vision Services	---	---	---
Outpatient Professional	---	---	---

*For a complete listing of services that are subject to copays, please view the 'Contract Benefits" section of iLinkBlue.

Accumulations

	Tier 1 Community Blue Network	Tier 2 Out of Network Preferred	Tier 3 Out of Network Non-Preferred
Deductible Amount	$1,000.00	$5,000.00	$5,000.00
Deductible Remaining	$1,000.00	$5,000.00	$5,000.00
Out-of-Pocket Amount	$7,350.00	$14,700.00	$14,700.00
Out-of-Pocket Remaining	$7,350.00	$14,700.00	$14,700.00

Coinsurance

	BCBSLA Coverage	Member Responsibility
Tier 1 Community Blue Network	80%	20%
Tier 2 Out of Network Preferred	60%	40%
Tier 3 Out of Network Non-Preferred	60%	40%

Medical Benefits Summary page shown above.

AUTHORIZATIONS

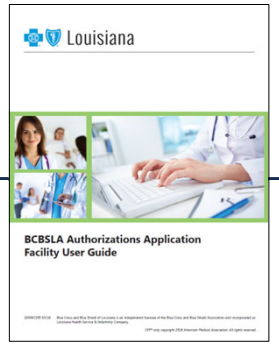
iLinkBlue – Authorizations Mandate

A streamlined process for requesting prior authorizations.

- Blue Cross no longer accepts authorization requests via phone or fax, with a few exceptions including transplants, dental services covered under medical and out-of-state services.
- Prior authorization requests, including new and extension authorizations, must be submitted through our online BCBSLA Authorizations application available in iLinkBlue.
- The application allows providers to request authorizations 24 hours a day, seven days a week, in real time.
- **In some cases, the application allows for immediate approval without Blue Cross personnel intervention.**

- **If the requested services are to treat a condition due to a complication of a non-covered service, claims will deny as non-covered regardless of medical necessity.**
- **Providers are responsible for checking member eligibility and benefits.**

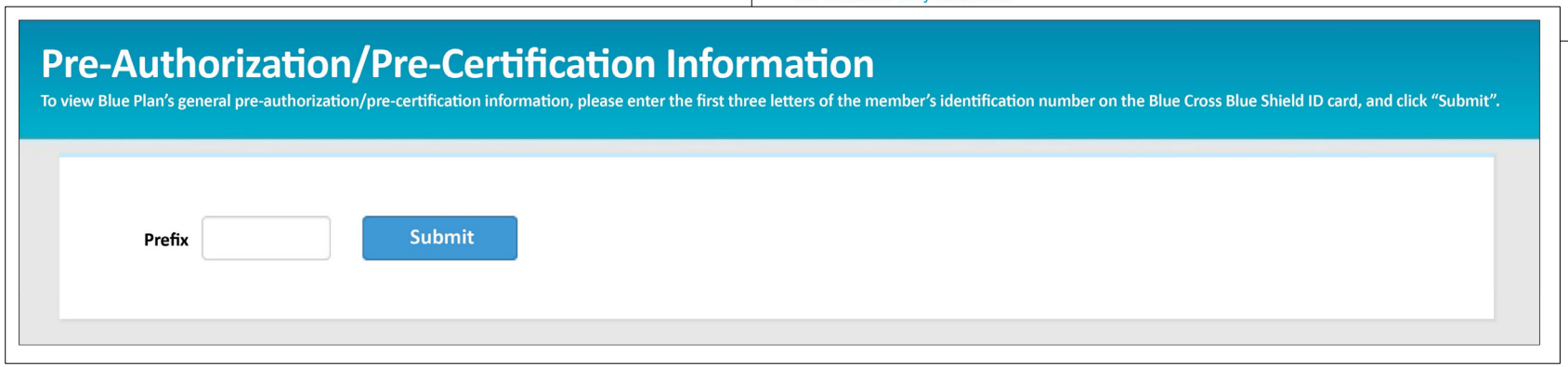
For more information on how to use our BCBSLA Authorizations application, the *BCBSLA Authorizations Tool Facility User Guide* is available on iLinkBlue under the "Resources" tab, then click "Manuals."



Where to Find Authorization Requirements

Do I need an authorization?

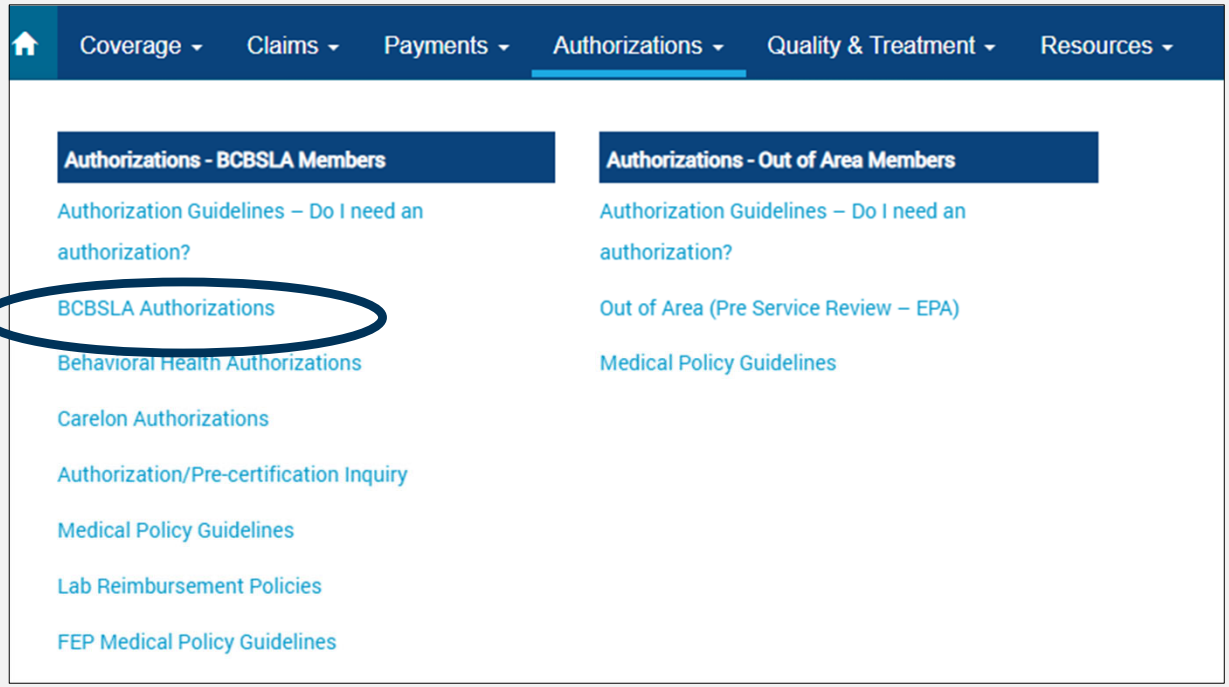
The Authorizations Guidelines application allows providers to research and view authorization requirements for BCBSLA and BlueCard (out-of-area) members.

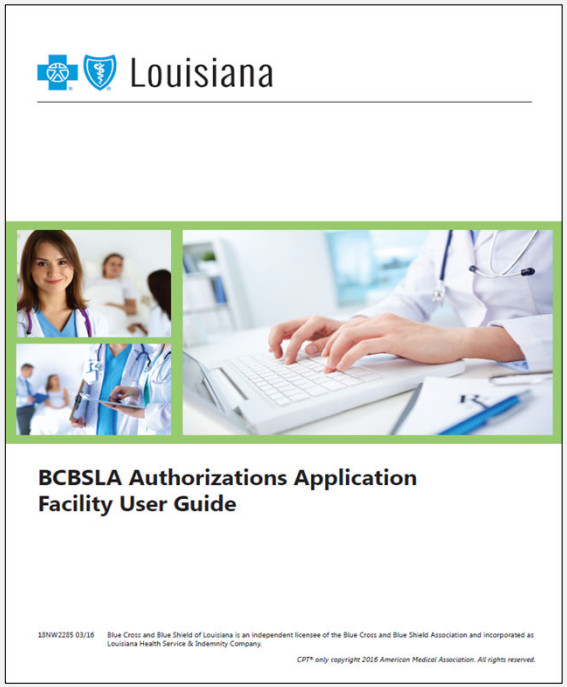


Simply enter the member's prefix (the first three characters of the member ID number) to access general pre-authorization/pre-certification information.

Requesting Authorizations thru iLinkBlue

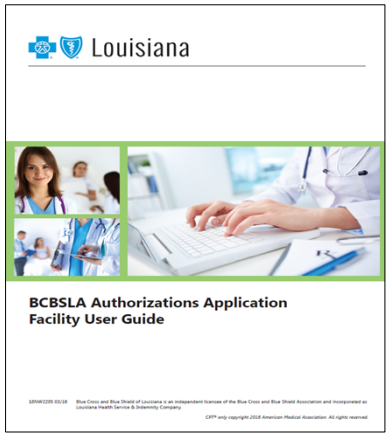
- Use the “Authorizations” menu option to access our authorization applications.
- An administrative representative must grant a user access to the following applications before a request can be submitted:
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Out of Area (Pre Service Review – EPA)
  - Carelon Authorizations

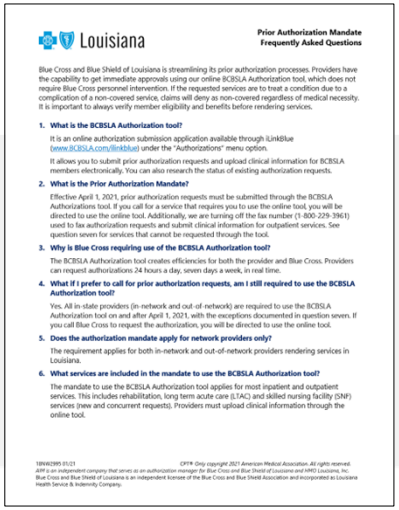




Authorizations Resources

Use the “Resources” menu option in iLinkBlue to access various provider manuals, including the **BCBSLA Authorizations Tool Facility User Guide**.





View our Prior Authorization Mandate Frequently Asked Questions at **www.bcbsla.com/providers** >Electronic Services >Authorizations, under the quick links section.

Failure to Obtain an Authorizations

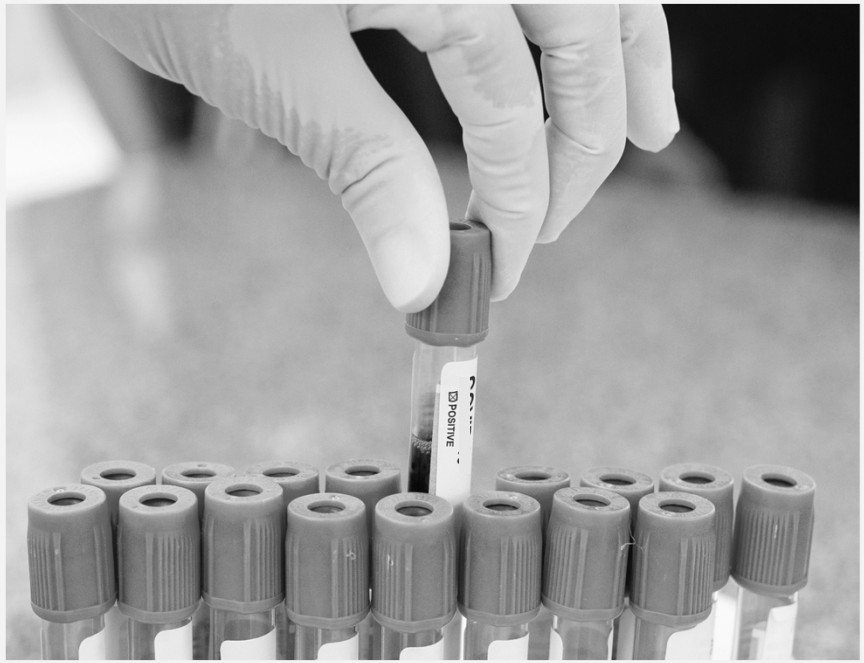
Failure to obtain a prior authorization can result in:

- A 30% penalty imposed on Preferred Care PPO and HMO Louisiana, Inc. network providers for failing to obtain authorization prior to performing an outpatient service that requires authorization.
- A $1,000 penalty applied to inpatient hospital claims if the patient's policy requires an inpatient stay to be authorized (Note: some policies contain a different inpatient penalty provision).
- The denial of payment for services for our Office of Group Benefits (OGB) members.
- A $500 penalty applied to inpatient hospital claims for Federal Employee Program (FEP) members with Standard Option, Basic Option and FEP Blue Focus benefits. For select outpatient services, no payment will be made if prior authorization is not obtained. If prior approval is not obtained for certain OP and IP services, a $100 penalty may be applied on Blue Focus.

Authorization penalties or services that deny for no authorization are not billable to the member.

Genetic and Molecular Testing

Effective January 1, 2023, genetic and molecular testing for Blue Cross members requires prior authorization before rendering services.



Please review our authorization policies located in the *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.bcbsla.com/ilinkblue**, click on "Resources," then "Manuals."

Process for Changing a BCBSLA Authorization

You can ask our Authorization Department to change or add a code to an already approved authorization when **all of the following** conditions are met:

- There is an approved authorization on file.
- Provider states a claim has not been filed.
- The requested code is surgical or diagnostic.
- The requested code is not on a Blue Cross medical policy or a non-covered benefit.

If the above criteria is met, an authorization can be changed within **seven** calendar days of the services being rendered. **This can be done by completing an Activity in the BCBSLA Authorizations application and uploading medical records and/or adding a note**.

If the procedure being added or changed is in a Blue Cross medical policy or is a non-covered benefit, it cannot be updated on the authorization.

Communicating with Blue Cross regarding Authorizations

Creating an "Activity" is the **only** way to communicate with BCBSLA regarding authorizations. Do **not** use the "Notes" tab, as our Authorizations Department will not be notified.

An "Activity" **must** be added to an authorization when attempting to complete any of the following:

- Corresponding with our Authorization Department
- Additional information is being forwarded
- Extending an authorization or adding additional services
- Changing an authorization
- Requesting peer-to-peer review (flag as critical)

The "Activity" must be assigned to: Provider Request Worklist

It is very important to follow this process to ensure authorizations are handled accurately and timely.

Blue Cross requires providers to request prior authorizations through our BCBSLA Authorizations application. It is available online in iLinkBlue (**www.bcbsla.com/ilinkblue**).

carelon℠ *(formerly AIM Specialty Health)*

AIM Specialty Health changed its name to **Carelon Medical Benefits Management**.

- This name change does not impact the services offered or create process changes for Blue Cross providers.
- Submitting authorization and checking case status remains the same.
- The ***Provider****Portal*$_{SM}$, which includes **Opti**Net®, continues to be accessible through iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Authorizations" tab, then click "Carelon Authorizations."

Utilization Management Programs

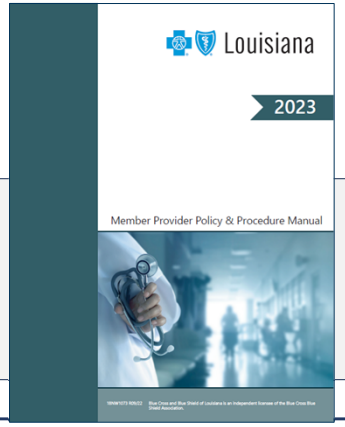
Blue Cross has several utilization management programs that require prior authorization for select elective services. Carelon Medical Benefits Management, an independent specialty benefits management company, serves as our authorization manager for these services:

- Cardiology
- High-tech Imaging
- Radiation Oncology
- Musculoskeletal (MSK)
  - Interventional Pain Management
  - Joint Surgery
  - Spine Surgery

Authorization requests may be completed online using the ***Provider****Portal*$_{SM}$ accessed through iLinkBlue. Carelon clinical appropriateness guidelines are available at **https://guidelines.carelonmedicalbenefitsmanagement.com**.

NOTE: When medical requests are requested by Carelon, please forward the records to them instead of Blue Cross.

Additional information can be found in the *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.bcbsla.com/ilinkblue**, click on "Resources," then "Manuals."



Carelon Guidelines for Changing Authorization

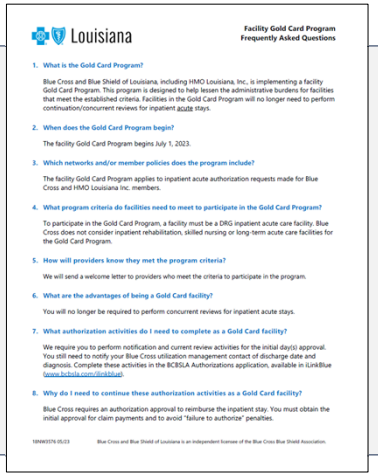
- Carelon allows **seven** days post the service (retro) for the provider to call and update the original request for MSK program.
- All other programs allows **two** days, with the exception of some cardiac services that allow 10 days post service.

Gold Card Program

Effective July 1, 2023, providers who met the program criteria, were enrolled in the Gold Card Program and receive the following benefits:

Provider Type	Gold Card Program Benefit	Participation Criteria
Facilities	Will no longer need to perform continuation/concurrent reviews for acute inpatient stays.	Acute Facilities that are not reimbursed on a per diem rate.

If you have questions or would like to request the Gold Card Program FAQs email **provider.relations@bcbsla.com**.



Louisiana

Facility Gold Card Program Frequently Asked Questions

1. **What is the Gold Card Program?**

   Blue Cross and Blue Shield of Louisiana, including HMO Louisiana, Inc., is implementing a facility Gold Card Program. This program is designed to help lessen the administrative burdens for facilities that meet the established criteria. Facilities in the Gold Card Program will no longer need to perform continuation/concurrent reviews for inpatient acute stays.

2. **When does the Gold Card Program begin?**

   The facility Gold Card Program begins July 1, 2023.

3. **Which networks and/or member policies does the program include?**

   The facility Gold Card Program applies to inpatient acute authorization requests made for Blue Cross and HMO Louisiana Inc. members.

4. **What program criteria do facilities need to meet to participate in the Gold Card Program?**

   To participate in the Gold Card Program, a facility must be a DRG inpatient acute care facility. Blue Cross does not consider inpatient rehabilitation, skilled nursing or long-term acute care facilities for the Gold Card Program.

5. **How will providers know they met the program criteria?**

   We will send a welcome letter to providers who meet the criteria to participate in the program.

6. **What are the advantages of being a Gold Card facility?**

   You will no longer be required to perform concurrent reviews for inpatient acute stays.

7. **What authorization activities do I need to complete as a Gold Card facility?**

   We require you to perform notification and current review activities for the initial day(s) approval. You still need to notify your Blue Cross utilization management contact of discharge date and diagnosis. Complete these activities in the BCBSLA Authorizations application, available in iLinkBlue (www.bcbsla.com/ilinkblue).

8. **Why do I need to continue these authorization activities as a Gold Card facility?**

   Blue Cross requires an authorization approval to reimburse the inpatient stay. You must obtain the initial approval for claim payments and to avoid "failure to authorize" penalties.

POLICIES AND PROCEDURES

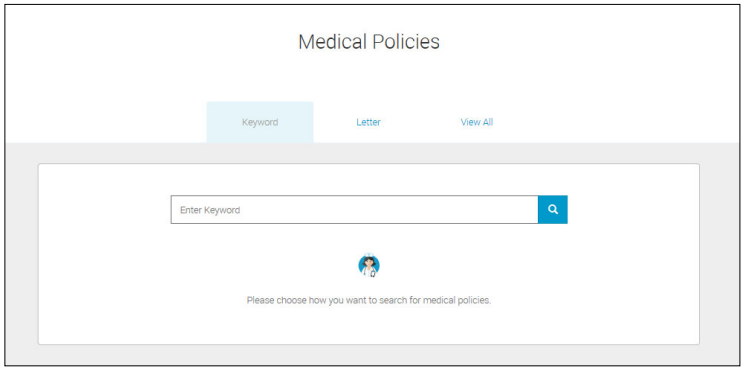
Accessing Our Medical Policies

- From the iLinkBlue menu, select “Authorizations” then “Medical Policy Guidelines” to open the **Medical Policy Index**.

- Policies are listed in alpha order, or you may search by keyword, procedure code, policy name or policy number.

1.

2.

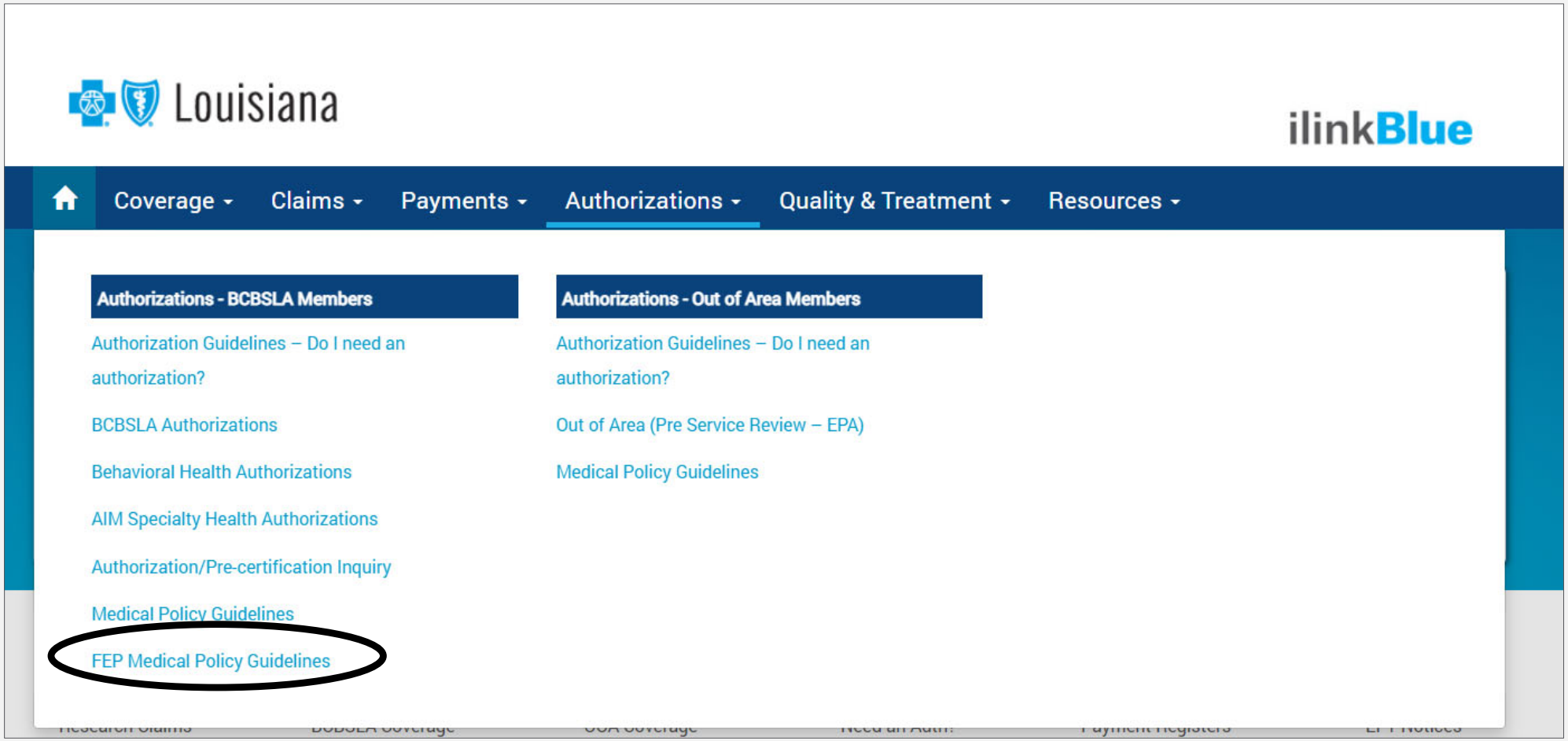


Medical policies are reviewed, updated and developed every month. We publish these updates in our quarterly *Provider Network News* newsletters, available online at **www.bcbsla.com/providers** >Newsletters.

Our medical policies include coverage eligibility, background information related to technology, devices and treatments, technology assessments, literature sources and the rationale for coverage determinations.

FEP Medical Policy Guidelines

FEP Medical Policy Guidelines can now be found on iLinkBlue (**www.bcbsla.com/ilinkblue**), under Authorizations.



Laboratory Benefit Management Program

Blue Cross has partnered with Avalon Healthcare Solutions to offer a laboratory benefit management program.

Avalon provides:

- Routine testing management services to ensure enforcement of laboratory policies.
- Automated review of high-volume, low-cost laboratory claims.

Blue Cross will apply Avalon's automated policy enforcement to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations.

Note: Laboratory services, tests and procedures provided in emergency room, hospital observation, and hospital inpatient settings are excluded from this program.

Providers can now review and research the lab policies and guidelines.
Go to **www.bcbsla.com/providers** >Medical Management >Lab Management.

Laboratory Benefit Management Denials

- If services were denied due to an Avalon policy, the policy number will appear on the provider payment register.
- You can then access our policies and procedures, put the policy number in the search field and it will display the policy and criteria.

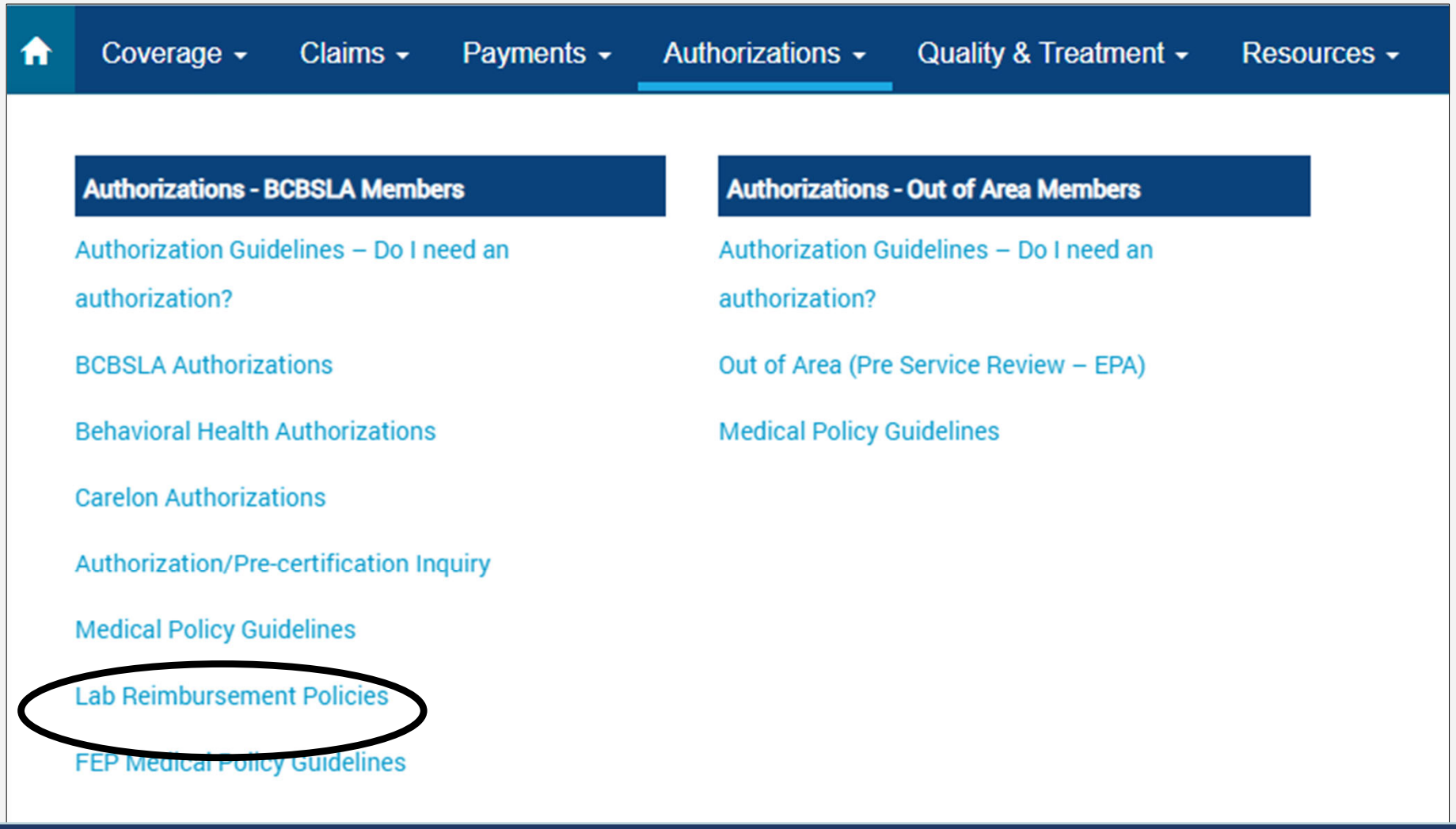
  SUBSCRIBER, JOE XUP20000000 1 7/2/2022 7/2/2022 220000080061 $137.98 $137.98 $0.00

  Lab Policy #G2050, Procedure Code: 80061, Decision: D06R - 1 per 1 Yr
- If you have questions about a policy and/or a payment related to a policy, you may contact Provider Relations at **provider.relations@bcbsla.com**.

Providers can now review and research the lab policies and guidelines.
Go to **www.bcbsla.com/providers** >Medical Management >Lab Management.

65

Lab Reimbursement Policies



Our medical policies can also be found online at **www.bcbsla.com/provider** >Medical Management >Medical Policies.

Laboratory Policies

Blue Cross and Blue Shield of Louisiana Health Laboratory Testing Policies

Blue Cross and Blue Shield of Louisiana (BCBSLA) has partnered with Avalon Healthcare Solutions for Laboratory Benefits Management (LBM) in order to administer Avalon's Routine Testing Management (RTM), a post-service pre-payment clinical claim editing program. The laboratory testing policies for the RTM program are accessible through the links below. These policies are specific to BCBSLA network and product requirements and in alignment with its policies, rules, and/or state and federal contracts. In the event of a conflict, BCBSLA's policies, rules, and/or state and federal contracts will take precedence.

The RTM policies below are effective for claims with a date of service of May 15th, 2022, and later.

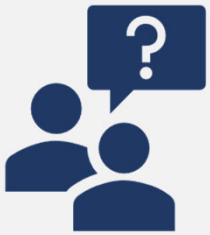
Search...

- F2019: Flow Cytometry
- G2002: Cervical Cancer Screening
- G2005: Vitamin D Testing
- G2006: Diabetes Mellitus Testing
- G2007: Prostate Biopsies
- G2008: Prostate Specific Antigen (PSA) Testing
- G2009: Preventive Screening in Adults
- G2011: Diagnostic Testing of Iron Hemostasis and Metabolism
- G2013: Testosterone

Intra-operative Monitoring Services

We require all intra-operative monitoring (IOM) services to be contracted with Blue Cross.

- When our members receive care provided in your facility by a non-contracted IOM, the members have higher out-of-pocket costs.
- When approached by an IOM to request privileges at your facility, please verify that they are in network with Blue Cross.



Provider Contracting Team

1-800-716-2299, option 1

provider.contracting@bcbsla.com

OptiNet®

OptiNet Registration in iLinkBlue

- Carelon Medical Benefits Management offers ***Opti****Net*® an online registration application that gathers information about the technical component capabilities of diagnostic imaging services and calculates provider scores based on self reported information.
- Through this application, we can offer members and their ordering providers the option to "shop" for quality, lower-cost diagnostic imaging services.
- Without an ***Opti****Net*® score, you miss out on this opportunity for exposure to Blue members.

Why Is Your Score So Important?

For any provider who performs imaging services and does not complete an assessment, a score will not be part of our benchmarking, meaning the provider will not be included in transparency programs such as our shopper program or future reimbursement incentives.

OptiNet Registration in iLinkBlue

How Is Your Score Calculated?

- The site score measures basic performance indicators that are applicable for the facility, such as general site access, quality assurance and staffing.
- The modality specific scoring is based on indicators such as MD certification, technologist certification, modality accreditation and equipment quality.

How to Access *OptiNet*®?

- Log into iLinkBlue (**www.bcbsla.com/ilinkblue**).
- Click on the "Authorizations" menu option, then click on the "Carelon Specialty Health Authorizations" link; this link takes you to the Carelon ***Provider****Portal*SM.
- Click on "Access Your ***Opti****Net*® Registration" on the left menu bar.
- Click the green "Access Your ***Opti****Net*® Registration" button.

BLUE DISTINCTION

Blue Distinction Specialty Care Centers

Blue Distinction Specialty Care Centers are part of a national designation program that recognizes facilities demonstrating expertise in delivering quality specialty care, safely and effectively. These designations are only awarded to the specific facility and specific location.

Two designation levels:

Blue Distinction® Center

Blue Distinction® Center+

The current programs are:

- Bariatric Surgery
- Cardiac Care
- Knee and Hip Replacement
- Maternity
- Spine Surgery
- Transplants

The Specialty Program selection criteria is available at **www.bcbs.com** >About Us >Capabilities & Initiatives >Blue Distinction >Blue Distinction Specialty Care.

Blue Distinction Level Comparison

Evaluation Criteria for Participation Focused on:	Blue Distinction® Center Healthcare facilities recognized for their **expertise** in delivering specialty care	Blue Distinction® Center+ Healthcare facilities recognized for their **expertise** and **efficiency** in delivering specialty care
Identifying those facilities that demonstrate **expertise in delivering quality specialty care** – safely and effectively	✓	✓
Nationally **established quality measures** with emphasis on **proven outcomes**	✓	✓
Cost of care calculated on procedures, using episode-based allowable amounts		✓

BILLING GUIDELINES

Timely Filing

Blue Cross, HMO Louisiana, Blue Connect, Community Blue, BlueHPN, Precision Blue & Signature Blue	Claims must be filed within 15 months *(or length of time stated in the member's contract)* of date of service.
FEP	Blue Cross FEP Preferred Provider claims must be filed within 15 months from date of service. Members/ Non-preferred providers have no later than December 31 of the year following the year in which the service were provided.
Blue Advantage	• Providers have 12 months from the date of service to file an initial claim. • Providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim.
OGB	• Claim must be filed within 12 months of the date of service. • Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim.
Self-funded & BlueCard	Timely filing standards may vary. Always verify the member's benefits, including timely filing standards, through iLinkBlue.

The member and Blue Cross are held harmless when claims are denied or received after the timely filing deadline.

Ordering/Referring Policy

The ordering/referring provider's first name, last name and NPI are **required** on all claims for the following provider types:

- Diagnostic Radiology Center
- Durable Medical Equipment Supplier
- Infusion Therapy
- Laboratory
- Sleep Disorder Clinic/Lab
- Specialty Pharmacy

Claims received without the ordering/referring provider's first name, last name and NPI will be returned, and the claim must be refiled with the requested information. The ordering/referring provider should not be the same as the rendering provider.

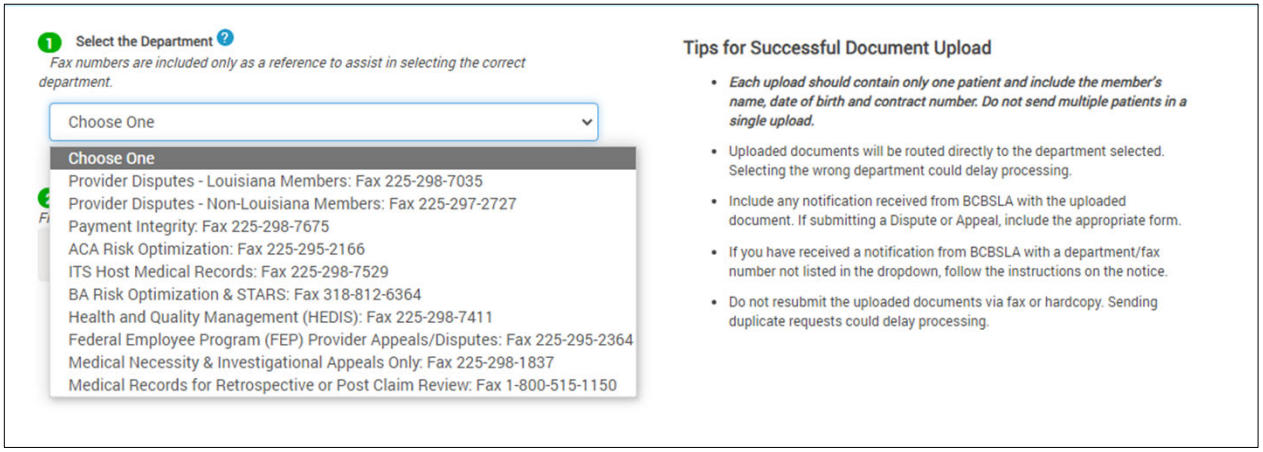
Please enter the ordering/referring provider's information for paper and electronic claims as indicated below:

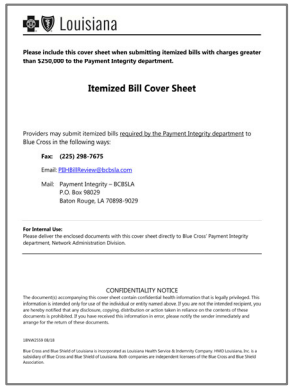
Paper Claims	• CMS-1500 Health Insurance Claim Form: Block 17B
Electronic 837P, Professional Claims	• Referring Provider - Claim Level: 2310A loop, NM1 Segment • Referring Provider - Line Level: 2420F loop, NM1 Segment • Ordering Provider - Line Level: 2420E loop, NM1 Segment

Pre-pay Itemized Bill Review

$100,000 minimum, please follow these guidelines:

- File the claim using your usual process for filing claims; in addition, please submit an itemized bill and include the Itemized Bill Cover Sheet.
- If the itemized bill is sent via fax or email, you will receive an acknowledgement of receipt.
- We highly recommended that you send itemized bills immediately after filing the claim or before filing the claim. Claims received with a billed amount of greater than $100,000 without itemized bill information may be denied or result in delayed reimbursement.
- The itemized bill must list each service and item supplied to the member and match the dollar amount and dates of service.
- If you have questions about this claim review process, please email the Payment Integrity department at **PIIHBillReview@bcbsla.com**.
- Submit your Itemized Bill Cover Sheet to Payment Integrity via the Document Upload feature on iLinkBlue **(www.bcbsla.com/ilinkblue)**.




Louisiana

Please include this cover sheet when submitting itemized bills with charges greater than $250,000 to the Payment Integrity department.

Itemized Bill Cover Sheet

Providers may submit itemized bills required by the Payment Integrity department to Blue Cross in the following ways:

Fax: (225) 298-7675

Email: PIIHBillReview@bcbsla.com

Mail: Payment Integrity – BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

For Internal Use:
Please deliver the enclosed documents with this cover sheet directly to Blue Cross' Payment Integrity department, Network Administration Division.

CONFIDENTIALITY NOTICE

The document(s) accompanying this cover sheet contain confidential health information that is legally privileged. This information is intended only for use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return of these documents.

Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

The **Itemized Bill Cover Sheet** is located online at **www.bcbsla.com/providers** >Resources >Forms.

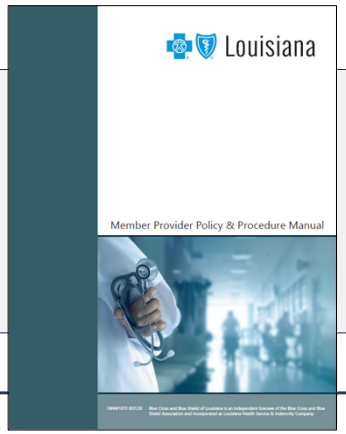
Inpatient Unbundling Policy

The inpatient unbundling policy is effective for all inpatient acute care claims.

- The policy identifies supplies, items and services that should bundle with room and board charges in an inpatient setting, according to CMS guidelines. The services and supplies identified in the inpatient unbundling policy are not separately reimbursable by Blue Cross and are not billable to our members.
- All Blue Cross inpatient acute care claims and itemized bills could be subject to review under this policy. Upon discovery of a supply, item or service identified by the policy, the associated charge will be deemed non-covered/ineligible. Should an adjustment be required to your claim, it will be reflected on your remittance advice.
- EXCD codes related to our provider integrity audits will appear on the payment register for the BCBSLA (excludes FEP and BlueCard claims) members only. Inpatient unbundling will be identified by the code **"VAS."**

Blue Cross will not separately reimburse for over-the-counter medications that are part of inpatient acute-care claims.

The full policy is available in the *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.bcbsla.com/ilinkblue**, click on "Resources," then "Manuals."



Routine Services

Routine services as those services included by the provider in a daily service charge– sometimes referred to as the "room and board" charge.

Routine supplies are included in general cost of the room where services are rendered. These items are considered floor stock and are generally available to all patients receiving services. As routine supplies, they cannot be billed separately. Examples include drapes, saline solutions and reusable items.

The following are examples of facility general and administrative costs and charges, including routine disposable and reusable equipment, supplies and items, which a facility may not separately bill for reimbursement.

- Oxygen transport fees
- Oximetry
- Personnel and additional staff
- Patient transportation fees
- Patient monitoring of any kind
- Maintenance of hospital equipment
- Any charge for the performance of a bedside procedure
- Call back time for physicians or staff
- Hospital emergency code alerts, rapid alert teams, code teams, etc.
- Supplemental feedings or nutrition such as Ensure, Isocal, including tube feeding, etc.
- Any nursing care service within the scope of normal nursing practice, i.e., admission, assessment, discharge, etc.

Inpatient Unbundling Reports

Blue Cross reviews inpatient acute care claims for billing accuracy based on the inpatient unbundling policy. In the past, when an inpatient acute care claim was unbundled, facilities had to request a report for how the claim was reprocessed.

Facilities can now use iLinkBlue (**www.bcbsla.com/ilinkblue**) to review automatically generated reports on how inpatient claims were unbundled.

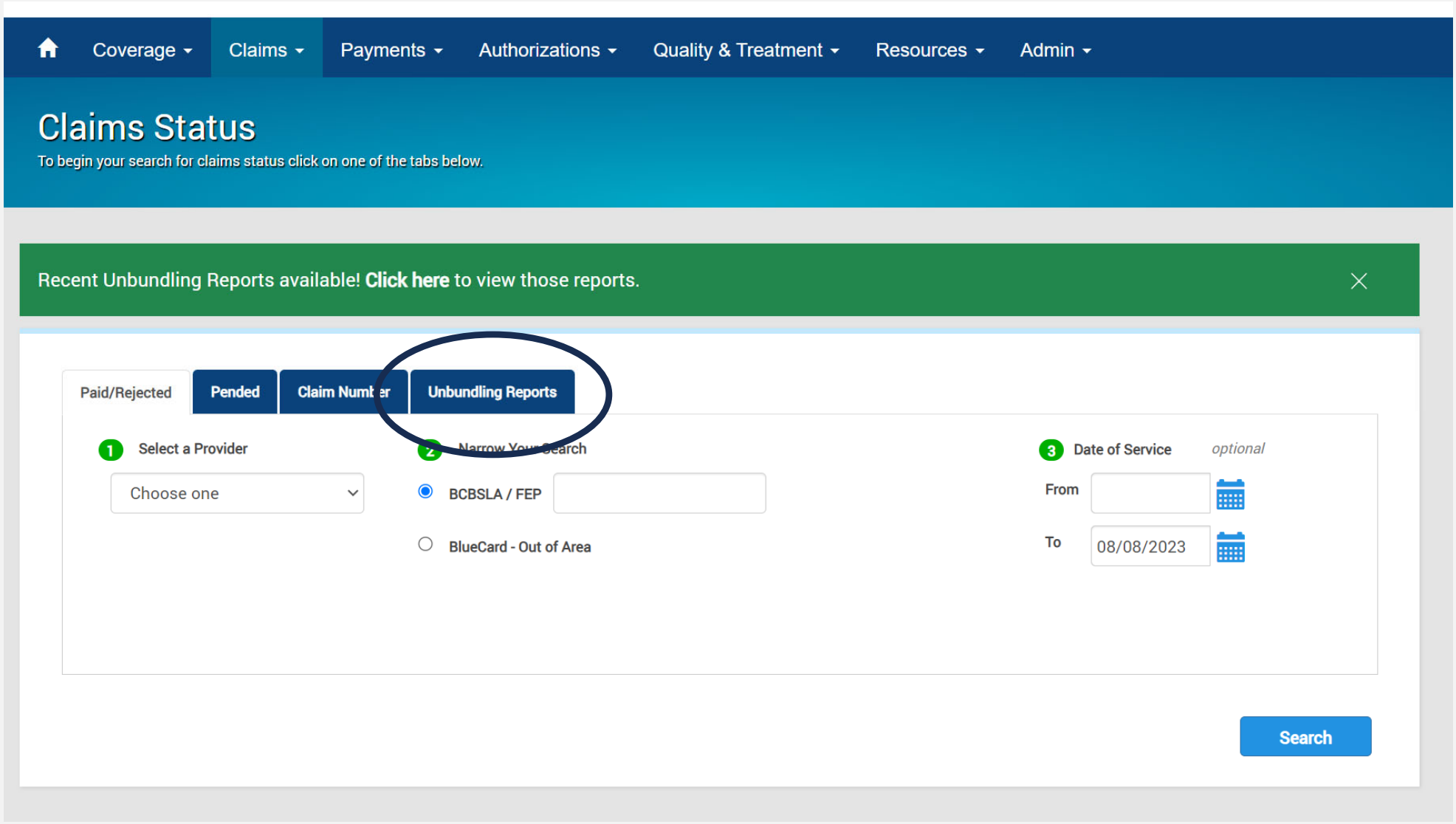
- If you have no reports, it simply means you have no unbundled claims.
- As of April 18, 2023, reports will be retained within iLinkBlue for 16 months from the date of generation.

Unbundling Reports will apply to the following:

- Prepay claims
- Acute Care Facilities
- Charges greater than $100,000

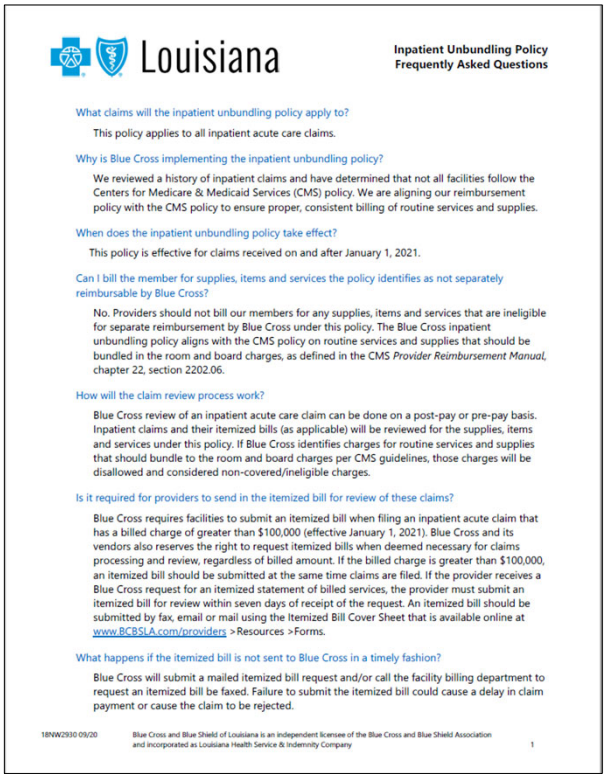
Viewing Inpatient Unbundling Reports

www.bcbsla.com/ilinkblue



Inpatient Unbundling Policy FAQs

For a copy of our *Inpatient Unbundling Policy Frequently Asked Questions,* email **provider.relations@bcbsla.com**.



Louisiana

Inpatient Unbundling Policy Frequently Asked Questions

What claims will the inpatient unbundling policy apply to?

This policy applies to all inpatient acute care claims.

Why is Blue Cross implementing the inpatient unbundling policy?

We reviewed a history of inpatient claims and have determined that not all facilities follow the Centers for Medicare & Medicaid Services (CMS) policy. We are aligning our reimbursement policy with the CMS policy to ensure proper, consistent billing of routine services and supplies.

When does the inpatient unbundling policy take effect?

This policy is effective for claims received on and after January 1, 2021.

Can I bill the member for supplies, items and services the policy identifies as not separately reimbursable by Blue Cross?

No. Providers should not bill our members for any supplies, items and services that are ineligible for separate reimbursement by Blue Cross under this policy. The Blue Cross inpatient unbundling policy aligns with the CMS policy on routine services and supplies that should be bundled in the room and board charges, as defined in the CMS *Provider Reimbursement Manual,* chapter 22, section 2202.06.

How will the claim review process work?

Blue Cross review of an inpatient acute care claim can be done on a post-pay or pre-pay basis. Inpatient claims and their itemized bills (as applicable) will be reviewed for the supplies, items and services under this policy. If Blue Cross identifies charges for routine services and supplies that should bundle to the room and board charges per CMS guidelines, those charges will be disallowed and considered non-covered/ineligible charges.

Is it required for providers to send in the itemized bill for review of these claims?

Blue Cross requires facilities to submit an itemized bill when filing an inpatient acute claim that has a billed charge of greater than $100,000 (effective January 1, 2021). Blue Cross and its vendors also reserves the right to request itemized bills when deemed necessary for claims processing and review, regardless of billed amount. If the billed charge is greater than $100,000, an itemized bill should be submitted at the same time claims are filed. If the provider receives a Blue Cross request for an itemized statement of billed services, the provider must submit an itemized bill for review within seven days of receipt of the request. An itemized bill should be submitted by fax, email or mail using the Itemized Bill Cover Sheet that is available online at www.BCBSLA.com/providers >Resources >Forms.

What happens if the itemized bill is not sent to Blue Cross in a timely fashion?

Blue Cross will submit a mailed itemized bill request and/or call the facility billing department to request an itemized bill be faxed. Failure to submit the itemized bill could cause a delay in claim payment or cause the claim to be rejected.

Readmissions Policy

- Readmissions to the same or an affiliated facility for the same condition, similar condition or a complication of the original condition within 30 days of discharge will not be reimbursed.
- The first admission payment will encompass full reimbursement for treatment of the condition and/or any related complications.
- Providers cannot bill members for service recouped as a result of this policy.
- EXCD codes related to our provider integrity audits will appear on the payment register for the BCBSLA (excludes FEP and BlueCard claims) members only. Readmissions will be identified by the code **"VT8."**

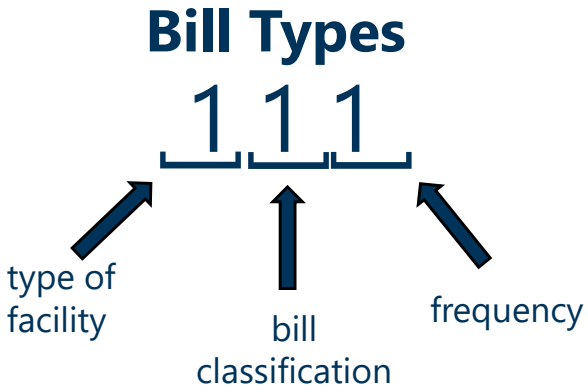
To view the full Blue Cross readmissions policy, refer to *our Member Provider Procedure & Policies Manual*, available in iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" menu option.

Facility Billing Guidelines

Facility claims must be submitted on a UB-04 form. Bill types are three digits, and each position represents specific information about the claim being filed.

Blue Cross does **not** exclude first or second digits of a bill type. However, there **are** limitations and/or exclusions for the third digit (frequency code).

Frequency Code	Description	Blue Cross Acceptance Rule
Non-interim Claims		
1	Admit Through Discharge Claim	Accepted
Interim Claims		
2	Interim (First Claim)	We accept interim claims only when the total charge is $800,000 or greater **and** the length of stay is at least 60 days of service.
3	Interim (Continuing Claims)	
Not Accepted		
4	Interim (Last Claim)*	Not Accepted
5	Late Charge Only	Not Accepted
6		Not Accepted
9	Final Claim for a Home Health PPS Episode	Not Accepted
Prior Claims		
7	Replacement of Prior Claim or Corrected Claim	Accepted
8	Void or Cancel of a Prior Claim	Accepted



**The final interim bill should aggregate all interim bills and late charge claims. (if applicable). The final interim bill should be submitted using a frequency code of 1 or 7.*

These guidelines are outlined in the *Member Provider Policy & Procedure Manual,* available on iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

Coordination of Benefits

Blue Cross would periodically and proactively request information from our members about other coverage. If we did not receive the information, we would pend or deny claims.

As of January 1, 2023, we no longer pend or deny claims based on the member's response status to other coverage inquiries. We do, however, continue to request the other coverage information from the member.

If Blue Cross or HMO Louisiana is not the primary insurer of a member, providers must submit an explanation of benefits from the primary carrier when filing a claim.

Scenarios in which claims may pend or deny due to coordination of benefits still exist and include (but not limited to):

- A member with Medicare, plus a group policy through Blue Cross.
- A child with coverage from different parents' group plans.

In these cases, claims will deny if we do not receive an explanation of benefits. Always verify member benefits before rendering services. You may find information about a member's network on their ID card.

This Act does not include Federal Employee Program (FEP) members or BlueCard® claims.

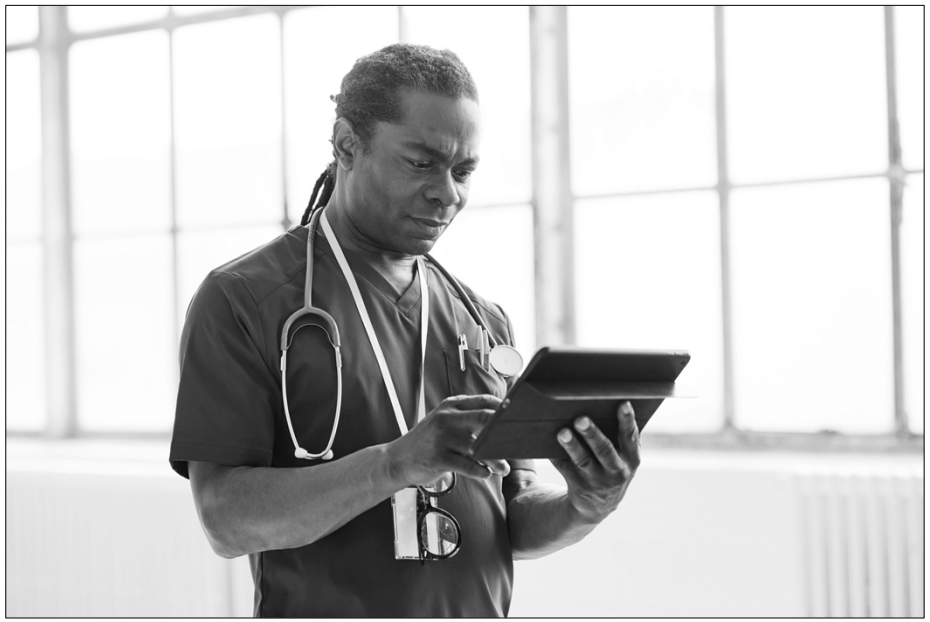
Updated Drug Allowables

- As part of our routine biannual drug and drug administration code pricing review, we are updating the reimbursement schedule for drug codes, effective for claims with dates of service on and after **September 1, 2023**.
- Facility providers can research allowable charges in iLinkBlue (**www.bcbsla.com/ilinkblue**). The application is available under the "Payments" section.
- By "Select a date," enter "09-01-2023" to access the allowable charges that will go into effect September 1, 2023.

If you have any questions, please contact your Provider Contracting Representative or email **provider.contracting@bcbsla.com**.

Outpatient Code Change Reminder

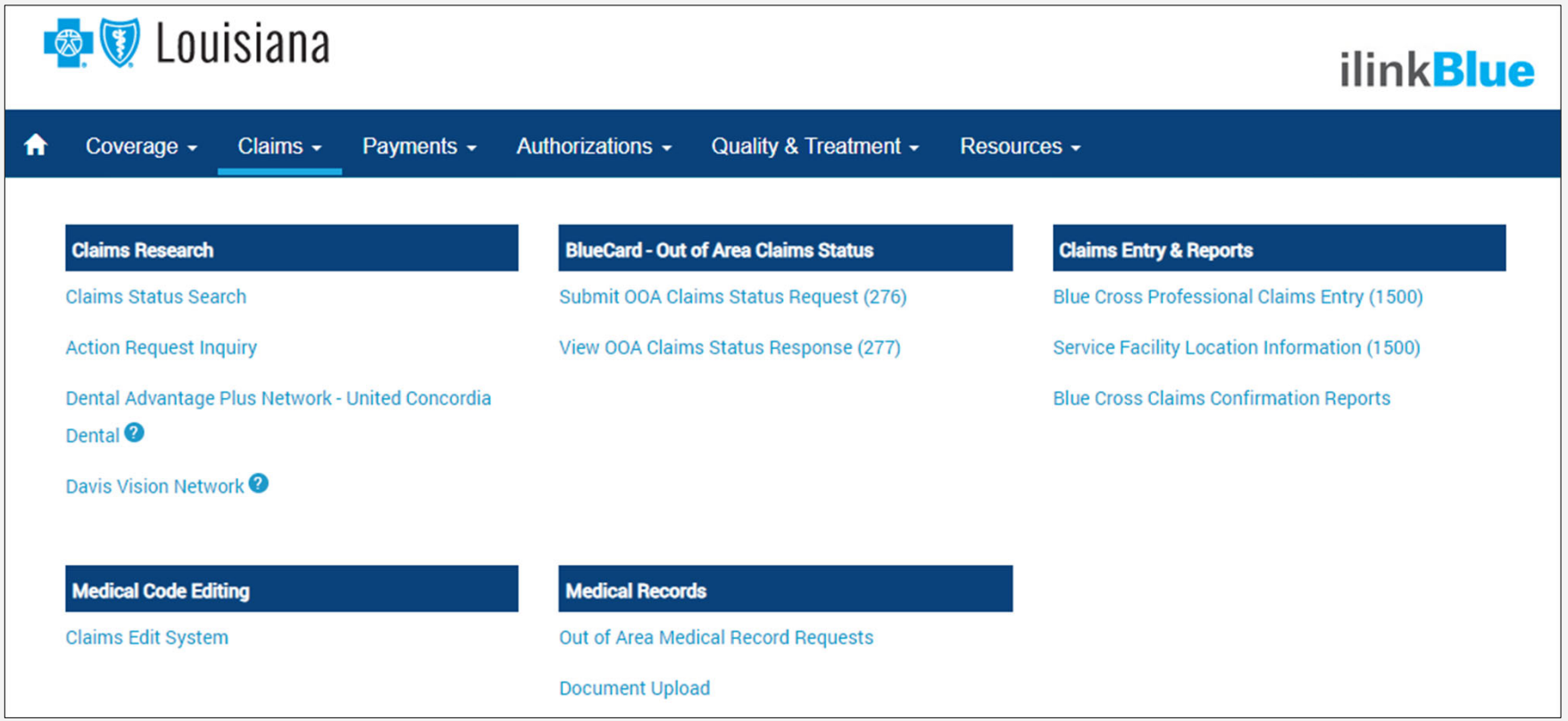
- Blue Cross made changes to outpatient code ranges related to the insertion and removal of drug delivery implants effective for dates of service on and after **September 1, 2023**.
- We removed CPT® codes 11981, 11982 and 11983 from the Outpatient Procedure Services code range and we added them to the Diagnostic and Therapeutic Services code range.



ILINKBLUE
SELF SERVICE

Finding Your Claims in iLinkBlue

Use iLinkBlue (**www.bcbsla.com/ilinkblue**) to research received, pended and paid claims.

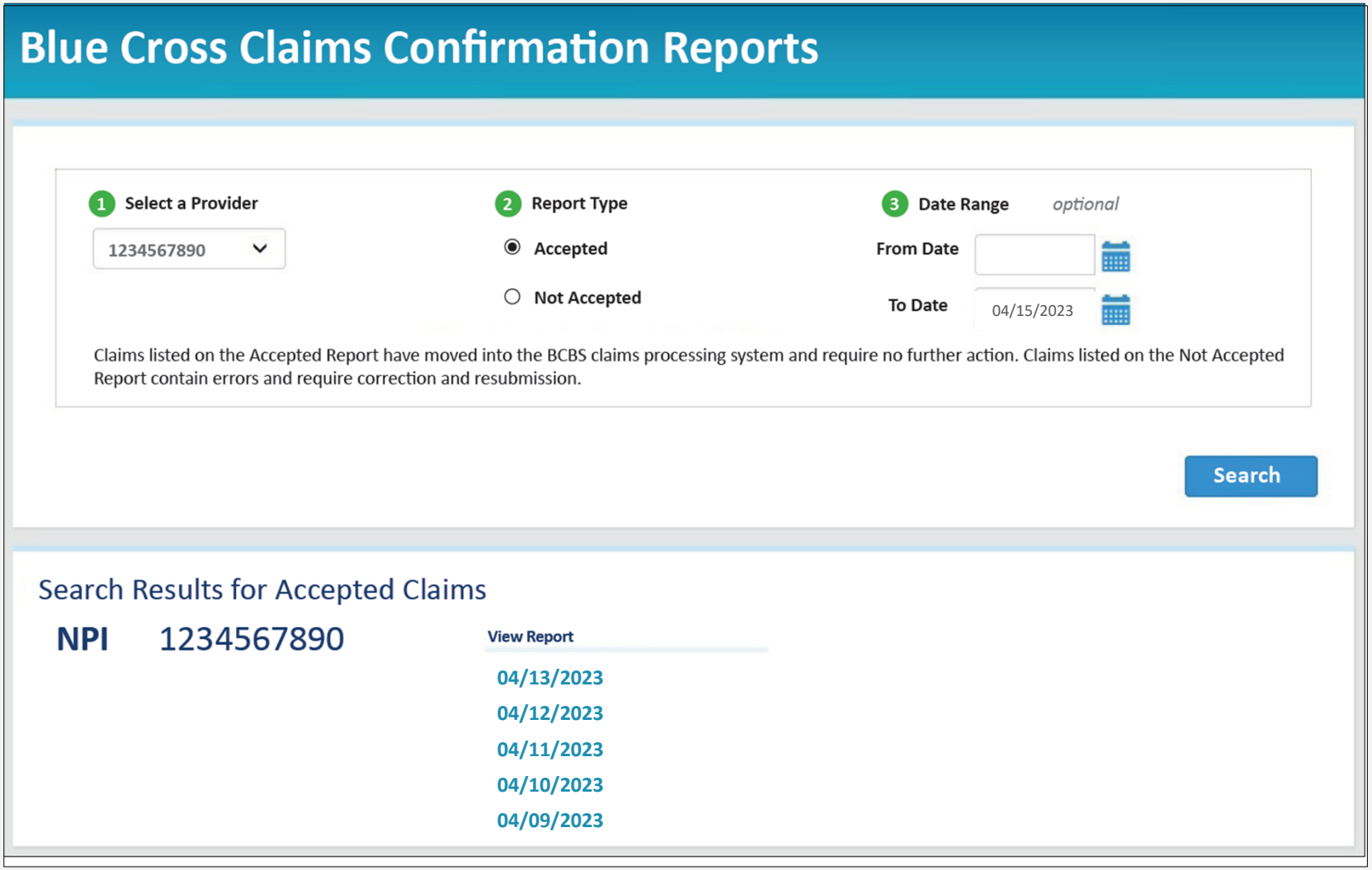


Claims Confirmation Reports in iLinkBlue

- These reports include detailed claim information on transactions that were accepted or not accepted by Blue Cross for processing.
- You may access these reports from the iLinkBlue menu by choosing “Claims,” then “Blue Cross Claims Confirmation Reports.”
- Reports are available up to 120 days.
- The reports include claims submitted through iLinkBlue, as well as, through a clearinghouse or billing agency.

Blue Cross Claims Confirmation Reports

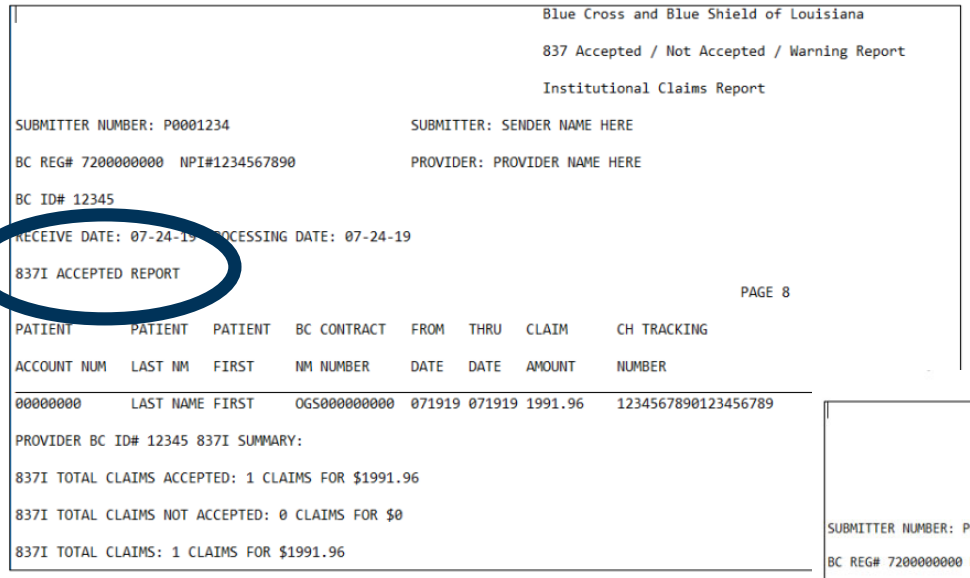
Confirmation reports can be found under at **www.bcbsla.com/ilinkblue** >Claims >Claims Entry and Reports >Blue Cross Claims Confirmation Reports.



Blue Cross Claims Confirmation Reports

Confirmation Reports indicate detailed claim information on transactions that were accepted or not accepted for processing. Providers are responsible for reviewing these reports and correcting claims appearing on the “Not Accepted” report.

Accepted Report



Blue Cross and Blue Shield of Louisiana

837 Accepted / Not Accepted / Warning Report

Institutional Claims Report

SUBMITTER NUMBER: P0001234 SUBMITTER: SENDER NAME HERE

BC REG# 7200000000 NPI#1234567890 PROVIDER: PROVIDER NAME HERE

BC ID# 12345

RECEIVE DATE: 07-24-19 PROCESSING DATE: 07-24-19

837I ACCEPTED REPORT PAGE 8

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST	BC CONTRACT NM NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	CH TRACKING NUMBER
00000000	LAST NAME FIRST		OGS000000000	071919	071919	1991.96	1234567890123456789

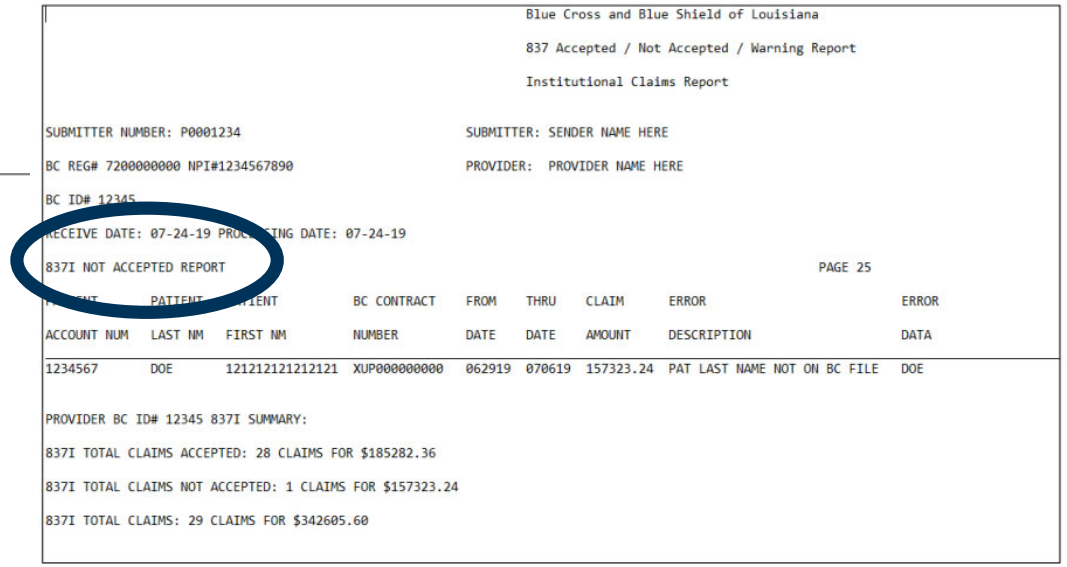
PROVIDER BC ID# 12345 837I SUMMARY:

837I TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $1991.96

837I TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0

837I TOTAL CLAIMS: 1 CLAIMS FOR $1991.96

Not Accepted Report



Blue Cross and Blue Shield of Louisiana

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SUBMITTER NUMBER: P0001234 SUBMITTER: SENDER NAME HERE

BC REG# 7200000000 NPI#1234567890 PROVIDER: PROVIDER NAME HERE

BC ID# 12345

RECEIVE DATE: 07-24-19 PROCESSING DATE: 07-24-19

837I NOT ACCEPTED REPORT PAGE 25

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
1234567	DOE	121212121212121	XUP000000000	062919	070619	157323.24	PAT LAST NAME NOT ON BC FILE	DOE

PROVIDER BC ID# 12345 837I SUMMARY:

837I TOTAL CLAIMS ACCEPTED: 28 CLAIMS FOR $185282.36

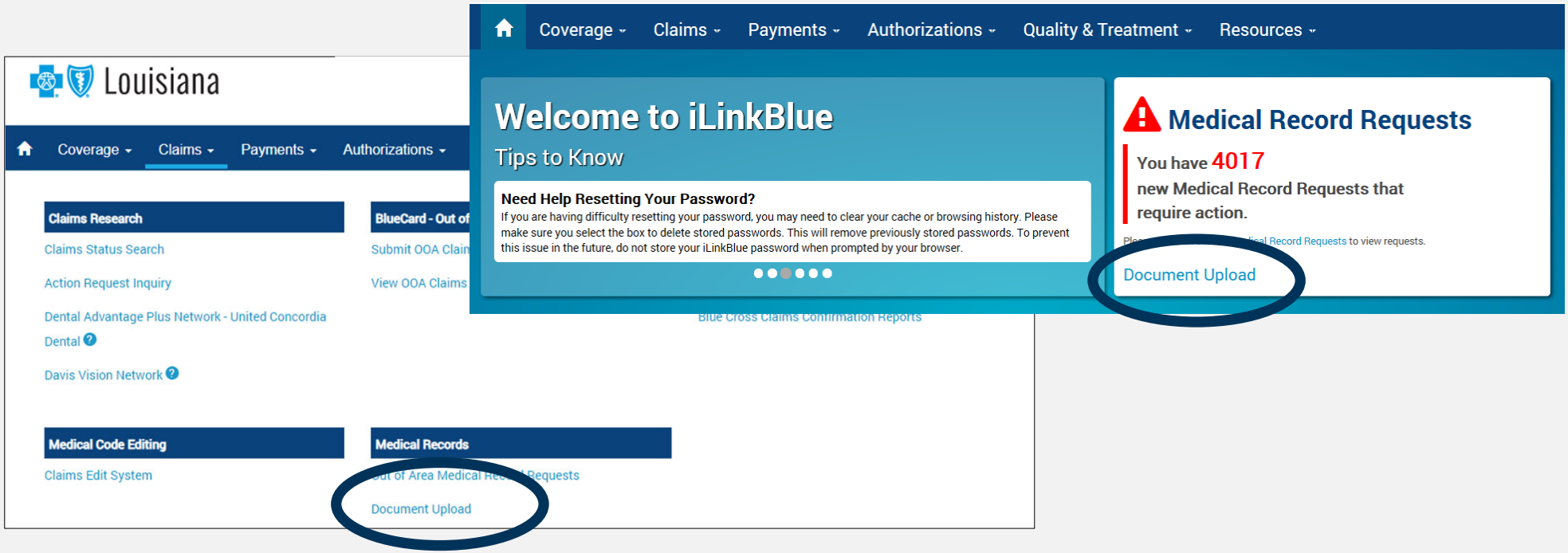
837I TOTAL CLAIMS NOT ACCEPTED: 1 CLAIMS FOR $157323.24

837I TOTAL CLAIMS: 29 CLAIMS FOR $342605.60

Document Upload Feature

We now offer a feature that allows providers to upload documents that would normally be faxed, emailed or mailed to select departments.

The new feature is quick, secure and available at any time through iLinkBlue.



The Document Upload feature can be accessed on iLinkBlue (**www.bcbsla.com/ilinkblue**) or under Claims >Medical Records >Document Upload.

Document Upload Feature

Select the department from the drop-down list you wish to send your document. The fax numbers are included only as a reference to assist in selecting the correct department.

Blue Cross accepts document uploads for:

- Provider Disputes
- Payment Integrity
- ACA Risk Optimization
- ITS Host Medical Records
- Health and Quality Management (HEDIS®)
- Federal Employee Program (FEP) Appeals
- Medical Necessity & Investigational Appeals Only
- Medical Records for Retrospective or Post Claim Review

Document Upload Feature FAQs

What should be included in the uploaded document?

- Include any notification, letter or form that is required with the request along with the medical records or other documentation requested. If submitting a dispute or appeal, include the appropriate form.

What file types are allowed in the upload process?

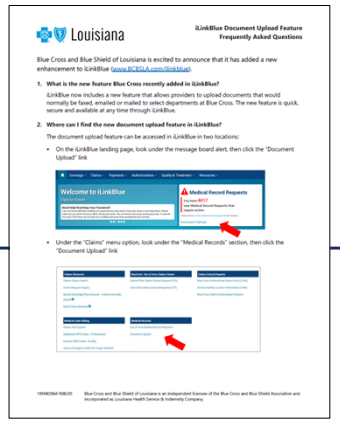
- DOC, DOCX, PDF, TIF, TXT

Do I need to send a fax or hard copy request in addition to upload?

- No. Sending the uploaded document thru fax, email or hardcopy mail **in addition** to uploading, will result in duplicate requests being received at Blue Cross. This will delay the processing of the request.

Is there a file size limitation?

- Files that are over 10MB in size will not be accepted for upload. Documents that exceed this limit will need to be faxed or mailed to Blue Cross.


Louisiana

iLinkBlue Document Upload Feature
Frequently Asked Questions

Blue Cross and Blue Shield of Louisiana is excited to announce that it has added a new enhancement to iLinkBlue (www.BCBSLA.com/ilinkblue).

1. **What is the new feature Blue Cross recently added in iLinkBlue?**

   iLinkBlue now includes a new feature that allows providers to upload documents that would normally be faxed, emailed or mailed to select departments at Blue Cross. The new feature is quick, secure and available at any time through iLinkBlue.

2. **Where can I find the new document upload feature in iLinkBlue?**

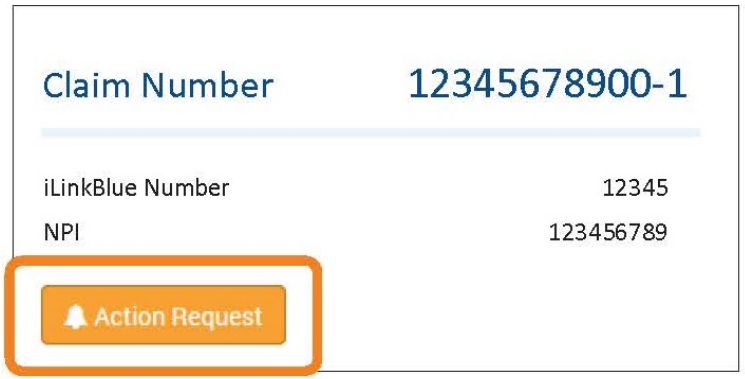
   The document upload feature can be accessed in iLinkBlue in two locations:

   - On the iLinkBlue landing page, look under the message board alert, then click the "Document Upload" link

   - Under the "Claims" menu option, look under the "Medical Records" section, then click the "Document Upload" link

For a copy of the Document Upload Feature FAQs send an email to **provider.relations@bcbsla.com**.

Submitting Action Requests



- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 business days for first request
- Check iLinkBlue for a claims resolution
- Submit a second action request for a review
- Allow 10-15 business days for second request

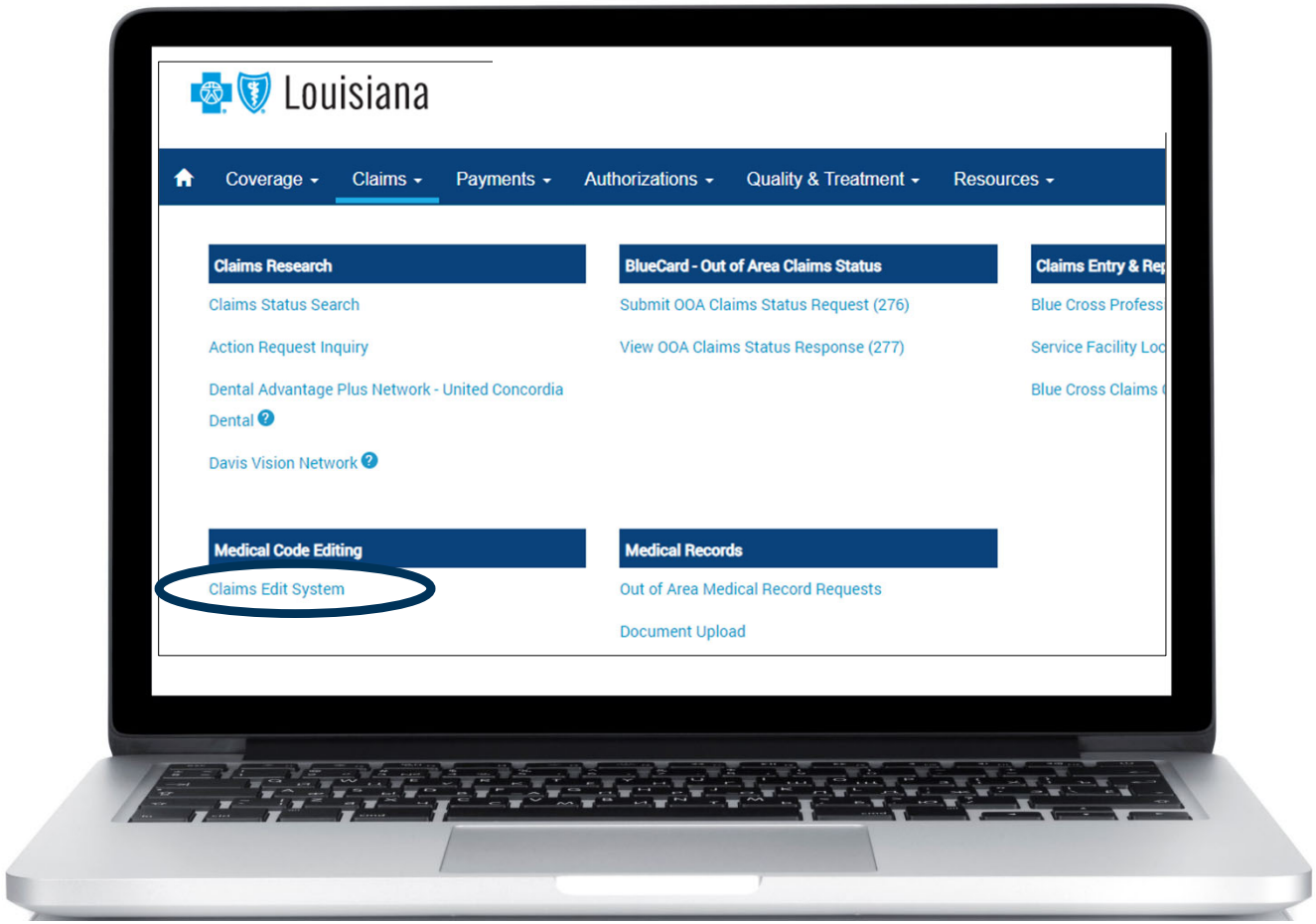
If you have followed the steps outlined here and still do not have a resolution, you may contact Provider Relations for assistance at **provider.relations@bcbsla.com**

Email an overview of the issue along with two action request dates OR two customer service reference numbers if one of the following applies:

- You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center at **1-800-922-8866**) and have allowed 10-15 business days after second request, or
- It is a system issue affecting multiple claims

Claims Editing System (CES) Application

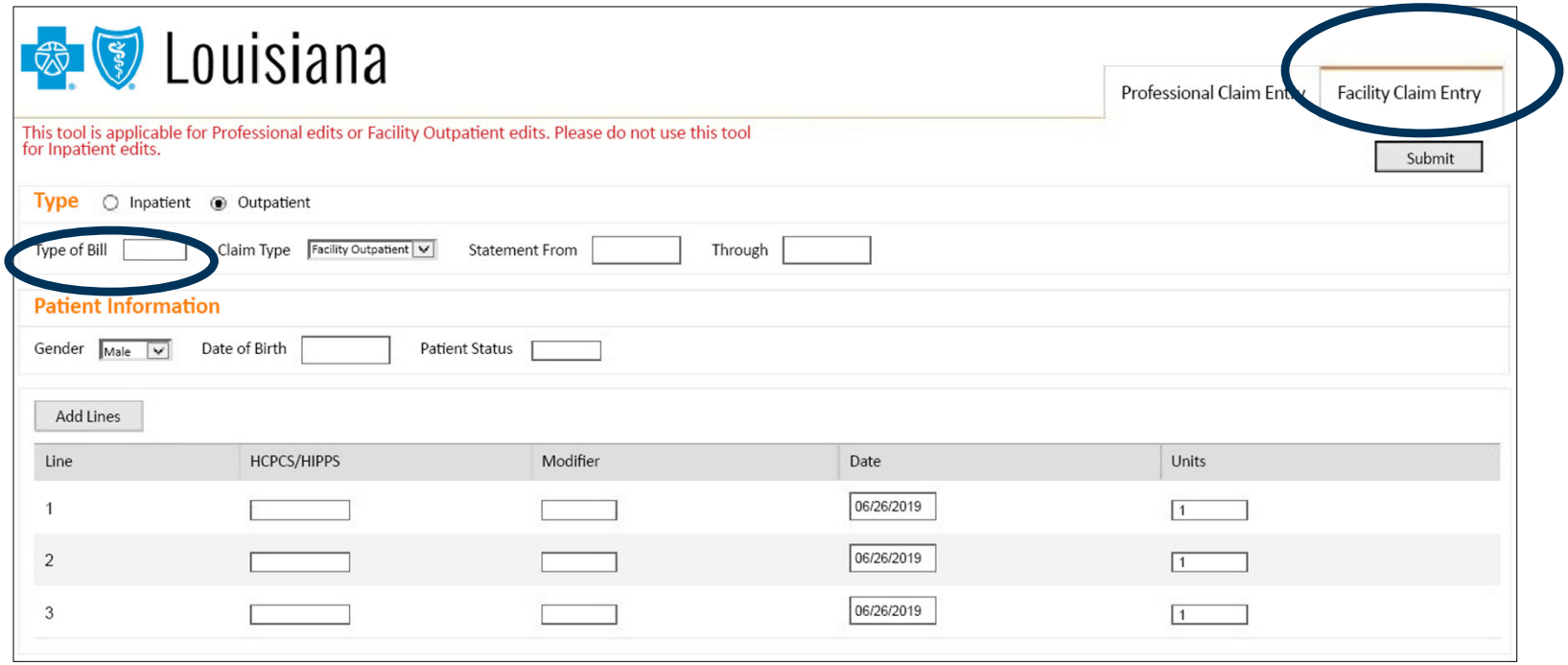
With the implementation of the CES system, we have an application in iLinkBlue for providers to calculate claim-edit outcomes.



www.bcbsla.com/ilinkblue

CES Application

The **Facility Claim Entry** screen is for entering codes for hospital outpatient and ambulatory surgery center (ASC) claims. **Do not use for inpatient claim edits.**



Required Fields:

- Type – select outpatient
- Type of Bill – enter an appropriate 3-digit type of bill
- Claim Type – select Facility Outpatient
- Statement From/Through – date range of the procedure
- Gender – this field defaults to Male
- Date of Birth
- Patient Status – enter appropriate 2-digit patient status
- HCPCS/HIPPS – enter the valid CPT/HCPCS code
- Modifier – appropriate modifier for this CPT code
- Units – enter the number of units, this field defaults to a value of one

MEDICAL RECORDS

Medical Record Requests

Medical Request Reminders:

- Per your Blue Cross network agreement, medical records should be provided at no cost.
- We will work with your copy center or vendor at no cost.
- Under the HIPAA Privacy Rule, data collection for HEDIS® is permitted, and a release of this information requires no special patient consent or authorization.
- We appreciate your cooperation in sending the requested medical record information in a timely manner (ideally in five to seven business days).

RADV Audits

Each year, Blue Cross contacts providers to request medical records for reviewing:

- Patient health risks
- Preventive service needs
- Thorough medical evaluations

This review is conducted in accordance with U.S. Department of Health and Human Services Risk Adjustment Data Validation (HHS-RADV) guidelines for applicable health benefit plans.

Reviewing medical records is a key component of the risk adjustment data validation audit process and enables us to identify conditions in the progress notes that were:

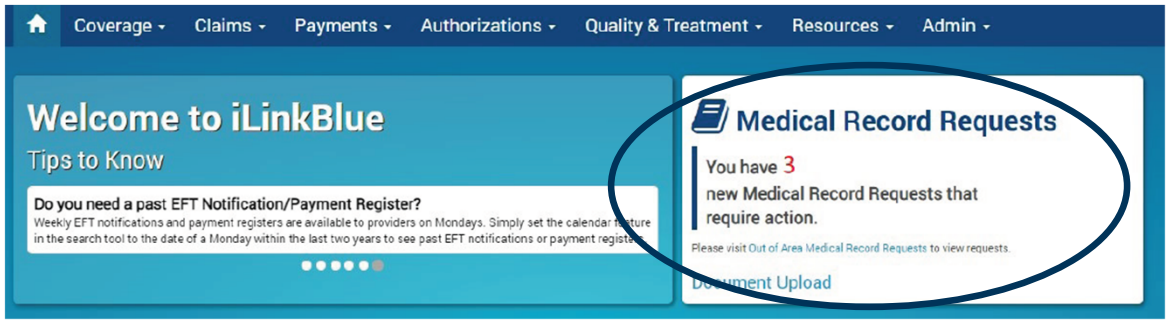
- Not included on the claim at the time of the visit; and/or
- Not coded to the highest degree of specificity at the time of the visit

RADV Audits

- Providers can submit records by email, fax or mail; or through an onsite visit within five to ten business days of receipt of notification. The notification will include contact information.
- Several providers have provided direct access to their records using electronic medical records (EMR) systems. Our team will review the records that are accessible through those EMRs.
- Only records that are unable to be found in the EMR, and from locations we do not have EMR access, will be requested.
- If you have questions about risk adjustment chart reviews or would like to lighten the burden on your office by providing EMR access to our team, please contact Taylor Lawrence by phone at (225) 298-1576 or email **taylor.lawrence2@bcbsla.com**.

BlueCard Medical Record Request

- Providers no longer receive hardcopy letters for BlueCard medical record requests. Instead, Blue Cross will only alert providers through iLinkBlue.
- This change does not affect non-BlueCard medical record requests. Blue Cross will continue to send hardcopy requests for non-BlueCard members.



For more information find our Medical Record Guidelines for BlueCard tidbit at **www.bcbsla.com/providers** >Resources >Tidbits.

Blue Advantage Medical Record Requests

- Blue Advantage is currently partnered with **Cognisight** to assist us in conducting medical record reviews.
- As a provider in our Blue Advantage network, you are not to charge a fee for providing medical records to Blue Advantage or vendors acting on our behalf.
- Additionally, the patient's Blue Advantage member contract allows for the release of information to Blue Advantage or its designee.
- In accordance with all applicable state and federal laws and HIPAA, any information shared with our vendors will be kept in the strictest of confidence.

Electronic Medical Records (EMRs)

- Granting Blue Cross access to your EMR can save you time!
- With your permission and agreement on file, Blue Cross can access your HEDIS, RADV and other **non-claims records** without having to request them from you, saving you time and effort.
- Simply send your EMR agreement to our Provider Relations Department at **provider.relations@bcbsla.com**.

HEDIS®

What is HEDIS?

Healthcare Effectiveness Data and Information Set

HEDIS is a set of health care performance measures developed by the National Committee for Quality Assurance (NCQA).

- It is used by more than 90% of America's health plans to measure and improve health care quality.
- HEDIS is a retrospective performance review of the prior calendar year and beyond.

Find more information online at **www.ncqa.org/hedis**.

Purpose of HEDIS Results

Health plans use HEDIS performance results to:

- Evaluate quality of care and services.
- Evaluate provider performance.
- Develop performance quality improvement initiatives.
- Perform outreach to members.
- Compare performance with other health plans.

HEDIS Data Collection Methods

Administrative Method - Obtained from our claims database and supplemental data.

Hybrid Method - Obtained from our claims database and medical record reviews.

Survey Method - Obtained from member surveys.

Tips for Improving Quality of Care HEDIS

- Encouraging patients to schedule preventive exams.
- Reminding patients to follow up with ordered tests and procedures.
- Ensure necessary services are being performed in a timely manner.
- Submitting claims with proper codes.
- Accurately documenting all completed services and results in the patient's chart.

If you have questions related to HEDIS measures or medical record collections, please contact the Health and Quality Department at **HEDISteam@bcbsla.com**.

HEDIS® Medical Record Requests

- Medical record requests are sent to providers from our Blue Cross HEDIS Team. Requests include:
  - Member Name
  - Provider Name
  - A description of the type of medical records and timeframes needed to close the HEDIS gaps.
- The team will coordinate with your office for data collection methods. These options include:
  - Remote electronic data collection
  - Onsite visits
  - Fax
  - Mail
  - Direct upload

SUPPORTING YOUR NEEDS

Call Centers

Customer Care Center	**1-800-922-8866**
FEP Dedicated Unit	**1-800-272-3029**
OGB Dedicated Unit	**1-800-392-4089**
Blue Advantage	**1-866-508-7145**

For information NOT available on iLinkBlue

Other Provider Phone Lines

BlueCard Eligibility Line® – **1-800-676-BLUE (1-800-676-2583)**
for out-of-state member eligibility and benefits information

Fraud & Abuse Hotline – **1-800-392-9249**
Call 24/7 and you can remain anonymous as all reports are confidential

Health Services Division – 1-800-716-2299

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding credentialing and provider record information
- **option 3** – for questions regarding iLinkBlue and clearinghouse information
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding security access to online services

Provider Relations

Kim Gassie – Director

Jami Zachary – Manager

Marie Davis – Sr. Provider Relations Rep.
Allen, Avoyelles, Beauregard, Caldwell, Catahoula**,** Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll, Acadia

Anna Granen – Sr. Provider Relations Rep.
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

Mary Guy
East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana, Livingston, Pointe Coupee, St. Martin, Terrebonne

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson**,** Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn, Jefferson Davis, St. Landry, Vermilion

Yolanda Trahan
Assumption, Iberia, Lafayette, St. Charles, St. James, St. John the Baptist, St. Mary, Calcasieu, Cameron, Lafourche

provider.relations@bcbsla.com | 1-800-716-2299, option 4

Paden Mouton, Supervisor

Provider Contracting

Jason Heck, Director – jason.heck@bcbsla.com

Diana Bercaw, Lead Provider Network Development Representative – diana.bercaw@bcbsla.com
Jefferson, Orleans, Plaquemines, St. Bernard, St. Tammany, Tangi and Washington parishes

Jordan Black, Sr. Provider Network Development Representative – jordan.black@bcbsla.com
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

Sue Condon, Lead Network Development & Contracting Representative – sue.condon@bcbsla.com
West Feliciana, East Feliciana, St. Helena, Pointe Coupee, West Baton Rouge, East Baton Rouge, Livingston, Ascension, Assumption and Iberville parishes

Cora LeBlanc, Sr. Provider Network Development Representative – cora.leblanc@bcbsla.com
St. John The Baptist, Terrebonne, Lafourche, St. Charles, St. James, Tensas, Madison, East Carroll, West Carroll, Franklin, Richland, Morehouse, Ouachita, Caldwell, Union, Concordia, Catahoula and Lasalle parishes

Dayna Roy, Sr. Provider Network Development Representative – dayna.roy@bcbsla.com
Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Grant, Jefferson Davis, Rapides and Vernon parishes

Lauren Viola, Provider Network Development Representative – lauren.viola@bcbsla.com
Caddo, Bossier, Webster, Claiborne, Desoto, Red River, Bienville, Sabine, Natchitoches, Winn, Jackson and Lincoln parishes

provider.contracting@bcbsla.com | 1-800-716-2299, option 1

Doreen Prejean **Mary Landry** **Karen Armstrong**

Future Educational Opportunities

iLinkBlue Training

- October 3
- October 5

BlueCard

- October 11

New to Blue Cross

- October 19

PCDM

- November 18

Invitations for webinars are included in our Weekly Digest emails that are sent on Thursdays.

Provider Engagement Survey

Your feedback is important!

THANK YOU to everyone who took our 2022 survey. Based on your feedback, we made changes including:

- Less Blue Cross emails to your inbox – we created the Provider Weekly Digest as a way to consolidated provider communications into one email digest that goes out every Thursday. It includes notifications, general announcements and provider training event information and registration options.
- iLinkBlue training webinars – we now offer iLinkBlue training webinars for new users.
- Improvement to our credentialing process – we have focused on improving our customer service and resolving provider issues timely.
- iLinkBlue enhancements (i.e., visits, limitations, etc.).

We would ❤ for you to complete our 2023 survey.

It ends on: **Oct. 8**

Participants could win 1 of 26 gift cards with top prize of $500.

If you have not received a survey link, send us an email to provider.communications@bcbsla.com and put "Provider Engagement Survey" in the subject line.

QUESTIONS

Appendix

Provider Support

Provider Credentialing & Data Management

Provider Network Setup, Credentialing, Contracting & Demographic Change

Vielka Valdez, Director, Provider Network Operations
vielka.valdez@bcbsla.com

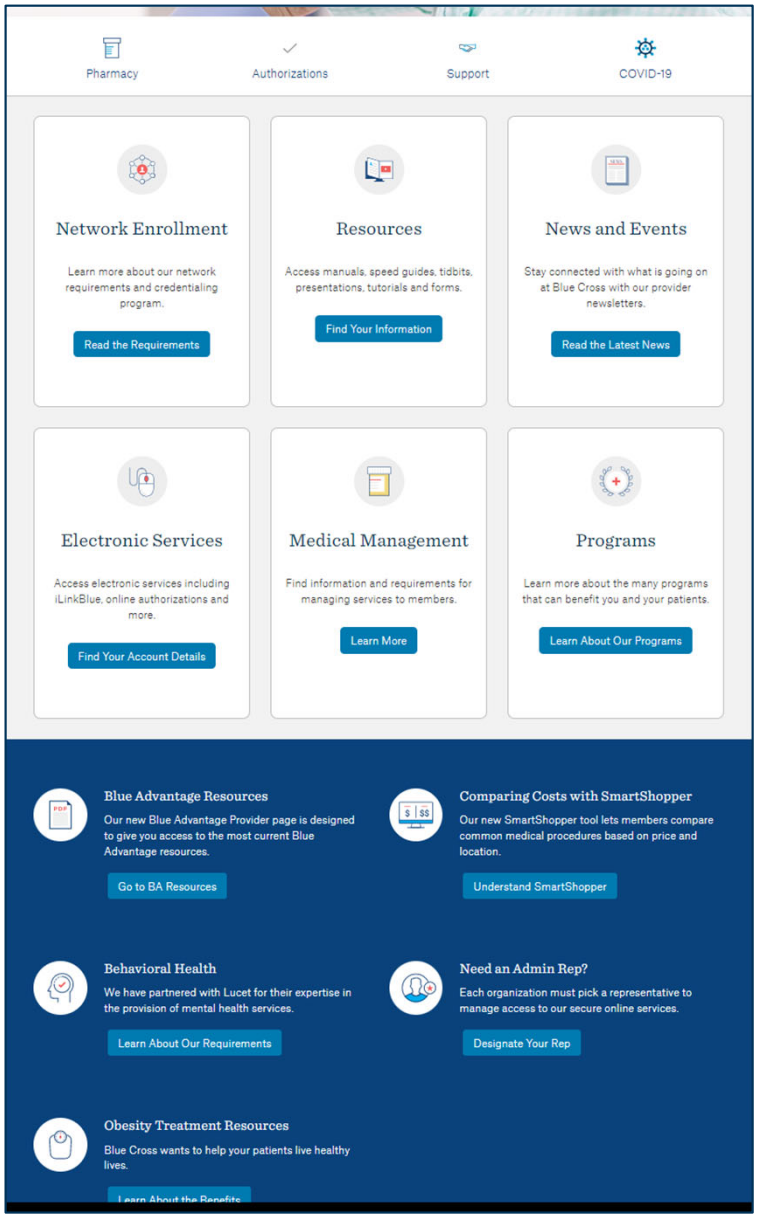
Kaci Guidry, Manager, Provider Credentialing and Data Management
kaci.guidry@bcbsla.com

Kristin Ross, Manager, Provider Contract Administration
kristin.ross@bcbsla.com

Chrisy Cavalier, Supervisor, Provider Information (PCDM Status)
chrisy.cavalier@bcbsla.com

If you would like to check the status on your credentialing application or provider data change or update, please contact the Provider Credentialing & Data Management Department by emailing **PCDMstatus@bcbsla.com** or by calling 1-800-716-2299, option 2.

Provider Page

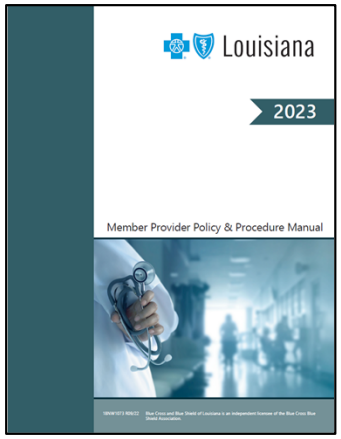


www.bcbsla.com/providers

The Provider page is home to online resources such as:

- Provider manuals
- Network speed guides
- Newsletters
- Provider forms
- And more

Manuals & Newsletters



Our provider **manuals** are extensions of your network agreement(s). The manuals are designed to provide the information you need as a participant in our network. Member Provider and Procedure manual is accessible through iLinkBlue only.

www.bcbsla.com/iLinkBlue >Resources >Manuals

Our provider **newsletters** are sent electronically and contain information and tips on changes to processes, such as claims filing procedures or reimbursement changes, along with a number of featured articles.

www.bcbsla.com/providers >Newsletters

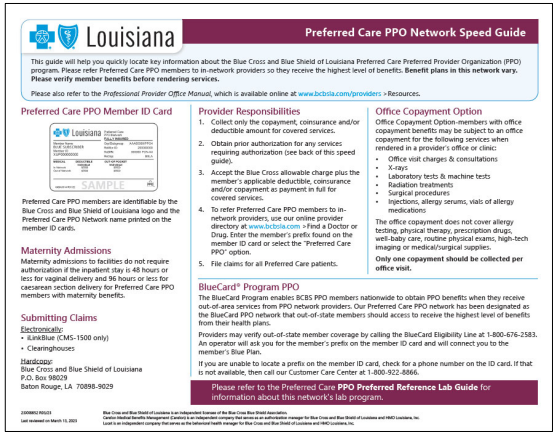
Not Getting Our Newsletters?

Send an email to **provider.communications@bcbsla.com**. Put "newsletter" in the subject line. Please include your name, organization name and contact information.

Speed Guides & Tidbits

Speed guides offer quick reference to network authorization requirements, policies and billing guidelines.

www.bcbsla.com/providers
>Resources >Speed Guides


Louisiana

Preferred Care PPO Network Speed Guide

This guide will help you quickly locate key information about the Blue Cross and Blue Shield of Louisiana Preferred Care Preferred Provider Organization (PPO) program. Please refer Preferred Care PPO members to in-network providers so they receive the highest level of benefits. **Benefit plans in this network vary. Please verify member benefits before rendering services.**

Please also refer to the *Professional Provider Office Manual*, which is available online at www.bcbsla.com/providers >Resources.

Preferred Care PPO Member ID Card

Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network name printed on the member ID cards.

Maternity Admissions

Maternity admissions to facilities do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for caesarean section delivery for Preferred Care PPO members with maternity benefits.

Submitting Claims

Electronically:
- iLinkBlue (CMS-1500 only)
- Clearinghouses

Hardcopy:
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Provider Responsibilities

1. Collect only the copayment, coinsurance and/or deductible amount for covered services.
2. Obtain prior authorization for any services requiring authorization (see back of this speed guide).
3. Accept the Blue Cross allowable charge plus the member's applicable deductible, coinsurance and/or copayment as payment in full for covered services.
4. To refer Preferred Care PPO members to in-network providers, use our online provider directory at www.bcbsla.com >Find a Doctor or Drug. Enter the member's prefix found on the member ID card or select the "Preferred Care PPO" option.
5. File claims for all Preferred Care patients.

Office Copayment Option

Office Copayment Option-members with office copayment benefits may be subject to an office copayment for the following services when rendered in a provider's office or clinic:
- Office visit charges & consultations
- X-rays
- Laboratory tests & machine tests
- Radiation treatments
- Surgical procedures
- Injections, allergy serums, vials of allergy medications

The office copayment does not cover allergy testing, physical therapy, prescription drugs, well-baby care, routine physical exams, high-tech imaging or medical/surgical supplies.

Only one copayment should be collected per office visit.

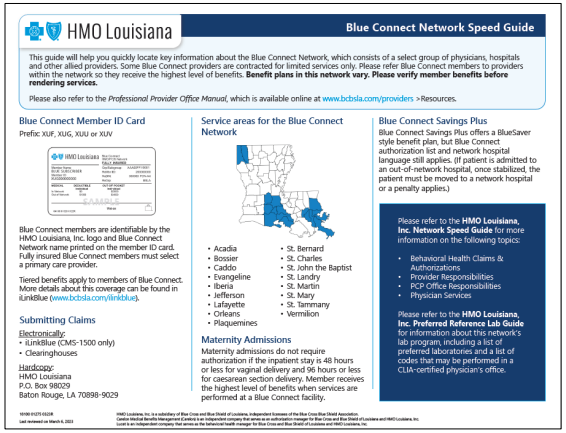
BlueCard® Program PPO

The BlueCard Program enables BCBS PPO members nationwide to obtain PPO benefits when they receive out-of-area services from PPO network providers. Our Preferred Care PPO network has been designated as the BlueCard PPO network that out-of-state members should access to receive the highest level of benefits from their health plans.

Providers may verify out-of-state member coverage by calling the BlueCard Eligibility Line at 1-800-676-2583. An operator will ask you for the member's prefix on the member ID card and will connect you to the member's Blue Plan.

If you are unable to locate a prefix on the member ID card, check for a phone number on the ID card. If that is not available, then call our Customer Care Center at 1-800-922-8866.

Please refer to the Preferred Care **PPO Preferred Reference Lab Guide** for information about this network's lab program.


HMO Louisiana

Blue Connect Network Speed Guide

This guide will help you quickly locate key information about the Blue Connect Network, which consists of a select group of physicians, hospitals and other allied providers. Some Blue Connect providers are contracted for limited services only. Please refer Blue Connect members to providers within the network so they receive the highest level of benefits. **Benefit plans in this network vary. Please verify member benefits before rendering services.**

Please also refer to the *Professional Provider Office Manual*, which is available online at www.bcbsla.com/providers >Resources.

Blue Connect Member ID Card

Prefix: XUF, XUG, XUU or XUV

Blue Connect members are identifiable by the HMO Louisiana, Inc. logo and Blue Connect Network name printed on the member ID card. Fully insured Blue Connect members must select a primary care provider.

Tiered benefits apply to members of Blue Connect. More details about this coverage can be found in iLinkBlue (www.bcbsla.com/ilinkblue).

Submitting Claims

Electronically:
- iLinkBlue (CMS-1500 only)
- Clearinghouses

Hardcopy:
HMO Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Service areas for the Blue Connect Network

- Acadia
- Bossier
- Caddo
- Evangeline
- Iberia
- Jefferson
- Lafayette
- Orleans
- Plaquemines
- St. Bernard
- St. Charles
- St. John the Baptist
- St. Landry
- St. Martin
- St. Mary
- St. Tammany
- Vermilion

Maternity Admissions

Maternity admissions do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for caesarean section delivery. Member receives the highest level of benefits when services are performed at a Blue Connect facility.

Blue Connect Savings Plus

Blue Connect Savings Plus offers a BlueSaver style benefit plan, but Blue Connect authorization list and network hospital language still applies. (If patient is admitted to an out-of-network hospital, once stabilized, the patient must be moved to a network hospital or a penalty applies.)

Please refer to the **HMO Louisiana, Inc. Network Speed Guide** for more information on the following topics:
- Behavioral Health Claims & Authorizations
- Provider Responsibilities
- PCP Office Responsibilities
- Physician Services

Please refer to the **HMO Louisiana, Inc. Preferred Reference Lab Guide** for information about this network's lab program, including a list of preferred laboratories and a list of codes that may be performed in a CLIA-certified physician's office.


Louisiana

providerTIDBIT

a guide to understanding our processes

Medical Record Guidelines for BlueCard®

1. Always direct medical records submissions to Blue Cross and Blue Shield of Louisiana when requested. You will be alerted of BlueCard medical record requests through our secure online tool iLinkBlue (www.BCBSLA.com/ilinkblue). These alerts will be visible on the iLinkBlue home page.

Welcome to iLinkBlue

Tips to Know

Medical Record Requests

You have 3 new Medical Record Requests that require actions.

Document Upload

2. If a claim denies for one of the following reasons: "lack of information received," "additional information needed" or "waiting on requested information," wait until you receive a medical records request in iLinkBlue before submitting records.

   For these types of denials, providers should wait 10 business days to allow us time to send a request for medical records. If you do not receive a request after 10 business days, contact customer service to verify the exact information needed.

3. Send medical records to us within 10 business days after receiving an alert.

4. Include a printed copy of the iLinkBlue medical record alert as the cover or first page of your submission.

Do NOT submit BlueCard Medical Records:
- unless you receive a request from Blue Cross and Blue Shield of Louisiana
- with a copy of the original claim as an attachment
- without the request for medical records notification from iLinkBlue attached
- by certified mail

Once confirmed that we received your records, please allow 30 days for Blue Cross and Blue Shield of Louisiana and/or the member's Blue Plan to complete the review process. If you receive no response after 30 days, please follow up with us by calling the Customer Care Center at 1-800-922-8866.

More

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Louisiana

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a guide to understanding our processes

Automated Benefits & Claim Status

Provider Services is an automated KEYPAD or VOICE RESPONSE telephone system designed to help providers reach the area of service needed. Use this guide to easily navigate this provider phone tool.

Customer Care Center 1-800-922-8866

Benefits are subject to the terms of a member's contract/certificate and our medical policies. Claims are subject to allowable charges, which are established by Blue Cross as the maximum allowed amount for services covered under the member contract/certificate.

Please have the following information ready when calling:
- Provider's NPI
- Provider's Tax ID Number
- Provider's ZIP Code
- Member ID Number
- Member's 8-digit Date of Birth
- Date of Service

Welcome to Blue Cross and Blue Shield of Louisiana Provider Services. To expedite your call please have the member identification number available. Which type of policy are you calling about?

1. Medical 2. Vision* 3. Dental 4. Life

(Pause for you to say or key-in a policy type)
Please say or enter your 10-digit NPI. (Pause for you to say or key-in NPI)
Please say or enter your nine-digit Tax ID. (Pause for you to say or key-in Tax ID)

*Note: If calling about a vision policy, you will be asked if your call is for routine eye coverage, such as an eye examine, prescription glasses, or contacts. Answer "yes" to route your call to an appropriate representative. Answer "no" to continue to the Provider Menu to reach the service needed.

Provider Menu

Provider menu. Which are you calling about?

1. Benefits
2. Claims
3. Authorizations
4. An Out-of-state Policy
5. A Payment Register Fax, or
6. None of the Above

More

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Provider tidbits are quick guides designed to help you with our current business processes.

www.bcbsla.com/providers
>Resources >Tidbits

iLinkBlue Highlights

Multi-factor Authentication verification for all iLinkBlue Users

- All iLinkBlue users are required to complete several verification steps before entering iLinkBlue (**www.bcbsla.com/ilinkblue**).

- Multi-factor Authentication (MFA) is a simplified, convenient and user-friendly self-service interface.

- Choose from various authentication methods, including email, text and smartphone authenticator app.

Security Setup Application

- Delegated Access, our security setup application for administrative representatives, is available through iLinkBlue only.
  - Replaced the existing Sigma Security Setup Tool previously used.
  - Gives administrative representatives a better user experience with simpler navigation while maximizing functionality.

If you have questions about these changes, please contact our Provider Relations Department at **provider.relations@bcbsla.com**.

Benefits Highlight

Tiered Benefits

Enhanced Tier 1 In-network Preferred	Tier 1 In-network Preferred	Tier 2 Out-of-network Preferred	Tier 3 Out-of-network Non-Preferred
Select providers in the Precision Blue network.	Providers in the member's network.	Providers participating with Blue Cross but NOT in the member's network.	Non-participating providers (do not participate in any Blue Cross network).
Member Benefit Plan:			
Precision Blue Only	• Blue Connect • Community Blue • Precision Blue • Signature Blue	• Blue Connect • Community Blue • Precision Blue • Signature Blue	• Blue Connect • Community Blue • Precision Blue • Signature Blue
Example Scenarios:			
• Precision Blue member sees a **select** Precision Blue network provider. • The accumulations and copayments identified as Enhanced Tier 1 are applied. • Provider may not bill the member for any amount over the allowed amount.	• Community Blue member sees a Community Blue network provider. • The accumulations, copayments and coinsurance identified as Tier 1 apply. • Provider may not bill the member for any amount over the allowed amount.	• A Community Blue member sees a Signature Blue network provider. • The accumulations, copayments and coinsurance identified as Tier 2 apply. • Provider may not bill the member for any amount over the allowed amount.	• A Community Blue member sees a non-participating provider. • The accumulations, copayments and coinsurance identified as Tier 3 apply. • Provider can bill the member for any amount over the allowed amount.

Billing Highlight

Submitting a Corrected Claim

When a claim is refiled for any reason, all services should be reported on the claim.

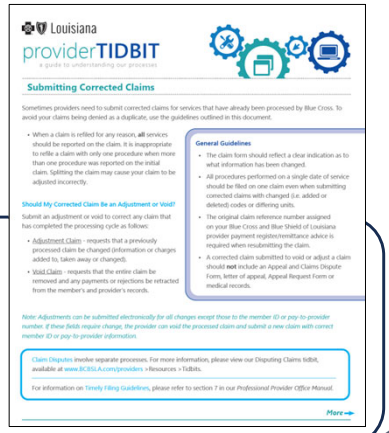
- Adjustment Claim – requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim – requests that the entire claim be removed, and any payments or rejections be retracted from the member's and provider's records.

Corrected claims submitted in the 837 format should include the following:

- In Loop 2300 Segment CLM05-03, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Loop 2300 in the REF segment, use "F8" as the qualifier and enter the original claim reference number.

Corrected claims submitted on a UB-04:

- In Block 4, Type of Bill, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Block 64, Document Control Number, enter the original claim reference number.


Louisiana
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a guide to understanding our processes

Submitting Corrected Claims

Sometimes providers need to submit corrected claims for services that have already been processed by Blue Cross. To avoid your claims being denied as a duplicate, use the guidelines outlined in this document.

- When a claim is refiled for any reason, **all** services should be reported on the claim. It is inappropriate to refile a claim with only one procedure when more than one procedure was reported on the initial claim. Splitting the claim may cause your claim to be adjusted incorrectly.

Should My Corrected Claim Be an Adjustment or Void?

Submit an adjustment or void to correct any claim that has completed the processing cycle as follows:

- Adjustment Claim - requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim - requests that the entire claim be removed and any payments or rejections be retracted from the member's and provider's records.

General Guidelines

- The claim form should reflect a clear indication as to what information has been changed.
- All procedures performed on a single date of service should be filed on one claim even when submitting corrected claims with changed (i.e. added or deleted) codes or differing units.
- The original claim reference number assigned on your Blue Cross and Blue Shield of Louisiana provider payment register/remittance advice is required when resubmitting the claim.
- A corrected claim submitted to void or adjust a claim should **not** include an Appeal and Claims Dispute Form, letter of appeal, Appeal Request Form or medical records.

Note: Adjustments can be submitted electronically for all changes except those to the member ID or pay-to-provider number. If these fields require change, the provider can void the processed claim and submit a new claim with correct member ID or pay-to-provider information.

Claim Disputes involve separate processes. For more information, please view our Disputing Claims tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

For information on Timely Filing Guidelines, please refer to section 7 in our *Professional Provider Office Manual*.

More→

For more information find our Submitting a Corrected Claim Tidbit at **www.bcbsla.com/providers** >Resources >Tidbits.

Authorizations Highlights

Tips for Online Authorizations in iLinkBlue

Troubleshooting tips for navigating BCBSLA Authorizations application:

- **Recurrent/Ongoing Services**: Use the initial authorization when the requested service code (CPT®/HCPC) and provider(s) are the same, even if a break in service has occurred. Do NOT create a new authorization. New authorizations will be voided in the system. Please initiate a new Activity in the original case and document the information in the "note" section of the Activity. Make sure the Activity is assigned to "Provider Request Worklist."
- **Member Search**: When searching for a member, enter the numbers following the three-character prefix. Do not enter the three characters in front of the member number on the ID card. The only instance where you would enter a letter in front of the member ID number is if the member number starts with an "R." The member ID number should be entered in the "Subscriber ID" field, not the "Member ID" field.
- **Overdue Tasks**: These tasks will not be visible on the "My Tasks" tab. To see your overdue tasks/activities, click on the "Overdue" tab.
- **Provider Access**: Users should use their own individual iLinkBlue login information to view authorizations. Provider groups with multiple iLinkBlue users should not login with the same user information.

BCBSLA Authorizations Application FAQs

What if my request is STAT, am I still required to use the authorization online?

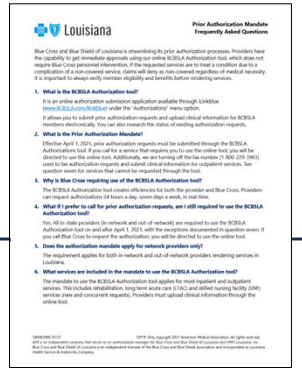
- Yes. Please submit STAT requests through the BCBSLA Authorizations application. They will be addressed timely and accordingly.

How do I check the status of my authorization in the BCBSLA Authorizations application?

- You may search by the patient's member ID number (found on the member ID card). You may also search by the reference number of the pending request.

How do I submit clinical information to Blue Cross?

- Clinical information can be supplied in one of three ways:
  - Complete criteria review via InterQual (IQ). You may receive an online approval when IQ is completed, and criteria are met. Some services will require additional review, such as a benefit review or a medical policy review regardless of an IQ approval. Completing an IQ review is not required.
  - Upload clinical information to the authorization request through the BCBSLA Authorizations application.
  - Document the clinical information in the notes section of the authorization request in the BCBSLA Authorizations application. You must then generate an activity within the request. If an activity is not generated, the clinical information will not be available for Blue Cross to review.


Louisiana

Prior Authorization Mandate
Frequently Asked Questions

Blue Cross and Blue Shield of Louisiana is streamlining its prior authorization processes. Providers have the capability to get immediate approvals using our online BCBSLA Authorization tool, which does not require Blue Cross personnel intervention. If the requested services are to treat a condition due to a complication of a non-covered service, claims will deny as non-covered regardless of medical necessity. It is important to always verify member eligibility and benefits before rendering services.

1. **What is the BCBSLA Authorization tool?**
   It is an online authorization submission application available through LinkBlue (www.BCBSLA.com/BlinkBlue) under the "Authorizations" menu option.
   It allows you to submit prior authorization requests and upload clinical information for BCBSLA members electronically. You can also research the status of existing authorization requests.
2. **What is the Prior Authorization Mandate?**
   Effective April 1, 2021, prior authorization requests must be submitted through the BCBSLA Authorizations tool. If you call for a service that requires you to use the online tool, you will be directed to use the online tool. Additionally, we are turning off the fax number (1-800-229-3963) used to fax authorization requests and submit clinical information for outpatient services. See question seven for services that cannot be requested through the tool.
3. **Why is Blue Cross requiring use of the BCBSLA Authorization tool?**
   The BCBSLA Authorization tool creates efficiencies for both the provider and Blue Cross. Providers can request authorizations 24 hours a day, seven days a week, in real time.
4. **What if I prefer to call for prior authorization requests, am I still required to use the BCBSLA Authorization tool?**
   Yes. All in-state providers (in-network and out-of-network) are required to use the BCBSLA Authorization tool on and after April 1, 2021, with the exceptions documented in question seven. If you call Blue Cross to request the authorization, you will be directed to use the online tool.
5. **Does the authorization mandate apply for network providers only?**
   The requirement applies for both in-network and out-of-network providers rendering services in Louisiana.
6. **What services are included in the mandate to use the BCBSLA Authorization tool?**
   The mandate to use the BCBSLA Authorization tool applies for most inpatient and outpatient services. This includes rehabilitation, long-term acute care (LTAC) and skilled nursing facility (SNF) services (new and concurrent requests). Providers must upload clinical information through the online tool.

View our Prior Authorization Mandate Frequently Asked Questions at **www.bcbsla.com/providers** >Electronic Services >Authorizations, under the quick links section.

OGB Authorizations

OGB authorization requirements are different. **Failure to obtain an authorization will result in denial of payment for services.**

OGB PLAN SERVICES REQUIRING AUTHORIZATION

Plan authorization is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary. When Medicare is primary, an authorization is required once the combined benefit limit of 50 visits of PT/OT have been achieved. Providers may request authorization by calling our Authorization line. Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans.

INPATIENT

- Hospital Admissions (except routine maternity stays*)
- Mental Health/Substance Use Disorder Admissions
- Organ, Tissue and Bone Marrow Transplant Services
- Skilled Nursing Facility

* Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for cesarean section delivery.

**Request for prior authorization for these services are handled directly by AIM Specialty Health (AIM).

STOP

Failure to obtain prior authorization for these services for OGB members will result in denial of payment for services.

OUTPATIENT

- Air Ambulance – Non-Emergency (no benefit without prior authorization)
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- CT Scans**
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000, including but not limited to defibrillators and insulin pumps
- Infusion Therapy – includes home and facility administration (exception: Physician's office, unless the drug to be infused may require authorization)
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA**
- Nuclear Cardiology**
- Oral Surgery (not required when performed in a Physician's office)
- Organ Transplant Evaluation
- Orthotic Devices (greater than $300)
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET Scans**
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Residential Treatment Centers
- Sleep Studies (except those performed as a home sleep study)
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknifeprocedures
- Vacuum Assisted Wound Closure Therapy

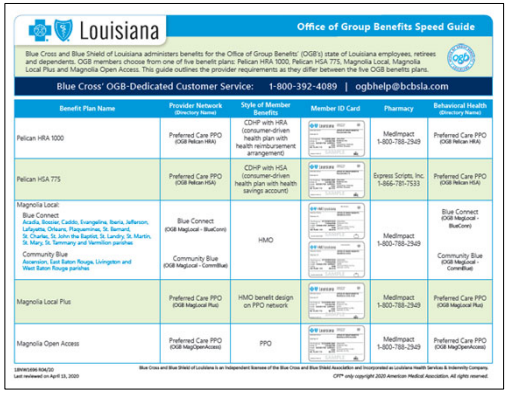
Louisiana

Blue Cross and Blue Shield of Louisiana
Member Provider Policy & Procedure Manual

4-10
December 2018

The list of OGB authorization requirements can be found in our *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.bcbsla.com/ilinkblue**, click on "Resources," then "Manuals."

The list also appears on the OGB Speed Guide located on **www.bcbsla.com/providers** >Resources.



Louisiana — Office of Group Benefits Speed Guide

Blue Cross and Blue Shield of Louisiana administers benefits for the Office of Group Benefits' (OGB's) state of Louisiana employees, retirees and dependents. OGB members choose from one of five benefit plans: Pelican HRA 1000, Pelican HSA 775, Magnolia Local, Magnolia Local Plus and Magnolia Open Access. This guide outlines the provider requirements as they differ between the five OGB benefits plans.

Blue Cross' OGB-Dedicated Customer Service: 1-800-392-4089 | ogbhelp@bcbsla.com

Benefit Plan Name	Provider Network (Directory Name)	Style of Member Benefits	Member ID Card	Pharmacy	Behavioral Health (Directory Name)
Pelican HRA 1000	Preferred Care PPO (OGB Pelican HRA)	CDHP with HRA (consumer-driven health plan with health reimbursement arrangement)		MedImpact 1-800-788-2949	Preferred Care PPO (OGB Pelican HRA)
Pelican HSA 775	Preferred Care PPO (OGB Pelican HSA)	CDHP with HSA (consumer-driven health plan with health savings account)		Express Scripts, Inc. 1-866-781-7533	Preferred Care PPO (OGB Pelican HSA)
Magnolia Local: Blue Connect: Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany and Vermilion parishes. Community Blue: Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes	Blue Connect (OGB MagLocal - BlueConn) Community Blue (OGB MagLocal - CommBlue)	HMO		MedImpact 1-800-788-2949	Blue Connect (OGB MagLocal - BlueConn) Community Blue (OGB MagLocal - CommBlue)
Magnolia Local Plus	Preferred Care PPO (OGB MagLocal Plus)	HMO benefit design on PPO network		MedImpact 1-800-788-2949	Preferred Care PPO (OGB MagLocal Plus)
Magnolia Open Access	Preferred Care PPO (OGB MagOpenAccess)	PPO		MedImpact 1-800-788-2949	Preferred Care PPO (OGB MagOpenAccess)

Find a copy of the OGB Speed Guide at **www.bcbsla.com/providers** >Resources >Speed Guides.

HEDIS Highlights

Administrative Method

- **Claims/Encounter data** is essential for measuring and monitoring quality, service utilization and differences in members' health care needs.
- **Correct coding of claims** is also very important. If a service or diagnosis is not coded correctly, the data may not be captured for HEDIS and may not be reflected accurately in the resulting quality scores.

Administrative data and accurate coding help us to better understand and meet the health care needs of our members, your patients.

Administrative Method: Supplemental Data

Standard Supplemental data are electronically generated files that come from service providers.

- Providers can submit data electronically to the health plan using the approved electronic medical record (EMR) Common Clinical Model layout.

Nonstandard supplemental data is used to capture missing service data not received through claims or encounters or in the standard electronically generated files described above.

- May be collected on an irregular basis (sometimes referred to as year-round HEDIS).
- Providers can allow remote access to EMRs.

Hybrid Method

Medical Records: Some HEDIS data cannot be collected through claims or historical data. It is very important that providers document medical records appropriately to abstract this HEDIS data from the medical records.